Substance Use Disorders and Harm Reduction

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Objectives:

1) To outline the basic principles of harm reduction and how to integrate these principles into clinical practice.

2) To provide an overview of harm reduction in hospital and community settings.

3) To present and critically analyze a reflective case study as it relates to harm reduction and substance use.
Introduction to Services

- Hours of operation 9-5 M-F.
- Contact Pager – 416-692-7539
- Inpatient consultation to all areas of the hospital
- Rapid Access Clinic M-W-F from 9-11
- Groups from 3-5 pm Tuesday and Thursday
- Community Case Management
- Peer Support
Harm Reduction

Aims to reduce the adverse health, social, and economic consequence of without reducing the substance consumption

(Canadian Nurses Association, 2017)

Harm reduction is NOT a one-size-fits
Key Principles of Harm Reduction

1) Focuses on reducing harms associated with a broad range of substances.
2) Does not require abstinence.
4) Empowers people (informed decisions/choice)
5) Non-judgmental.
6) Cost effective and evidence based.

(Canadian Nurses Association, 2017)
Goal of Harm Reduction for Healthcare Providers

To prevent death and disability by supporting safer substance use for:

- Clients
- Families
- Communities

(Canadian Nurses Association, 2018)
In Canada in 2014 substance use cost $38.4 billion:
- health care costs
- lost productivity
- criminal justice system
- other direct costs

(Canadian Centre of Substance Use and Addiction, 2018)

The prevalence of substance use in Canada is 11%.

(Hering, et al. 2014)
# Opioid Related Deaths 2016 and 2017 in Canada

<table>
<thead>
<tr>
<th>Manner of Death</th>
<th>2016</th>
<th></th>
<th>2017</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>Accident (unintentional)</td>
<td>2624</td>
<td>88%</td>
<td>3671</td>
<td>92%</td>
</tr>
<tr>
<td>Suicide</td>
<td>258</td>
<td>9%</td>
<td>173</td>
<td>4%</td>
</tr>
<tr>
<td>Undetermined</td>
<td>96</td>
<td>3%</td>
<td>143</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2978</td>
<td></td>
<td>3987</td>
<td></td>
</tr>
<tr>
<td>(Government of Canada, 2018)</td>
<td></td>
<td>= 25% increase in opioid deaths</td>
<td></td>
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</tbody>
</table>
### Accidental opioid-related deaths involving fentanyl or fentanyl analog (Government of Canada, 2018)

<table>
<thead>
<tr>
<th>Province or territory (top 3)</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>British Columbia</td>
<td>656</td>
<td>67%</td>
</tr>
<tr>
<td>Alberta</td>
<td>352</td>
<td>64%</td>
</tr>
<tr>
<td>Ontario</td>
<td>330</td>
<td>45%</td>
</tr>
<tr>
<td>Canada</td>
<td>1424</td>
<td>55%</td>
</tr>
</tbody>
</table>
People Who Use Drugs (PWUD) – AWOL SMH

• Jan 1 2013 – Dec 31, 2016
• Substance use as a person who had a diagnosis at ANY visit, including diagnoses after an AMA encounter

• 99,622/yr (on avg) visits to ED with 15,174 (15.2%) suspected to have an SUD

• 34,186/yr (on avg) inpatient visits, with 1,843 (5.4%) suspected to have an SUD (Guimond et al., 2018)
• **3.02** (CI pending) of leaving AMA from the ED once seen by MD

• **15.10** (CI pending) to leave hospital AMA once admitted

(Guimond et al., 2018)
Infectious Disease Associated with IDU

1) Anthrax
2) Botulism
3) Group A Streptococcal Disease
4) Hepatitis B and C
5) HIV/AIDS
6) Malaria
7) Meningitis (bacterial, viral, and others)
8) Streptococcus pneumonia
9) Tetanus
10) Other

(Durham Region Health Department, 2016)
IDU and infections

- Higher rates of:
  - infective endocarditis
  - abscesses
  - septicemia

  = need to complete antibiotic therapy

  (Billick, 2017)
Injecting into PICC lines

- Injecting into PICC lines versus injecting in veins
  - no evidence to support higher infection rates
  - increase overdose rate
  - increase morbidity or mortality

(Billick, 2017)
Systematic Review – Supervised Injection Sites

- To identify current available evidence regarding SIS – induced benefits and harms
- 75 articles met inclusion criteria
- 85% of articles originated from Canada or Australia, although most SIS are located in Europe
- In Canada much of research done in Vancouver. (Potier et al., 2014)
Systematic Review Findings

- Attracting the most marginalized people
- All promoted safer injection
- Enhanced access to primary health care
- Reduced overdose frequency
- Enhanced connection with addiction and social services
- Decreased injecting in public and fewer dropped syringes
- Effective in educating around infectious disease spread such as HIV and Hep C

(Potier et al., 2014)
• SIS did not increase injecting or trafficking in the surrounding environments
• Barrier some parts of population (people under 18, pregnant women, and people who cannot self inject did not have equal access)  
  (Potier et al., 2014)
IDU Rates

- 16 million people inject drugs worldwide
- 125,000 inject drugs in Canada in major cities (Montreal, Ottawa, Toronto)

(Jozaghi & Reid, 2015)
Safe Injections Sites in Toronto Cost Effective

- Cost savings of $728,620 per year for two safe injection sites – conservative estimate
- Based on HCV and HIV prevention (HIV infected IDU = 4% and HCV infected = 70%)
- Cost of HCV per lifetime per person $30,000-$69,188 Canadian
- Cost of HIV per lifetime per person $174,410-$667,000 Canadian

(Jozaghi & Reid, 2015)
Harm Reduction Activities

- Naloxone distribution (onset 2-4 min, last 45)
- Opioid patch return programs
- HIV pre-exposure prophylaxis (PrEP) (↓48.9%)
- Safe injection sites
- Needle exchange program / clean needles
- Opiate replacement Methadone/Suboxone
- Daily observed dosing of controlled substances
- Safely injecting into Picc lines
- Condoms and birth control
- Safer smoking kits

(Durham Region Health Department, 2016)
Harm Reduction in Hospital Settings

- Decrease stigma
- Partner with people with lived experience
- Staff and patient education
- Timely referral to the Addiction Service
- Adequately treat withdrawal and cravings
  - Medication assisted therapy
  - Reduce number of AWOLS
  - Improve outcomes – antibiotics (Sharma et al., 2017).
Harm Reduction in Hospitals Con’t

• Offer
  - safe injections sites
  - safe injection/safer smoking kits
  - naloxone distribution /PrEP
  - screening for TB, HIV, Hep C, etc.
  - sexual counselling/contraception
  - vaccinations – Hep B, etc.

• Discharge education/ Networking
  - information on harm reduction supplies
  - harm reduction resources

(Sharma et al., 2017).
Harm Reduction in the Community

Rapid Access Clinic (RAC)

- Outpatient drop in clinic for addictions
- Monday, Wednesday, Friday 0900-1100
- 1 Staff MD, NP or resident, 1 RN, 1 Community Case Worker
- Access to addiction medicine, and connecting to community supports
- No requirement for abstinence
Harm Reduction in the Community

Withdrawal Management Services (WMS)

- 16 bed Men only detox
- Voluntary admission
- Supportive stay up to 1 week
- Access to 2 Human Service Counselor’s and 1 RN
- Assistance in connecting to community resources and treatment
- Abstinence required while at detox
- Non-medical
Harm Reduction in the Community

Addictions Groups

- Thursdays from 1530-1700
- Engagement group based in Motivational Interviewing
- Community Reinforcement Approach (CRA) and Cognitive Behavioural Therapy (CBT)
- SMH Day Program Monday-Friday at Fred Victor
- No requirement for abstinence
Harm Reduction in the Community

- Naloxone Kit
- NA
- Harm Reduction
- Clean Needle Kit
- Abstinence vs. Non Abstinent
- Clean Crack Kit
- WMS
- Medical Model
- Peer Support
- Education
- CA
- AA

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Case Study

Our case study today is a 40 year old male with a 6 plus year history of daily IVDU. He has had at least 8 ICU/CCU admissions over a 24 month period. He was diagnosed with infective endocarditis and underwent major surgery. Prior to his substance use he was a successful business owner and a commercial landlord. Our patient subsequently lost his home, his business and his properties.

Our patient states he dreads the stigma he typically is confronted with from the hospital frontline care providers.
Case Study Questions

1) What else do you need to know about Mr. M.?
2) Should Mr. M. have a Picc line?
3) What is better for Mr. M. harm reduction or abstinence and why?
4) What harm reduction teaching do you feel Mr. M. needs?
5) Is there any hope for people who inject drugs? Yes, no, or maybe?
6) How would your treatment approach differ if Mr. M. was a relative, friend, or co-worker?
Questions

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