

# Can we make hospitals safe for people who use drugs?

## Lessons from Halifax & beyond

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PGY5 General Internal Medicine  
Dalhousie University & Nova Scotia Health

NLCSU Conference – November 9, 2023

# Acknowledgments & Disclosures

- I live and work in Mi'kma'ki, the ancestral and unceded territory of the Mi'kmaq. We are all Treaty people.
- The generosity of people with lived/living experience of criminalized drug use, who share their knowledge and experience with me.
- The generosity of colleagues across the country.
- No relationship with industry.

# Key messages

1. Hospitals should partner with and learn from community-based harm reduction organizations who are already doing this work.
2. People who use drugs are experts in their own lives and should have leadership role in improving care and policies.
3. Advocacy outside “the system” can be quicker but additional strategies are needed for sustainable change.

# Outline

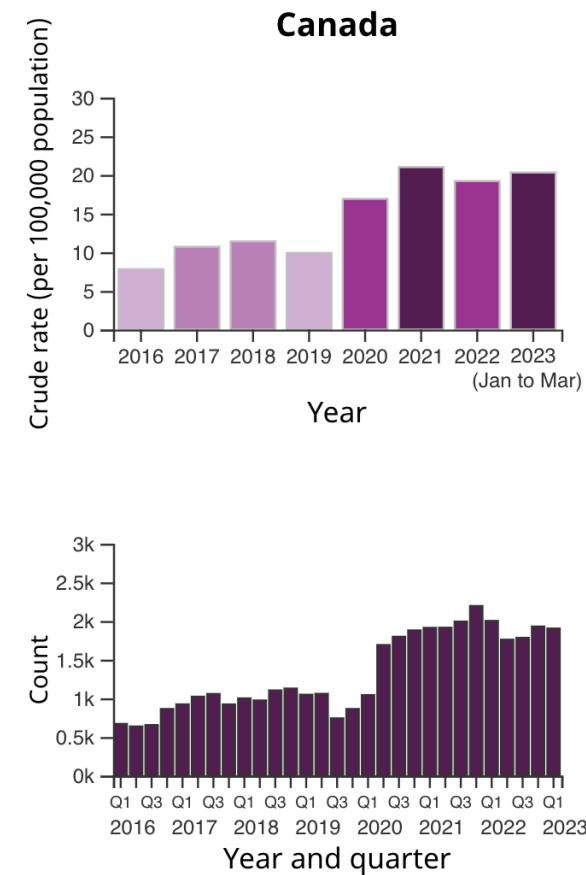
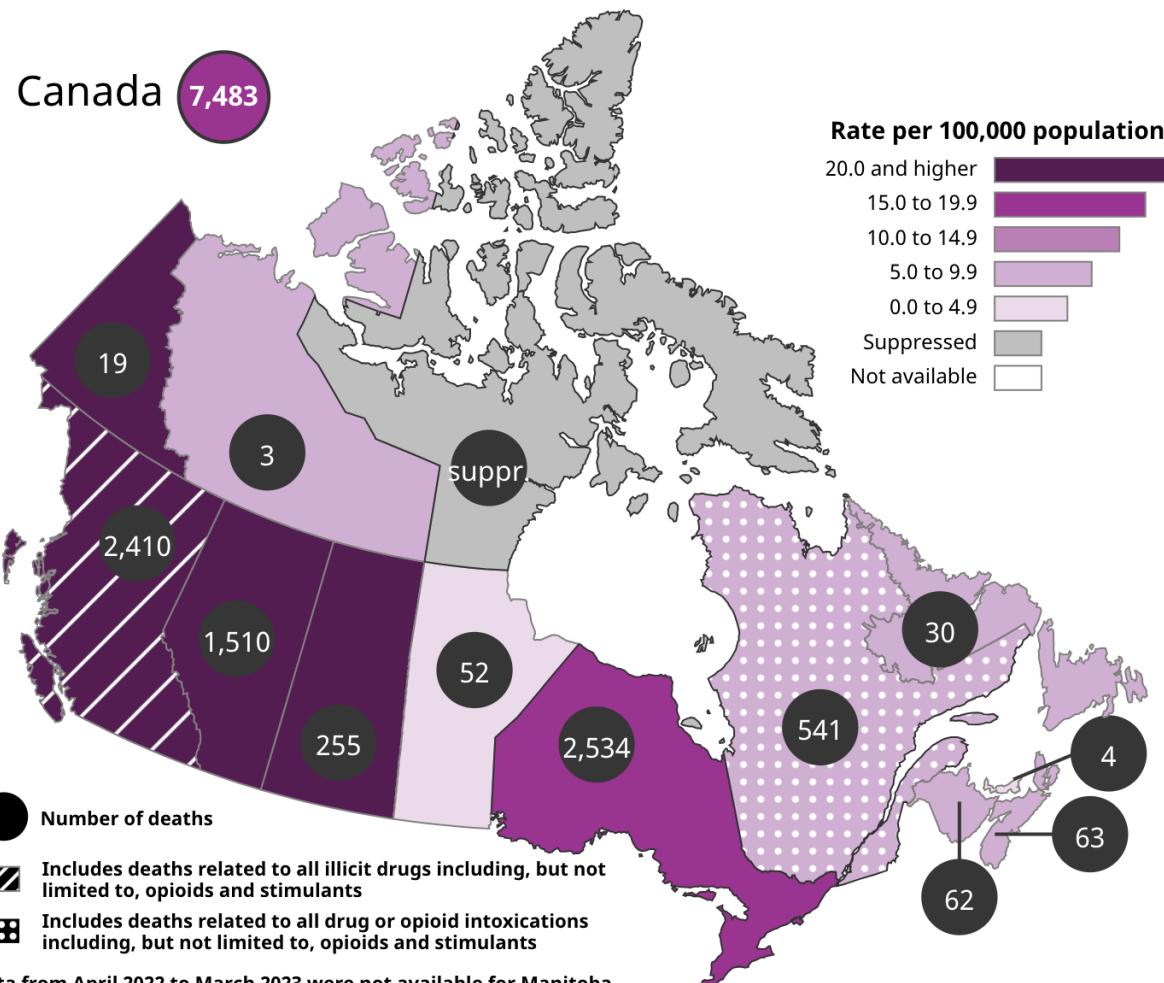
1. Hospitals as high-risk environment for people who use drugs
2. Our journey in Halifax:
  - Need assessment
  - Hospital “in-reach”
  - Opioid withdrawal & opioid agonist treatment
  - Addiction medicine consult service
  - Take-home naloxone kits
  - Sterile injecting equipment
  - Policy development
3. Reflections and next steps

- 26yo M with S. aureus endocarditis
- Developed cellulitis and skin abscess three weeks ago
- Injects 48-72mg hydromorphone per day
  - (960-1440mg oral morphine equivalents)
- Multiple recent overdoses; more fentanyl use
- Staying on friends' couch
- Pain; leaving hospital multiple times
- “Well, I don’t want to die”

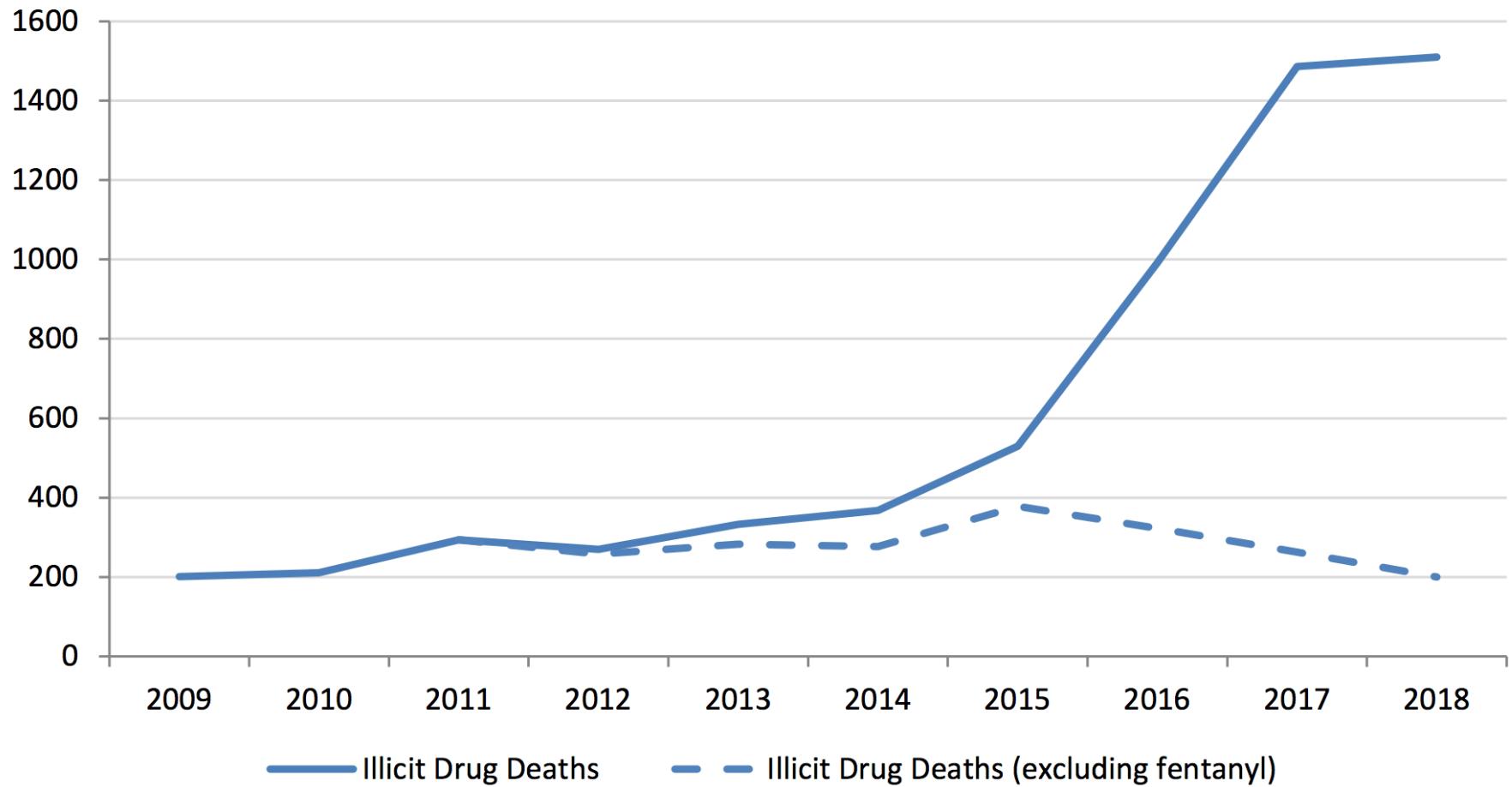


# Hospitals as high-risk environments

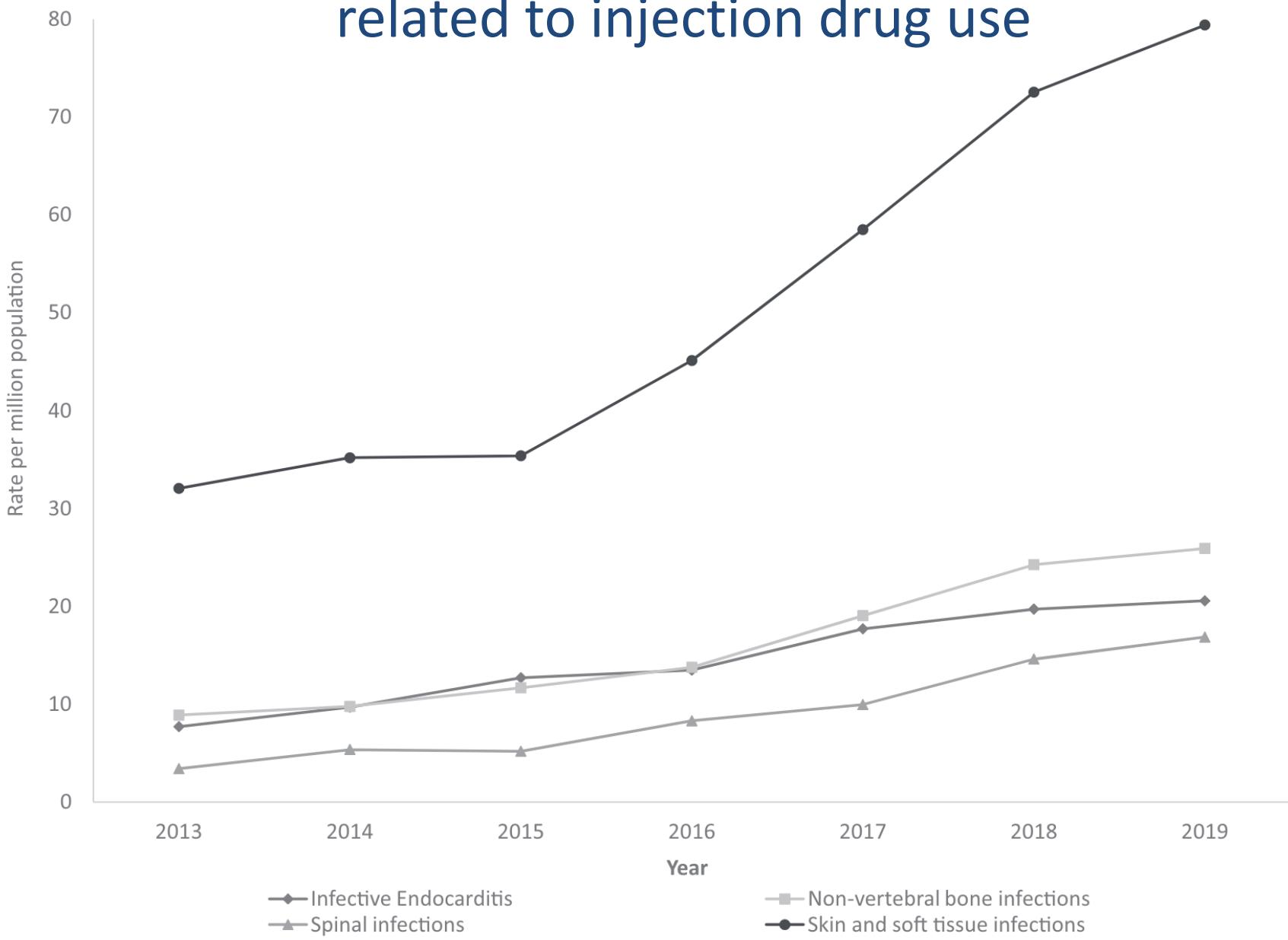
# Overdose Deaths in Canada in 2022



# Overdose Deaths in British Columbia, 2009-2018

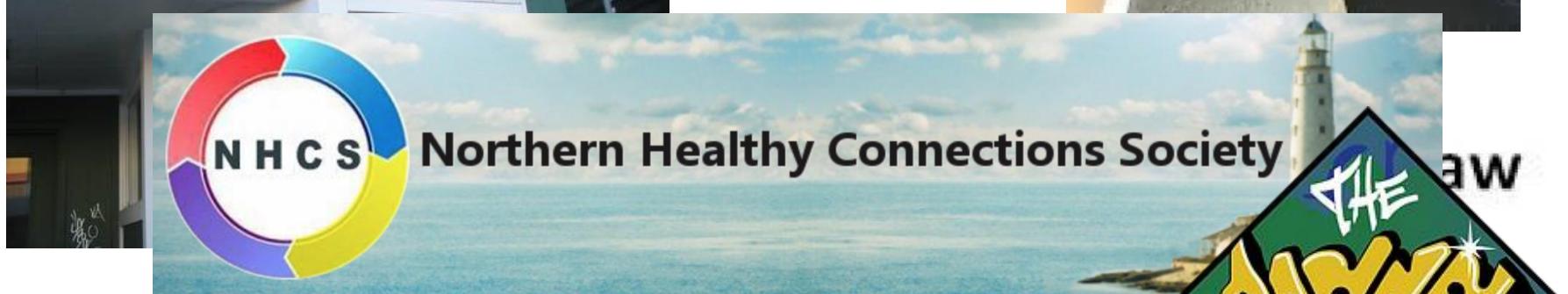


# Increasing rates of bacterial infections related to injection drug use





Substance User Network  
of the Atlantic Region



ReFi





# Hospitals as high-risk environments

- Abstinence only policies (written or unwritten)
- Lack of harm reduction supports
- Stigma

- Delayed presentation for care
- Inadequate pain & withdrawal management
- Premature discharges “against medical advice”

- Poor treatment outcomes
- Increased morbidity and mortality for people who use drugs



I had to get out of there while I could move because I was losing so much weight... When I begged and begged to get some help [i.e., prescription opioids], they couldn't, weren't gonna do anything and so I just said, "Fine, I'm leaving." [...] I was concerned [*about the health consequences of leaving hospital*]. You know, I got this other thing [*opiate dependency*] and it's...it's like you're stuck between a rock and a hard spot. I mean, how can I even fight off the infection if I can't stop puking and shitting? [*Participant #15, Caucasian Female, 47 years old*]

<sup>a</sup>British Columbia Centre for Excellence in HIV/AIDS, St. Paul's Hospital, 608-1081 Burrard Street, Vancouver, BC V6Z 1Y6, Canada

<sup>b</sup>Faculty of Health Sciences, Simon Fraser University, Burnaby, BC, Canada

[*Security guards*] yell and scream at you...When there's nobody around, [they say], "You fucking junkie." [...] A few times, I've been shaken down [searched] by [*security guards*] even though [I had] nothing to get high [i.e., *had no drugs in her possession*]. They search you, destroy your property, cause a scene, and make sure everybody there knows that you're a drug addict. [...]They use their authority to pull power trips more or less. It's not right. [*Participant #12, Aboriginal Female, 29 years old*]

in ongoing observational cohort studies of people who inject drugs who reported that they had been discharged from hospital against medical advice within the previous two years. Data were analyzed thematically, and by drawing on the 'risk environment' framework and concepts of social violence. Our findings illustrate how intersecting social and structural factors led to inadequate pain and withdrawal management, which led to continued drug use in hospital settings. In turn, diverse forms of social control



## Social Science &amp; Medicine

They [*i.e. nurses*] don't give rigs [*i.e. syringes*] to us...I think that they should. If not, we're reusing our rigs or we're having to risk getting kicked out for stealing them or people'll be sharing them. [...] I know one girl was using her same rig for days to the point where it was tearing and she was suffering every time she'd do her fix. She just didn't have it in her to go and try and steal clean rigs. Whereas for me, my friend that I was with had no problem. She would just sneak in and grab some for both of us. [*Participant #30, Aboriginal Female, 28 years old*]

<sup>a</sup>British Columbia Centre for Excellence in HIV/AIDS, St. Paul's Hospital, 608-1081 Burrard Street, Vancouver, BC V6Z 1Y6, Canada

<sup>b</sup>Faculty of Health Sciences, Simon Fraser University, Burnaby, BC, Canada

<sup>c</sup>Department of Medicine, University of British Columbia, Vancouver, BC, Canada

If you're sharing a room with somebody, there's always that threat that somebody's just gonna come in and not realize you're in there [*the bathroom*] and open [*the door*]. [...] I think they pretty much have zero tolerance in [*the hospital*]. I was worried about getting kicked out and then not getting the proper health care that I needed to get better. [...] I'd turn the tap so, if they came in my room to check to see if I was okay, then they'd hear the water running so they'd figure oh she's just in the bathroom. [*Participant #25, Caucasian Female, 44 years old*]

## RESEARCH ARTICLE

# Fatal opioid overdoses during and shortly after hospital admissions in England: A case-crossover study

Dan Lewer<sup>1,2,3\*</sup>, Brian Eastwood<sup>1</sup>, Martin White<sup>1</sup>, Thomas D. Brothers<sup>1,3,4</sup>,  
Martin McCusker<sup>5</sup>, Caroline Copeland<sup>1,6,7</sup>, Michael Farrell<sup>1,3</sup>, Irene Petersen<sup>1,8</sup>

- Study of >13,000 opioid overdose deaths in England (2010-2019)
- Same risk during hospitalization as during time in community
- Four times higher risk in first few days after hospital discharge compared to time out of hospital
- Eight times higher risk if discharge was “against medical advice”

# “Care” we offered in 2015

- Refused to provide opioid medications “because they are addicted to opioids”
  - Stigmatizing and judgmental language
  - Restricted from leaving unit “because they might use drugs”
- 
- Left hospital prematurely
  - Blamed for “noncompliance”
  - Returned to ED even sicker
- 
- Mainline needle exchange supported them throughout



How can we make things  
better?

Our journey in Halifax



2015

Provincial  
health authority  
amalgamation

Policy vacuum



# Ongoing hospital in-reach



MOBILE OUTREACH  
STREET HEALTH



# Learning from community



Natasha

Natasha Pace



John Fraser



Patti Melanson

# Needs assessment

PLOS ONE

RESEARCH ARTICLE

## Unequal access to opioid agonist treatment and sterile injecting equipment among hospitalized patients with injection drug use-associated infective endocarditis

Thomas D. Brothers  <sup>1,2\*</sup>, Kimiko Mosseler<sup>3</sup>, Susan Kirkland<sup>1,4</sup>, Patti Melanson<sup>5†</sup>, Lisa Barrett<sup>1,6</sup>, Duncan Webster<sup>1,7</sup>

**1** Department of Medicine, Dalhousie University, Halifax, Nova Scotia, Canada, **2** UCL Collaborative Centre for Inclusion Health, Institute of Epidemiology and Health Care, University College London, London, United Kingdom, **3** Dalhousie Medicine New Brunswick, Dalhousie University, Saint John, New Brunswick, Canada, **4** Department of Community Health & Epidemiology, Dalhousie University, Halifax, Nova Scotia, Canada, **5** Mobile Outreach Street Health (MOSH), Halifax, Nova Scotia, Canada, **6** Division of Infectious Diseases, Nova Scotia Health, Halifax, Nova Scotia, Canada, **7** Division of Infectious Diseases, Saint John Regional Hospital and Dalhousie University, Saint John, New Brunswick, Canada

† Deceased.

\* [thomas.brothers.20@ucl.ac.uk](mailto:thomas.brothers.20@ucl.ac.uk)



# Harm reduction policies at Saint John Regional Hospital

## INTRAVENOUS N

Sta



Atlantic Health Sciences Corporation  
Corporation des sciences de la santé de l'Atlantique

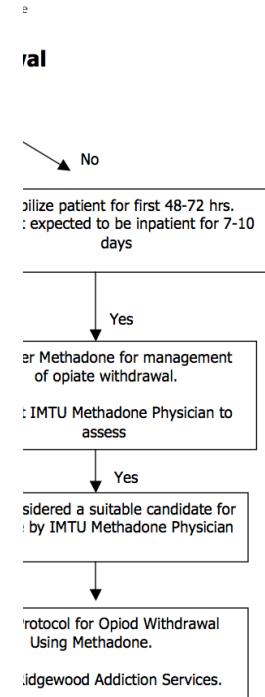
1. Sharps containers will be provided for all prescription parenteral infusions.
2. Needles will be provided on a regular basis, to include period of hospitalization and in consideration of discharge.
3. Safe injection sites will be identified and respected in consideration of patient safety.
4. In unusual circumstances, patients will be consulted for assistance by the IMTU Methadone Physician or departmental chief resident.
5. Patients with parenteral non-prescription drugs will be placed in their bed. This will minimize the risk of needle exchange.

## Appendix E

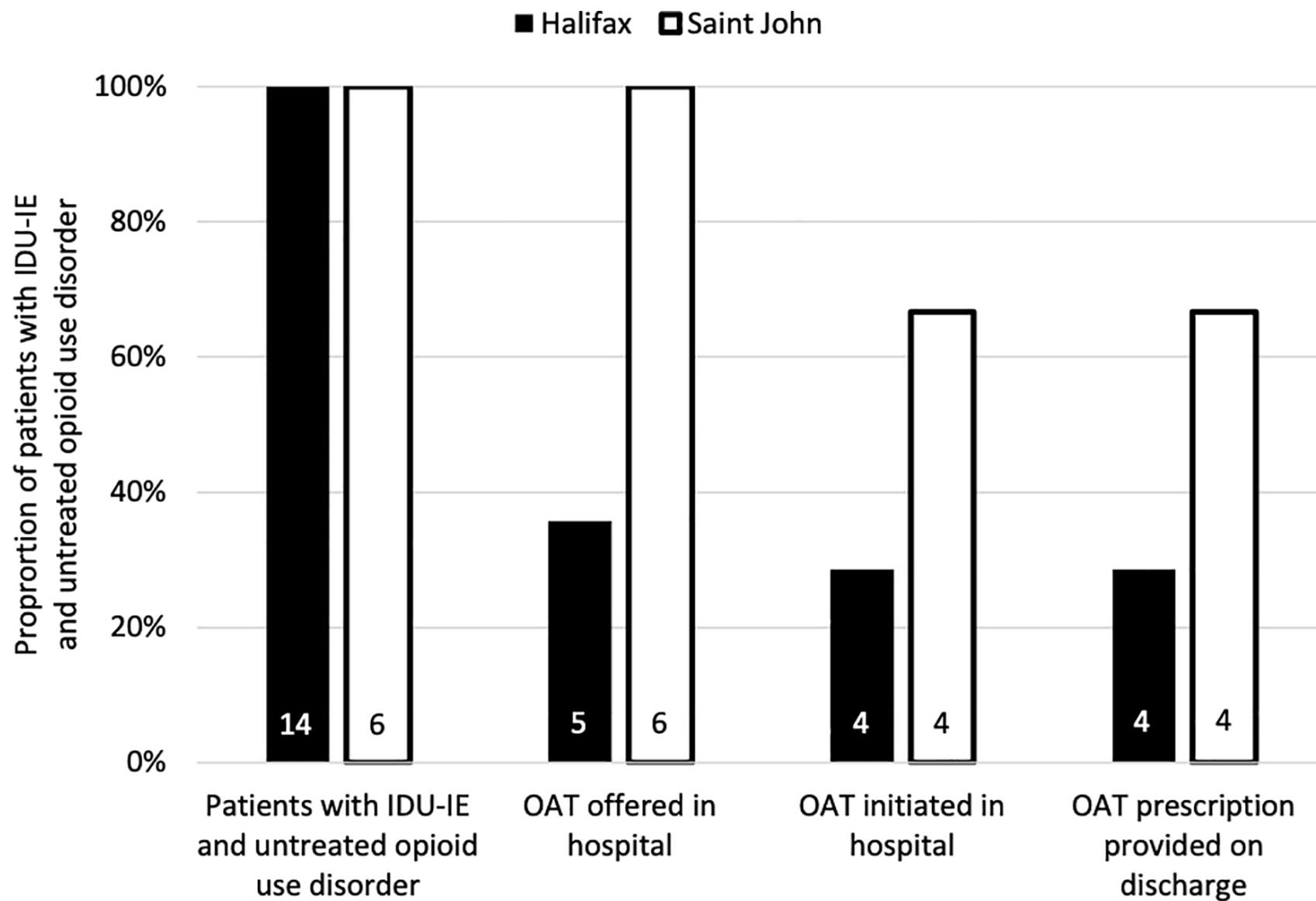
### Protocol for Opioid Withdrawal Order Guide

1. Complete Drug Inventory Assessment Form
2. Have patient sign the Patient Agreement for Management of Opioid Withdrawal
3. Labs completed on Admission:
  - Hepatitis A Total (IgG+IgM)
  - Hepatitis B surface antigen
  - Hepatitis B surface antibody or Hepatitis B titre to check immunity
  - Hepatitis C screen
  - HIV Screen
  - RPR
  - Pregnancy test (urine). If pregnant, place patient on opiate maintenance and consult Obstetrics. If history suggests possibility of early pregnancy, confirm with serum beta HCG.
  - Urine for Gonorrhea, Chlamydia
  - PPD (Protein Purified Derivative 0.5 TU intradermally)
  - Urine Abuse Screen on admission and weekly thereafter
4. Vaccinations (all vaccinations should be entered to be administered 72 hours after administration)
  - Assess for previous adverse reactions or contraindications
  - Twinrix vaccine (Hepatitis A & B)1.0 ml IM Q 7 days times three doses. Day 0 \_\_\_, Day 7 \_\_\_, Day 14 \_\_\_. Do not wait for hepatitis serology results before giving first dose. Advise patient that a booster dose will be required at 12 months.
  - Engenerix-B 20 mcg (1.0 ml) IM Q7 days times 3 doses: Day 0 \_\_\_, Day 7 \_\_\_, Day 14 \_\_\_. Advise patient that a booster will be required at 12 months.
  - Pneumovax 0.5 ml IM given on \_\_\_\_\_ if never received and no contraindications
  - Td Booster0.5 ml IM given on \_\_\_\_\_ if none received in past 10 years
  - Influenza vaccine 0.5 ml given on \_\_\_\_\_ if available and no contraindications
  - Record vaccination in vaccine card at time of vaccination and give to patient prior to discharge.

## Appendix A



# Access to OAT in hospital



# Injecting equipment in hospital

	Halifax 21 hospitalizations	Saint John 17 hospitalizations
Offered sterile injecting equipment in hospital	0%	24%
Confiscated patients' own injecting equipment in hospital	24%	12%

# Unmet needs in hospital

	<b>Halifax</b> <b>21 hospitalizations</b>	<b>Saint John</b> <b>17 hospitalizations</b>
<b>Uncontrolled pain or undertreated opioid withdrawal</b>	76%	53%
<b>Illicit or non-medical substance use in hospital</b>	33%	29%
<b>Premature hospital discharges</b>	10%	12%

# Getting organized

SUBSTANCE ABUSE

<https://doi.org/10.1080/08897077.2020.1856291>



Taylor & Francis  
Taylor & Francis Group

BRIEF REPORT

OPEN ACCESS

Check for updates

## Implementation and evaluation of a novel, unofficial, trainee-organized hospital addiction medicine consultation service

Thomas D. Brothers, MD<sup>a</sup> , John Fraser, MD<sup>b</sup>, Emily MacAdam, MD<sup>a</sup> , Brendan Morgan, MD<sup>c</sup>, Jordan Francheville, MD<sup>a</sup> , Aditya Nidumolu, MD<sup>d</sup>, Christopher Cheung, MD<sup>c</sup>, Samuel Hickcox, MD<sup>e</sup>, David Saunders, MD<sup>f,g</sup>, Tiffany O'Donnell, MD<sup>h,i</sup>, Leah Genge, MD<sup>b,f,i</sup>, and Duncan Webster, MD<sup>a,j</sup>

<sup>a</sup>Department of Medicine, Dalhousie University, Halifax, Nova Scotia, Canada; <sup>b</sup>Mobile Outreach Street Health, North End Community Health Centre, Halifax, Nova Scotia, Canada; <sup>c</sup>Department of Anesthesia, Pain Management & Perioperative Medicine, Dalhousie University, Halifax, Nova Scotia, Canada; <sup>d</sup>Department of Psychiatry, Dalhousie University, Halifax, Nova Scotia, Canada; <sup>e</sup>Mental Health and Addictions, Nova Scotia Health Authority, Halifax, Nova Scotia, Canada; <sup>f</sup>Direction 180, Halifax, Nova Scotia, Canada; <sup>g</sup>The Open Door Clinic, Dartmouth, Nova Scotia, Canada; <sup>h</sup>Hospitalist Medicine Unit, Nova Scotia Health Authority, Halifax, Nova Scotia, Canada; <sup>i</sup>Department of Family Medicine, Dalhousie University, Halifax, Nova Scotia, Canada; <sup>j</sup>Division of Infectious Diseases, Saint John Regional Hospital, Saint John, New Brunswick, Canada

- 82% of patients with untreated opioid use disorder started treatment in hospital
- 89% of these patients continued after discharge

**ORDER SET**

Department, Division

**Order Title**

Patient: \_\_\_\_\_ Allergies: \_\_\_\_\_

Items preceded by a **bullet** (\*) are active orders. Items preceded by a **checkbox** (□) are only to be carried out if checked**PATIENT POPULATION**

- Adults with suspected or diagnosed Opioid Use Disorder (Agonist Therapy) who have consented to begin treatment

**COMMON CAUTIONS/RELATIVE CONTRAINDIC.**

- Any sedating medications/drugs: benzodiazepines, alcohol withdrawal, severe liver dysfunction, severe respiratory depression
- To avoid precipitating withdrawal, wait at least 12 hours at least 24 hours after long-acting opioid; and at least
- Liver enzymes must be less than 5 times normal value

**ASSESS OPIOID WITHDRAWAL SEVERITY:**

- Assess patient for signs of opioid withdrawal using the first sign of opioid withdrawal (see appendix: COWS)
- Assess patient q2h until COWS is 9, then q1h until COWS is 12
- When COWS score is 12 or greater, notify prescriber

**PATIENT PREPARATION**

- Cancel all opioid medication orders
- Review ePMP or the DIS for concurrently prescribed controlled substances
- Provide information sheets on buprenorphine/naloxone withdrawal
- Provide Nova Scotia Health Authority "Take-Home N
- Consider referral to MOSH and social work for housing
- Confirm patient has finances (pharmacare, personal s

**INVESTIGATIONS:**

- |  |                              |
|--|------------------------------|
| <input type="checkbox"/> Liver enzymes                     | <input type="checkbox"/> Hgb |
| <input type="checkbox"/> Urine bhcg                        | <input type="checkbox"/> Hb  |
| <input type="checkbox"/> Urine for gonorrhea and chlamydia | <input type="checkbox"/> Hct |

Prescriber's Signature \_\_\_\_\_ Date \_\_\_\_\_

Prescriber's Name \_\_\_\_\_ Reg. No. \_\_\_\_\_  
Print \_\_\_\_\_

Page 1 of 3 Dec XX, 2019

**ORDER SET**

Department, Division

**Order Title**

Patient: \_\_\_\_\_ Allergies: \_\_\_\_\_

Items preceded by a **bullet** (\*) are active orders. Items preceded by a **checkbox** (□) are only to be carried out if checked**SUPPORTIVE MANAGEMENT OF WITHDRAWAL SYMPTOMS:**

- acetaminophen 975 mg PO q.i.d. PRN for pain
- ibuprofen 400 mg PO q4h PRN for headache and muscle/joint pain
- dimenhydrinate 25 mg to 50 mg PO q6h PRN for nausea/vomiting
- ondansetron 4 mg PO/SL q4h PRN for nausea/vomiting
- loperamide 4 mg PO PRN x1 for diarrhea, then 2 mg PO PRN with each loose BM in 24h
- clonidine 0.1 mg po bid prn diaphoresis, restlessness or agitation clonidine

**STARTING SUBOXONE (BUPRENORPHINE/NALOXONE):****STEP 1 – Prescriber must verify COWS is greater than 12 and give approval to treat before first dose is administered:**

- Advise patient pre-moisten mouth with water and to dissolve tablet completely and slowly. It may take up to 10 minutes; DO NOT swallow saliva or tablet, talk, or drink during this time.

 Suboxone 4 mg SL (i.e. 2 Buprenorphine/naloxone 2 mg/ 0.5 mg tablets)**OR if frail:** Suboxone 2 mg SL (i.e. 1 Buprenorphine/naloxone 2 mg/ 0.5 mg tablet)

- Assess COWS 60 minutes after initial dose
- If COWS increases, hold buprenorphine-naloxone and notify prescriber immediately. Administer supportive management of precipitated withdrawal.

**STEP 2 – Based on response 60 minutes after initial dose, select either [A] or [B]:****[A] If COWS score less than 7 when assessed 60 minutes after initial dose:**

- No further buprenorphine/naloxone doses required for first 24 hours. Proceed to STEP 3, as appropriate

**[B] If COWS score 7 or greater when assessed 60 minutes after initial dose:**

- Suboxone 2 mg SL (Buprenorphine/naloxone 2mg/0.5mg 1 tab) q1h, until COWS is less than 7
- Maximum: buprenorphine/naloxone 16mg/4mg in the first 24 hours.
- Assess COWS 60 minutes after each dose.
- Once COWS score less than 7, notify prescriber and proceed to STEP 3 or 4

Prescriber's Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Prescriber's Name \_\_\_\_\_ Reg. No. \_\_\_\_\_  
Print \_\_\_\_\_

Page 2 of 3 Dec XX, 2019

Form ID: NS\_C

Prescriber's Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Prescriber's Name \_\_\_\_\_ Reg. No. \_\_\_\_\_  
Print \_\_\_\_\_

Page 3 of 3 Dec XX, 2019

Form ID: NS\_OSXXX

**ORDER SET**

Department, Division

**Order Title**

Patient: \_\_\_\_\_ Allergies: \_\_\_\_\_

Items preceded by a **bullet** (\*) are active orders. Items preceded by a **checkbox** (□) are only to be carried out if checked**STEP 3 – Once COWS score less than 7 OR 16 mg buprenorphine/naloxone dispensed in 24 hours:**

- If patient is being admitted, write order for total dose of suboxone received in first 24 hours as once daily, daily witnessed ingestion, while in ED or as inpatient.
- Contact consulting/admitting service to ensure ongoing prescribing

**STEP 4 – Discharge (from Emergency Department only)**

- Write discharge prescription for total dose of buprenorphine-naloxone received in Emergency Department per 24 hours as once daily, daily witnessed ingestion, for 5 days
- The prescription must be written on a NSPMP duplicate pad
- Contact follow-up provider of choice directly by phone if open (see referral sheet)
- Fax referral to follow-up provider of choice if closed (see referral sheet)
- Give copy of referral form to social work

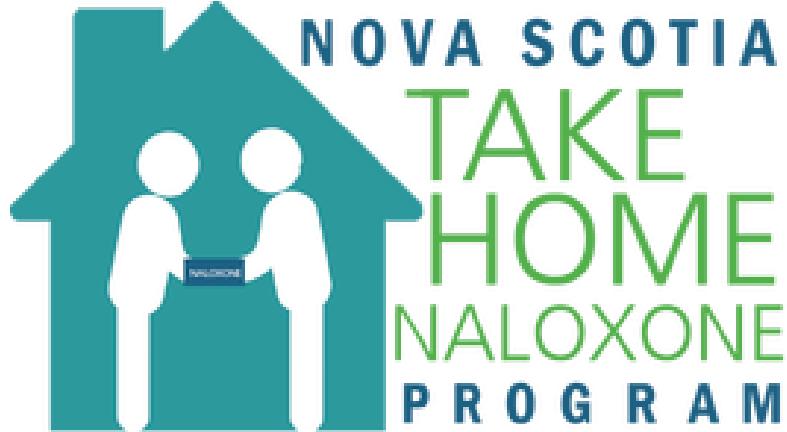
<b>Addictions Medicine Consult Service (AMCS)</b>	For expert advice on diagnosis and management of substance use disorders in adults, adolescents, and children; and manage medications related to substance use.  This service is not for coordinating appointments or managing chronic pain unrelated to substance misuse	Monday – Friday 8:30-4:30pm  1-855-970-0234
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# Opioids for opioid withdrawal

- “Home dose” – expect around 48-72mg hydromorphone IV daily
- ~1000mg oral morphine equivalents daily
  - = hydromorphone 200mg PO daily
  - = hydromorphone 24mg PO q3h
- Consider starting at ~1/3 of “home dose”
- Dose & response, titrate to effect
- Frequent re-assessments, communication
- Shared decision-making, ask for expert help

You  
Undertreated  
withdrawal or  
pain is more likely  
to lead to  
relapse/illicit use

# Take-home naloxone kits



Engagement &  
care

Use in hospital



## MENTAL HEALTH AND ADDICTIONS

### Policy & Procedure

Title:	Provision of Opioid Overdose Prevention/Naloxone Administration Training and Take Home Naloxone Hydrochloride (Naloxone) Kit	Number:	MA-HPP-001
Sponsor:	Senior Director Mental Health and Addictions	Page:	1 of 16
Approved by:	VP Integrated Health Services, Community support and Management  VP Integrated Health Services, Program of Care 2, CNO	Approval Date:	2018-04-24
Applies To:		Effective Date:	2018-06-12

**Applies to NSHA Staff who have successfully completed the required education and have been deemed competent to implement this policy within approved Take Home Naloxone Program sites.**

DEBATE

Open Access

# Naloxone urban legends and the opioid crisis: what is the role of public health?



Alexis Crabtree<sup>1\*</sup> and Jeffrey R. Masuda<sup>2</sup>



# Sterile injecting equipment



"(The bags) each include 10 clean syringes, 10 alcohol swabs, a tie, some water and a few cookers," said Ashton Manktelow, an outreach worker with Mainline Needle Exchange.



People in need of safe supplies can ask for a 'brown bag' at pharmacies across Nova Scotia. **Alexa MacLean/Global Halifax**

## PRACTICE GUIDELINE

### Assessment & Interventions:

If a patient is assessed to be an unsafe sharps risk (e.g. uncapped needles found in room, belongings, on person), the following actions should be taken:

- Discuss unsafe sharps concern with patient
- Educate patient re: safe disposal of sharps
- Create patient specific sharps support plan in collaboration with Clinical Nurse Lead (CNL) (as per instructions on back of Unsafe Sharps Risk Support Plan)
- Notify Addiction Medicine Consult Team of concern and sharps support plan
- Place Unsafe Sharps Risk Support Plan in front of patient Kardex.
- Place sharps risk signage on patient's door
- Review Unsafe Sharps Risk Support Plan at review date for potential revisions or discontinuation

risk to health care staff

- The goal is to eliminate the risk of unintended needle stick injury to any persons having contact with the patient or their belongings e.g. nurses, allied health, housekeepers, physicians, etc.
- The goal to reduce or stop substance use is a decision made over time and abstinence may not be the primary goal of care nor is it always achievable.

# Inpatient Addiction Medicine Consult Service at the Halifax Infirmary

***Would your team benefit from expert guidance on care for patients who drink alcohol or use drugs?***



The Inpatient Addiction Medicine Consult Service (IAMCS) is a NEW consult service at the Halifax Infirmary site. The service supports teams and patients within the QEII Emergency Department and the Halifax Infirmary inpatient units. IAMCS will improve access to evidence-based substance use and addiction care for patients in these Halifax Infirmary acute care settings.

This multi-disciplinary team of addiction medicine physicians, nurse, social worker and peer support worker is available for in-person consults from Monday to Friday, 8:00 a.m. to 5:00 p.m.

## ***How to request a consult?***

The Most Responsible Physician, or designate, can call QEII Locating to be connected to one of the team's addiction medicine physicians.

# Care we can offer in 2023

- Staff education, culture change
- Short-acting opioids (e.g., hydromorphone) titrated to relieve withdrawal and pain
- Opioid agonist treatment (methadone, buprenorphine, slow-release oral morphine)
- Multidisciplinary addiction medicine consult service with peer support worker
- Inviting community-based organizations to participate in care
- Take-home naloxone kit
- Sterile injecting equipment (incl. cookers, filters, water, Vit c)
- Screening for HIV, hepatitis, syphilis
- Hepatitis C treatment



# Next steps

# Harm reduction policy development

- Multidisciplinary working group on internal medicine ward
- Lived experience and harm reduction organizations
- Focus groups with people who use drugs
- Model for province-wide policies
- Recognizing that harm reduction policies and practices are:
  - Compassionate, patient-centered care
  - Evidence-based
  - Promote human rights
  - Limit institutional liability

# Harm reduction policy development

- Time off ward
- Sharps safety
- Drugs found in bedside table
- Need for sterile injecting equipment
- Safer PICC line use
- Patient self-administration of controlled medications
- Scheduling investigations

How might we apply harm reduction principles to these scenarios?

Are protocols in place to guide staff?



“Patients who use psychoactive substances have the right to receive equitable, non-judgmental, and evidence-based health care services regardless of whether the substances they use are legal or illegal”

Clinical Operations Executive Committee

December 16, 2013

“Individuals with lived experience have expertise to contribute as partners in the creation of programs, policies, and harm reduction strategies designed to serve them, and their input is valued and respected”

If you have any questions or comments regarding the information in this document, please contact the Policy & Forms Department.

“Programs, services, and health care providers across the care continuum shall provide low threshold access to harm reduction services, treatment, and/or referral for patients (e.g., opioid agonist therapy, managed alcohol program)”

(including controlled drugs such as alcohol, tobacco and prescription drugs). This policy is intended:

- To clarify the responsibility of **health care providers** to provide **patients** who use psychoactive substances with accessible, equitable, non-judgmental, compassionate

# Overdose Prevention Site @ St. Paul's Hospital

- Opened May 2018
- Serves inpatients and community
- Partnership between Providence Health Care, Raincity Housing and Vancouver Coastal Health

## WHAT IT IS:

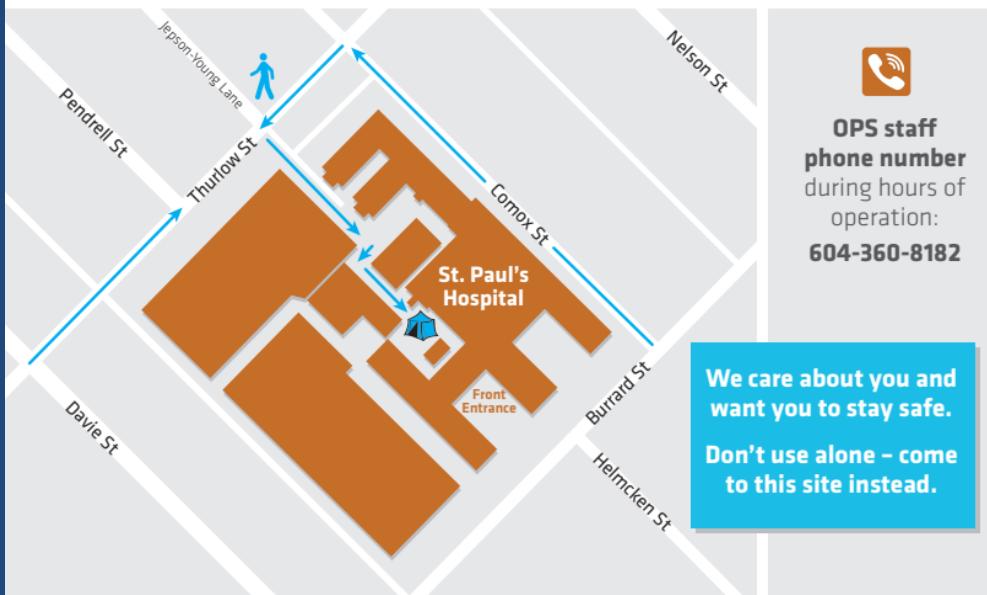
- A non-judgmental and safer place to use drugs in the West End.
- A confidential and respectful site to connect with support workers and peers.
- A place that provides monitoring of any overdoses and gets you emergency care if you need it.

## WHAT IT OFFERS:

- Take-home naloxone kits and training.
- Clean injection supplies.
- Safe needle disposal.
- Peer support.
- Referrals to health and community services.
- Drug testing.

## HOURS:

- Opens at **11 am** with last visit at **10:30 pm**. Open **7 days a week**.
- If you need emergency help when the OPS is closed, call 911 or visit St. Paul's Emergency Department.



BRIEF REPORT

Open Access

# Implementation of overdose prevention sites learned from Canada

Elizabeth Dogherty<sup>1</sup>, Carlin Paterson<sup>2</sup>, Jennifer Gibson<sup>3</sup>, Sam Gill<sup>1</sup>, Sean



# Supervised Consumption Service (SCS)

24/7 supervised consumption  
service for Royal Alexandra  
Hospital (RAH) inpatients.

*We look forward to meeting  
you!*



CASE STUDY

Open Access



# Self-injecting non-prescribed substances into vascular access devices: a case study of one health system's ongoing journey from clinical concern to practice and policy response

Jocelyn Chase<sup>1,2,3</sup>, Melissa Nicholson<sup>3</sup>, Elizabeth Dogherty<sup>3</sup>, Emma Garrod<sup>3,4</sup>, Jocelyn Hill<sup>3</sup>, Rupinder Brar<sup>1,3,5,6</sup>, Victoria Weaver<sup>1,3,4,6,7</sup> and William J. Connors<sup>1,3,7\*</sup>



Providence  
Health Care

PROCEDURE

DOCUMENT #B-00-13-10256

## Dispensing HYDROmorphine (DILAUDID®) Tablets for Self-Administration: Pharmaceutical Alternatives in Acute Care (PAAC)

### Site Applicability

St. Paul's Hospital (SPH): **Urban Health (UH) unit 8A ONLY**

### Practice Level

RNs/RPNs working on SPH 8A: Advanced Competency. Additional education required:

- SPH 8A UH unit-specific orientation and/or education from the Nurse Educator for Substance Use, Addiction Medicine Consult Team (AMCT) Liaison Nurse, or 8A UH unit Nurse Educator.

# Care we should offer in 2028

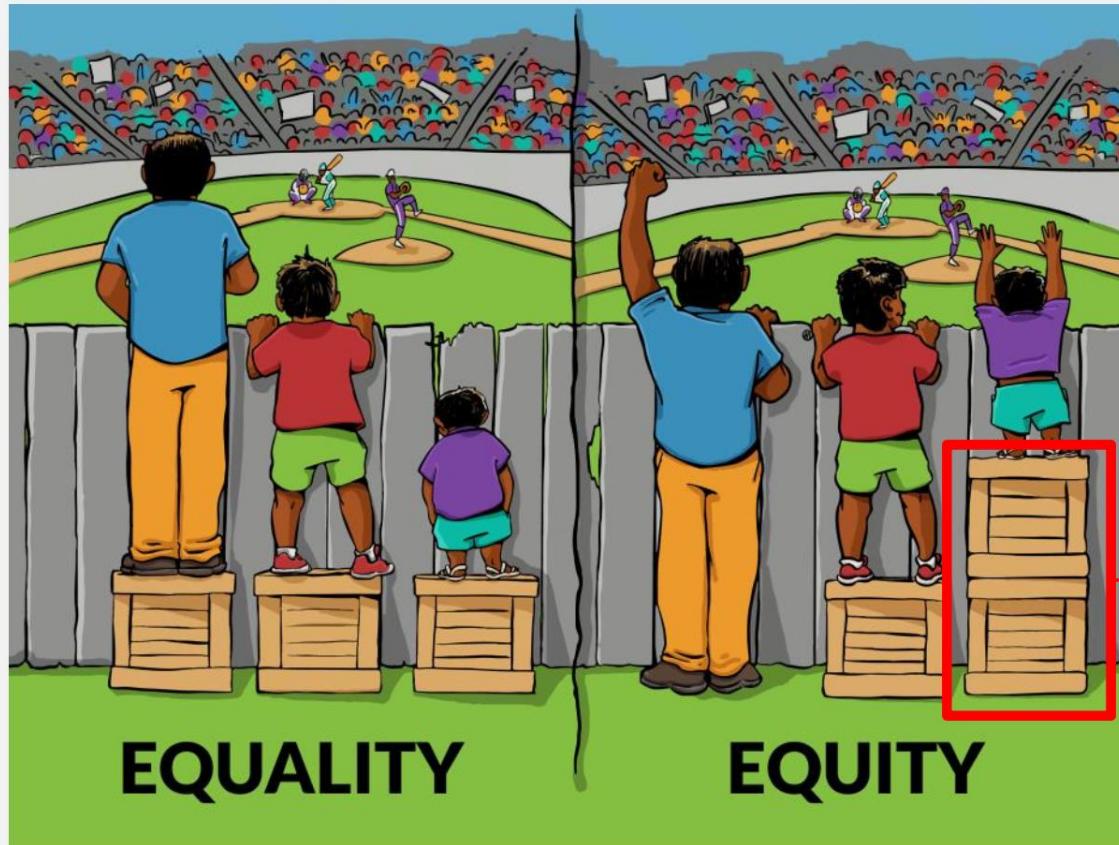
- Compassionate, culturally safe care that is consistent
- Hospital policies and permanent funding to sustain it all
- People who use drugs supported to have leadership roles in care and policy design and care delivery
- In-hospital supervised consumption services, including support from inhalation
- Respite housing for prolonged antibiotics with option to transition to Housing First
- Injectable OAT and safer supply options to start in hospital and continue in community



# Reflections

# Challenges for care providers





What does  
this look like?

# Where to start?

- Explicit commitment to equity and harm reduction
- Support patients to use drugs safely while hospitalized
- Support staff/teams to provide supplies for use and disposal
- Work with community partners
- Create and clarify policy and procedures – consider clinicians, support staff, security
- Engage in ongoing dialogue and learning
- Include people who use(d) drugs in learning and decision making
- Individual practice changes easier than system changes

# Resources

Commentary

## Hospital policy as a harm reduction intervention for people who use drugs

Robin Lennox <sup>a,c,\*</sup>, Leslie Martin <sup>b,c</sup>, Candice Brimner <sup>c</sup>, Tim O'Shea <sup>c,d</sup>



<sup>a</sup>Department of Family Medicine, McMaster University, Hamilton, Canada

<sup>b</sup>Department of Medicine, Division of General Internal Medicine, McMaster University, Hamilton, Canada

<sup>c</sup>St. Joseph's Healthcare, Hamilton, Canada

<sup>d</sup>Department of Medicine, Division of Infectious Diseases, McMaster University, Hamilton, Canada

International Journal of Drug Policy 97 (2021) 103324

## Caring for people who inject drugs when they are admitted to hospital

Thomas D. Brothers MD, John Fraser MD, Duncan Webster MD

■ Cite as: CMAJ 2021 March 22;193:E423-4. doi: 10.1503/cmaj.202124

# Guidance Document

on the Management  
of Substance Use  
in Acute Care





# **A Harm Reduction nursing perspective on the care of PWID with endocarditis**

Tali Magboo Cahill, RN MSN



Spring 2022 Seminar Series - Improving care for people who inject drugs with endocarditis

A harm reduction nursing perspective on the care of people who inject drugs with endocarditis

# Key messages

1. Hospitals should partner with and learn from community-based harm reduction organizations who are already doing this work.
2. People who use drugs are experts in their own lives and should have leadership role in improving care and policies.
3. Advocacy outside “the system” can be quicker but additional strategies are needed for sustainable change.

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 @tdbrothers

902-817-8989



# Appendix slides

# First principles

- All patients deserve evidence-based treatment
- Addiction is a chronic (long-term), remitting-relapsing health condition and not a moral failing
- Addiction means “continued use despite harm”
- People use drugs for lots of reasons & most people who use drugs do not have an addiction
- There are many ways to use drugs more safely
- Long-term recovery from addiction is common
- People with addiction can’t recover if they’re dead

# Substance use-related terminology

- Substance use
- Unhealthy substance use
  - Risky/high-risk substance use
  - Substance use disorder
- Substance use disorder (DSM criteria)
  - 2-3 criteria = mild SUD
  - 4-5 = moderate SUD
  - 6+ = severe SUD
- “Addiction” ≈ moderate-severe SUD

# 3 C's of addiction

- Loss of control
- Compulsive use
- Consequences

## “Person-first” & specific language

- Person who uses drugs, person with SUD
- Words like “abuse”, “misuse” are stigmatizing, non-specific, and unhelpful

# care

NDC 0986-0749-11

**Zocor®**  
(Simvastatin) Tablets

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Each tablet contains 40 mg of simvastatin.

NDC 0910-0725-00 90 tablets

**CRESTOR®**  
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**Livalo®**  
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**Mevacor®**  
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Manufactured by Mevacor, Inc.  
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1000 Corporate Park Drive,  
Mahwah, NJ 07430-1000  
© 2000 Pfizer Consumer  
Healthcare, New York, NY 10020  
Pfizer International USA  
Each tablet contains 40 mg  
**60 Tablets**

90 tablets NDC 0003-5178-05

**20 mg**  
**PRAVACHOL®**

NDC 0009-2150-30

Rx only

**Caduet®**

(amlodipine besylate/  
atorvastatin calcium)

NOVARTIS NDC 0375-023

**Lescol®**  
(fluvastatin sodium)



# Harm reduction in health care

- Evidence-based interventions:
  - Peer outreach; information on safer practices
  - Needle and syringe programs (“needle exchange”)
  - Overdose prevention education & naloxone distribution
  - Supervised consumption sites / overdose prevention sites
  - Drug checking (e.g. fentanyl test strips)
  - Opioid agonist treatment (e.g. methadone)
  - Treating withdrawal and pain in hospital with opioids
  - Managed alcohol programs
  - Non-abstinence-based housing
  - Linkage to health care, housing, and social services

# Harm reduction as a social movement

- A commitment to the human rights of people who use drugs
- People who use drugs organizing, advocating, and providing mutual aid
- Protecting themselves and each other from harms of criminalization, poverty, racism, and other harmful social and political forces
- Recognizing that people are experts in their own lives and working to empower them

# Working with patients who use drugs

1. Assess substance use (type, frequency, route)
2. Explore difference between substance use, risky use, and addiction
3. Discuss actual and potential harms
4. Explore goals regarding substance use
  - Use same, reduce harms?
  - Use less, reduce harms?
  - Stop using (abstinence), reduce harms?

1. Foster engagement and participation of people who have experience with substance use and marginalization in shaping the care they and their peers receive.

2. Recognize that people's health, health care, priorities and experiences are influenced by history and policies that criminalize drug use.

#### HEALTH CARE AND ILLICIT DRUG USE

People who use illicit drugs often have histories of trauma. The stigma associated with drug use is important to consider in health care settings. Patients' experiences with health care and, if admitted, to leave before their care is complete.

3. Consider how past histories of trauma and violence, layers of disadvantage and stigma may affect patients' ability to engage with providers and care plans.

Hospital staff provide care that is safe and empathetic and emphasizes the holistic needs of the patient.

4. Emphasize relationships and trust as priority outcomes.

to help nurses provide ethical, safe and appropriate care when working with patients from diverse backgrounds, including poverty.

5. Promote a culture of respect and safety within the unit or workplace, where all patients are valued and seen as deserving of care.

The culture of the hospital includes nursing staff who are experienced in working with patients from diverse backgrounds, including those with a history of substance use and mental illness. The organization promotes a culture of respect and safety within the unit or workplace, where all patients are valued and seen as deserving of care.

"It is recognized that not all women are able to abstain from substance use and that no woman will voluntarily experience withdrawal."

In the event that an illegal substance is found, health care team members will:

- Discuss with the woman, her need for continued use of illegal substances
- Request the woman's permission to consult with her addiction care team
- A supportive plan of care will be developed
- Security will be notified, to dispose of the substance according to health centre policies

alcohol and/or prescribed medications in a non-prescribed manner.

A

**What if I suspect a woman has illegal substances in her possession? Can a search of her belongings be performed?**

*Answer:*

It is not the IWK Health Centre policy to search a patient or her belongings for illegal drugs and substances.

# Hospital as a “reachable moment”

## BRIEF REPORT

### Planning and Designing the Improving Addiction Care Team (IMPACT) for Hospitalized Adults with Substance Use Disorder

Honora Englander, MD<sup>1,2\*</sup>, Melissa Weimer, DO, MCR<sup>1,3</sup>, Rachel Solotaroff, MD, MCR<sup>2</sup>, Christina Nicolaidis, MD, MPH<sup>1,4</sup>, Benjamin Chan, MS<sup>1</sup>, Christine Velez, MSW<sup>4</sup>, Alison Noice, MA, CADC-III<sup>3</sup>, Tim Hartnett, MSW, MHA<sup>3</sup>, Ed Blackburn, MA<sup>2</sup>, Pen Barnes, MBBS, PhD<sup>1</sup>, P. Todd Korthuis, MD, MPH<sup>1</sup>

- Most hospital inpatients (67%) with SUDs are interested in cutting back or quitting substance use
- Most patients (54%) want medication treatment to start in hospital
- Patients value treatment choice, providers who understand SUDs

including a hospital, community SUD organizations, and Medicaid accountable care organizations, to design a care model for medically complex hospitalized patients with SUD. Needs assessment showed that 58% to 67% of participants who reported active substance use said they were interested in cutting back or quitting. Many reported interest in medication for addiction treatment (MAT). Participants had high rates of costly readmissions and longer than expected length

pital SUD treatment, and a medically enhanced residential care model that integrates antibiotic infusion and residential addiction care. We developed a business case and secured funding from Medicaid and hospital payers. IMPACT provides one pathway for hospitals, payers, and communities to collaboratively address the SUD epidemic. *Journal of Hospital Medicine* 2017;12:339-342. © 2017 Society of Hospital Medicine

# Management of opioid use disorders: a national clinical practice guideline

Julie Bruneau MD MSc, Keith Ahamad MD, Marie-Ève Goyer MD MSc, Ginette Poulin MD,  
Peter Selby MBBS MHSc, Benedikt Fischer PhD, T. Cameron Wild PhD, Evan Wood MD PhD; on behalf of the  
CIHR Canadian Research Initiative in Substance Misuse

■ Cite as: *CMAJ* 2018 March 5;190:E247-57. doi: 10.1503/cmaj.170958

The full guideline in English and French is available in Appendix 1 at [www.cmaj.ca/lookup/suppl/doi:10.1503/cmaj.170958/-/DC1](https://www.cmaj.ca/lookup/suppl/doi:10.1503/cmaj.170958/-/DC1)

CMAJ Podcasts soundcloud.com/cmajpodcasts/170958-guide-eng; entrevue en français au <https://soundcloud.com/cmajpodcasts/170958-guide-fr>

See related article <https://www.cmaj.ca/lookup/doi/10.1503/cmaj.180209>

Opioid use disorder is one of the most challenging forms of addiction facing the Canadian health care system, and a major contributor to the marked rises in opioid-related morbidity and death that Canada has been seeing in recent years. The evolving landscape of nonmedical opioid use has become increasingly dominated by prescription opioids diverted from the medical system and, more recently, by highly potent, illicitly manufactured synthetic opioids (e.g., fentanyl and its analogues, including carfentanil).<sup>1</sup>

The mean national rate of hospital admissions related to opioid poisonings increased from 9 hospital admissions per day in 2007/08 to more than 13 admissions per day in 2014/15.<sup>2</sup> A corresponding rise in injection of prescription opioids has been observed among people who inject drugs in Canada,<sup>3,4</sup> and has been associated with an increased risk of hepatitis C and HIV infections.<sup>5-7</sup> For 2016, the mean rate of apparent opioid-related overdose deaths has reached 7.9 per 100 000 population (i.e., corresponding to a total of 2861 fatalities), with the highest death rates reported for western Canada.<sup>8</sup> This upsurge in opioid-related harms, including overdose deaths,<sup>2-6,8,9</sup> underscores the critical need for coordinated, evidence-based approaches to prevention,

Key

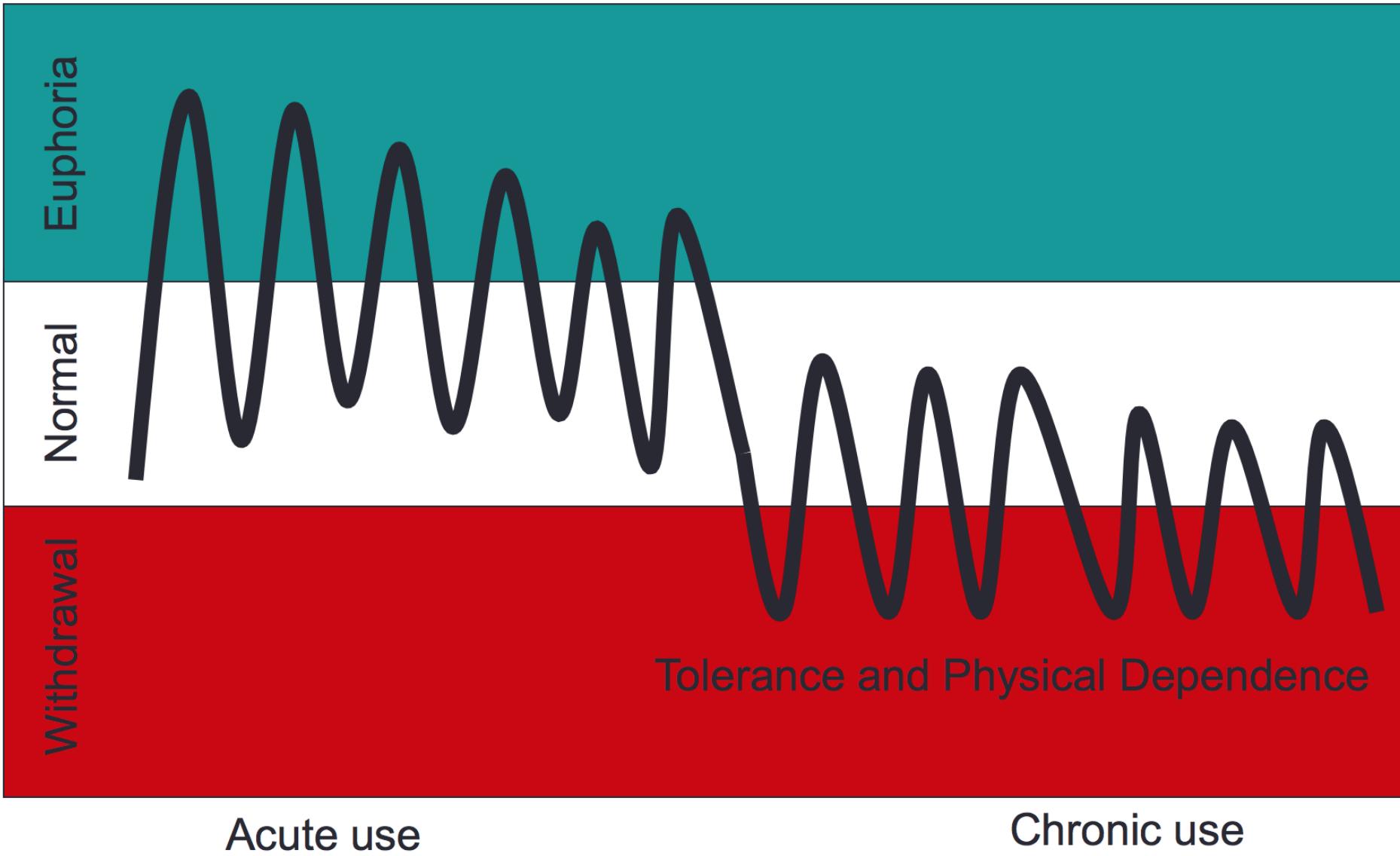
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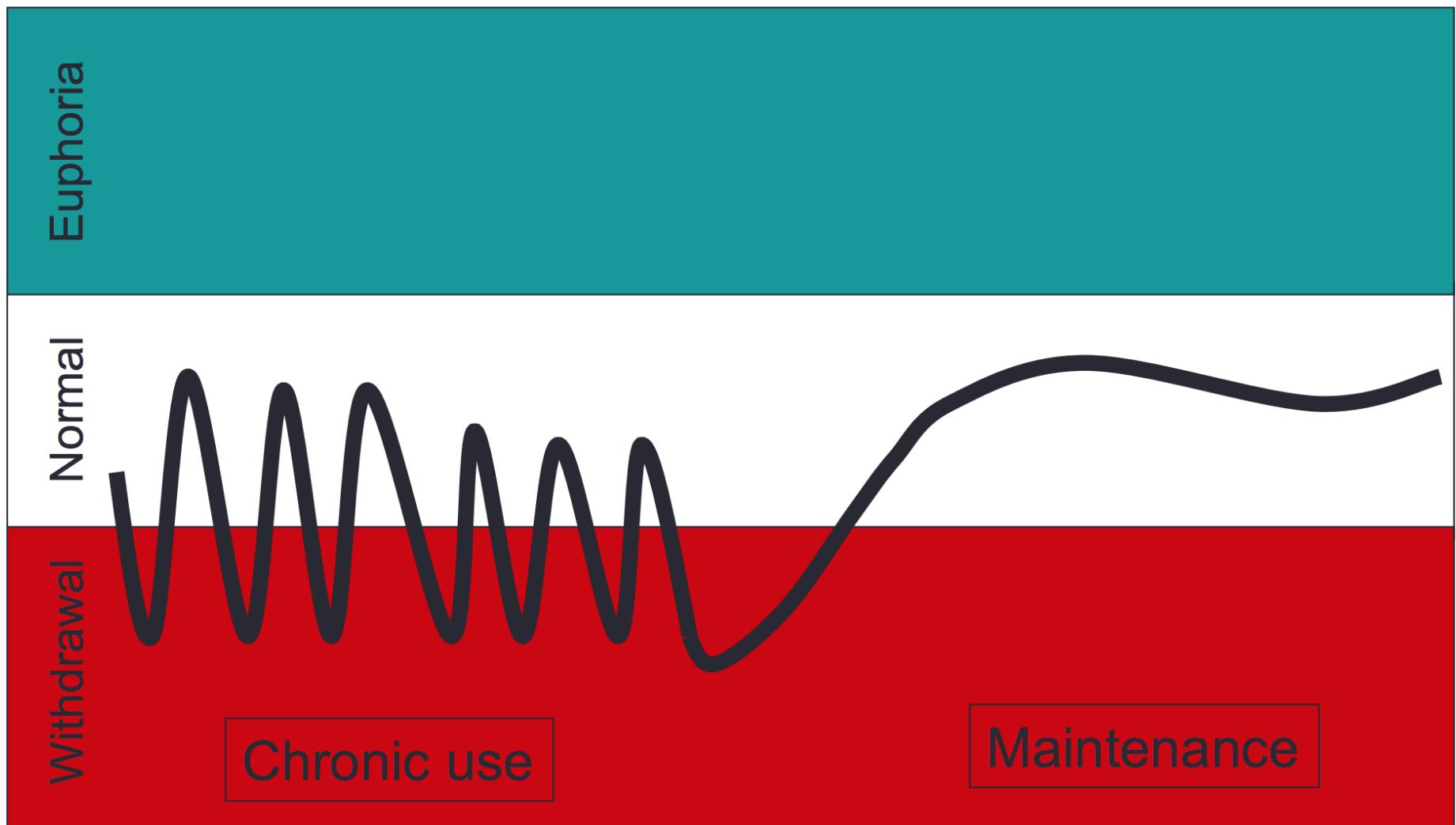
“Rehab”?

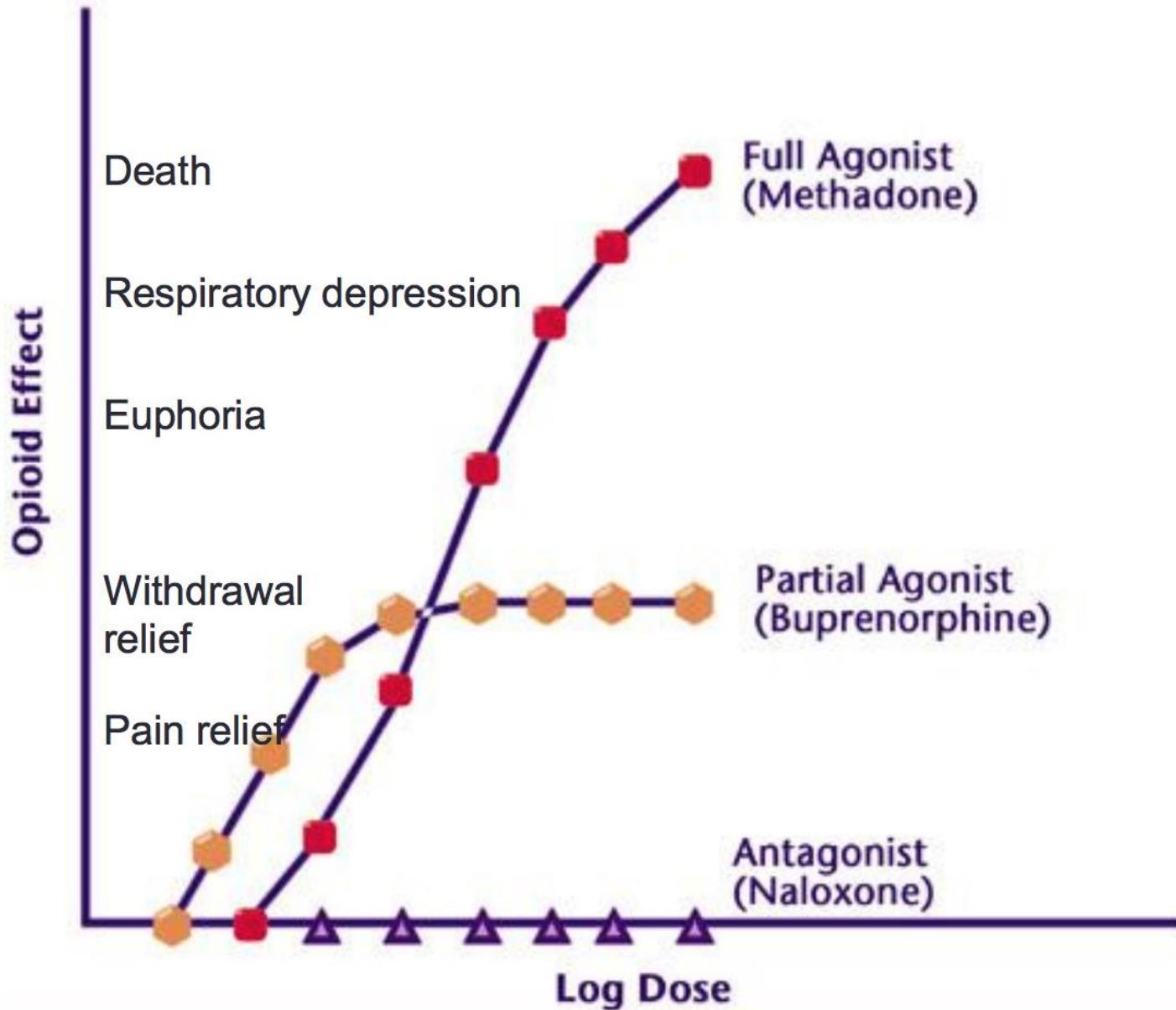
- This guideline strongly recommends opioid agonist treatment with buprenorphine–naloxone as the preferred first-line treatment when possible, because of buprenorphine’s multiple advantages, which include a superior safety profile in terms of overdose risk.
- Withdrawal management alone is not recommended, because this approach has been associated with elevated risks (e.g., syringe sharing) and death from overdose in comparison to providing no treatment, and high rates of relapse when implemented without immediate transition to long-term evidence-based treatment.
- This guideline supports using a stepped and integrated care approach, in which treatment intensity is continually adjusted to accommodate individual patient needs and circumstances over time, and recognizes that many individuals may benefit from the ability to move between treatments.

# Opioid agonist treatment

- Methadone
- Buprenorphine (“Suboxone”)
- 24-hour slow-release morphine (“Kadian”)









OPEN ACCESS

# Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies

Luis Sordo,<sup>1,2,3</sup> Gregorio Barrio,<sup>4</sup> María J Bravo,<sup>1,2</sup> B Iciar Indave,<sup>1,2</sup> Louisa Degenhardt,<sup>5,6</sup> Lucas Wiessing,<sup>7</sup> Marica Ferri,<sup>7</sup> Roberto Pastor-Barriuso<sup>1,2</sup>

<sup>1</sup>National Centre for Epidemiology, Carlos III Institute of Health, Madrid, Spain

<sup>2</sup>Consortium for Biomedical Research in Epidemiology and Public Health (CIBERESP), Madrid, Spain

<sup>3</sup>Dep Med Facult Complutense University, Madrid, Spain

## ABSTRACT

### OBJECTIVE

To compare the risk for all cause and overdose mortality in people with opioid dependence during and after substitution treatment with methadone or

out of buprenorphine treatment (2.20, 1.34 to 3.61). In pooled trend analysis, all cause mortality dropped sharply over the first four weeks of methadone treatment and decreased gradually two weeks after leaving treatment. All cause mortality remained stable

## Methadone reduces all-cause mortality by 69%

Systematic review and meta-analysis.

1000 person years in and out of methadone treatment (unadjusted out-to-in rate ratio 4.80, 2.90 to 7.96) and

## Buprenorphine reduces all-cause mortality by 55%

<sup>4</sup>National Drug and Alcohol Research Centre, University of New South Wales, Sydney, Australia

<sup>5</sup>Melbourne School of Population and Global Health, University of Melbourne, Melbourne, Australia

<sup>7</sup>Sector Best Practices, Knowledge Exchange and Economic Issues, European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), Lisbon, Portugal

### STUDY SELECTION

Prospective or retrospective cohort studies in people with opioid dependence that reported deaths from all causes or overdose during follow-up periods in and out of opioid substitution treatment with methadone or buprenorphine.

### DATA EXTRACTION AND SYNTHESIS

Two independent reviewers performed data extraction and assessed study quality. Mortality rates in and out of treatment were jointly combined across methadone or buprenorphine cohorts by using multivariate random effects meta-analysis.

is associated with substantial reductions in the risk for all cause and overdose mortality in people dependent on opioids. The induction phase onto methadone treatment and the time immediately after leaving treatment with both drugs are periods of particularly increased mortality risk, which should be dealt with by both public health and clinical strategies to mitigate such risk. These findings are potentially important, but further research must be conducted to properly account for potential confounding and selection bias in comparisons of mortality risk between opioid substitution treatments, as well as the long-term



**Cochrane**  
**Library**

**Cochrane** Database of Systematic Reviews

## **Oral substitution treatment of injecting opioid users for prevention of HIV infection (Review)**

Reductions in potentially harmful drug use practices:

- illicit opioid use
- injecting use, frequency of injecting
- sharing & re-using of injecting equipment
- exchanges of sex for drugs or money

**Original Investigation**

# Buprenorphine Treatment for Hospitalized, Opioid-Dependent Patients A Randomized Clinical Trial

Jane M. Liebschutz, MD, MPH; Denise Crooks, MPH; Debra Herman, PhD; Bradley Anderson, PhD;  
Judith Tsui, MD, MPH; Lidia Z. Meshesha, BA; Shernaz Dossabhoy, BA; Michael Stein, MD

People started on buprenorphine in hospital & continued after discharge were...

**OBJECTIVE** To determine whether buprenorphine administration during medical

7X more likely to engage in treatment after discharge

75% vs. 11%

Of these, 303 did not meet eligibility criteria. A total of 115 eligible patients consented to participation in the randomized clinical trial. Of these, 139 completed the baseline interview and were assigned to the detoxification ( $n = 67$ ) or linkage ( $n = 72$ ) group.

**INTERVENTIONS** Five-day buprenorphine detoxification protocol or buprenorphine induction, intrahospital dose stabilization, and postdischarge transition to maintenance buprenorphine OAT affiliated with the hospital's primary care clinic (linkage).

**MAIN OUTCOMES AND MEASURES** Entry and sustained engagement with buprenorphine OAT at 1, 3, and 6 months (medical record verified) and prior 30-day use of illicit opioids (self-report).

**Original Investigation**

# Emergency Department-Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence A Randomized Clinical Trial

Gail D'Onofrio, MD, MS; Patrick G. O'Connor, MD, MPH; Michael V. Pantalon, PhD; Marek C. Chawarski, PhD; Susan H. Busch, PhD; Patricia H. Owens, MS; Steven L. Bernstein, MD; David A. Fiellin, MD

**IMPORT**  
medical

**78% vs. 38% engaged in addiction treatment  
after 30 days**

Video and  
interview at

**OBJECTIVE** To test the efficacy of 3 interventions for opioid dependence: (1) screening and referral to treatment (referral); (2) screening, brief intervention, and facilitated referral to community-based treatment services (brief intervention); and (3) screening, brief intervention, ED-initiated treatment with buprenorphine/naloxone, and referral to primary care for 10-week follow-up (buprenorphine).

[jamanetworkcme.com](http://jamanetworkcme.com) and  
CME Questions page 1670

**DESIGN, SETTING, AND PARTICIPANTS** A randomized clinical trial involving 329 opioid-dependent patients who were treated at an urban teaching hospital ED from April 7, 2009, through June 25, 2013.

**INTERVENTIONS** After screening, 104 patients were randomized to the referral group, 111 to the brief intervention group, and 114 to the buprenorphine treatment group.

**MAIN OUTCOMES AND MEASURES** Enrollment in and receiving addiction treatment 30 days after randomization was the primary outcome. Self-reported days of illicit opioid use, urine testing for illicit opioids, human immunodeficiency virus (HIV) risk, and use of addiction treatment services were the secondary outcomes.

# Opioid agonist treatment and risk of death or rehospitalization following injection drug use-associated bacterial and fungal infections: A cohort study in New South Wales, Australia

Thomas D. Brothers<sup>1,2,3\*</sup>, Dan Lewer<sup>1,2</sup>, Nicola Jones<sup>1</sup>, Samantha Colledge-Frisby<sup>1</sup>, Michael Farrell<sup>1</sup>, Matthew Hickman<sup>4</sup>, Duncan Webster<sup>3,5</sup>, Andrew Hayward<sup>2</sup>, Louisa Degenhardt<sup>1</sup>

**1** National Drug and Alcohol Research Centre (NDARC), UNSW Sydney, Sydney, Australia, **2** UCL Collaborative Centre for Inclusion Health, Institute of Epidemiology and Health Care, University College London, London, United Kingdom, **3** Department of Medicine, Dalhousie University, Halifax, Canada, **4** Population Health Sciences, University of Bristol, Bristol, United Kingdom, **5** Division of Infectious Diseases, Saint John Regional Hospital, Saint John, Canada

\* [thomas.brothers.20@ucl.ac.uk](mailto:thomas.brothers.20@ucl.ac.uk)

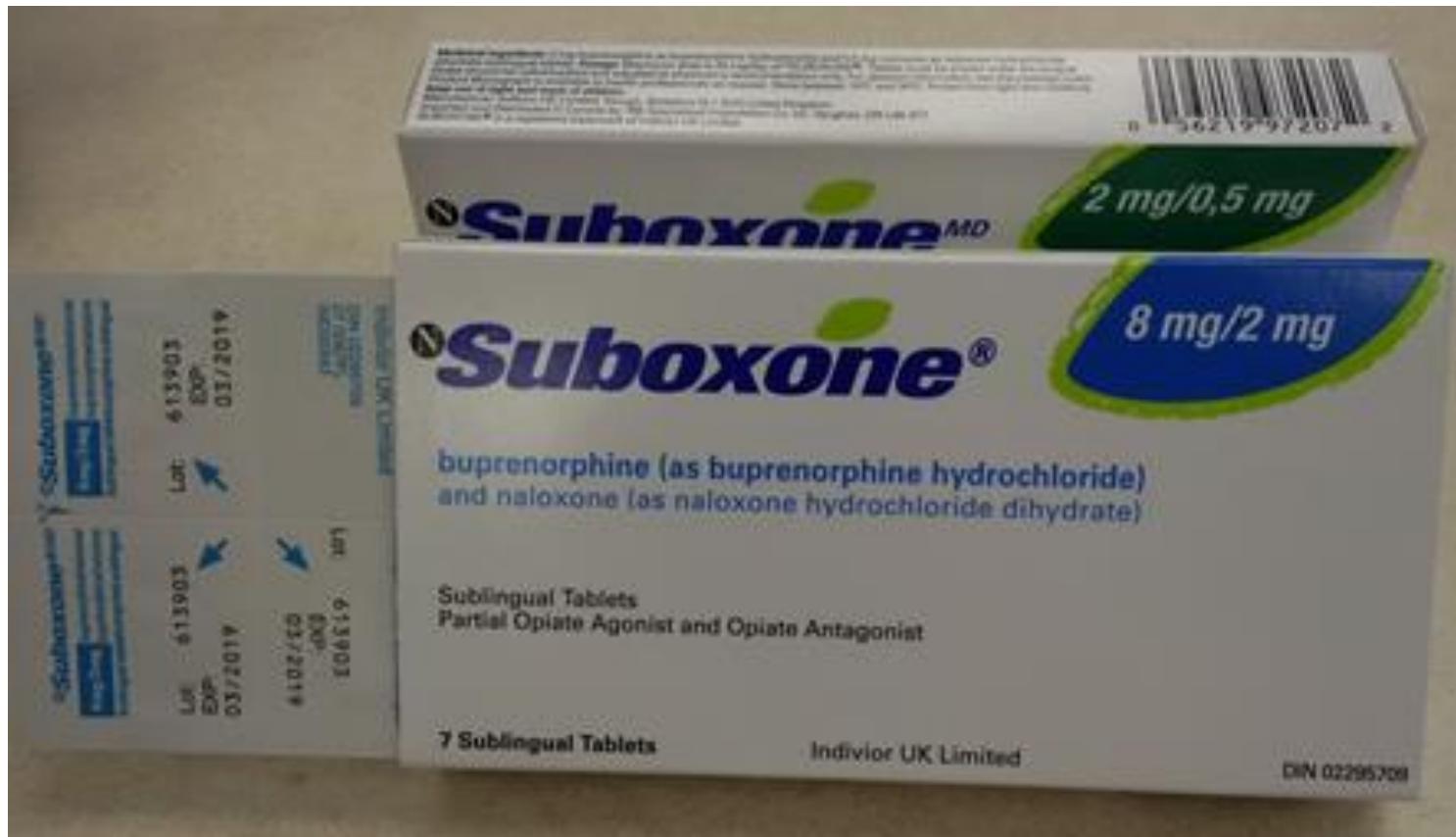
Patients receiving opioid agonist treatment after hospital discharge were...

37% less likely to die

11% less likely to be readmitted with recurrent infection

Greatest benefit with starting OAT as soon as possible

# Buprenorphine-naloxone ("Suboxone")



# Starting buprenorphine treatment

1. Wait for moderate opioid withdrawal  
(to avoid precipitated withdrawal)
  - COWS $\geq$ 8 w/ objective signs; or patient report
2. Buprenorphine 2-4mg SL x 1 to start
3. Assess at 1 hour for precipitated withdrawal
4. Buprenorphine 2mg q1h until comfortable, to max dose of 12-16mg on day 1
5. Follow-up on day 2 and titrate as needed

# “Micro-dosing” buprenorphine induction (continue full-agonist opioid throughout)

Day 1	0.5mg BID
Day 2	1mg BID
Day 3	2mg BID
Day 4	3mg BID
Day 5	4mg BID
Day 6	12mg once

# Starting methadone treatment

1. Starting dose:
  - 30mg PO daily – if uncomplicated patient
  - 20mg PO daily – if high risk for toxicity
2. Titration (up to 60mg daily):
  - Increase by 10mg every three days OR 15mg every five days
3. Titration (after 60mg daily):
  - Increase by 10mg q 5-7 days
  - Typical maintenance dose = 80-120mg daily

# Starting OAT in hospital

- Focus on withdrawal first
- Benefits of a hospital setting
- Timing
- Discharge planning

# What do to after starting OAT

- Identify & contact outpatient prescriber
- Identify preferred pharmacy
- Contact pharmacy and ask if capacity to do daily-witnessed dispensing for this patient
- Prescribe in communication w/ outpatient prescriber
- Provide take-home naloxone kit, if available
- High-fives all-around!

“To prevent the hospital from being charged with illegal possession, employees must report the existence of any potentially harmful or illegal items/substances over to the police.”

Distribution: District Wide

Date:

1-16-0

“The patient will then be searched... if the patient refuses, he/she will be asked to leave the Emergency Department. If the patient refuses to leave the Emergency Department, the local police will be called.”

“If the patient’s chart has been flagged in relation to banned items, the Triage Nurse contacts Security. ... He/she is informed that Security is required to perform a search, using a metal detector, of the patient and his/her belonging, because of the patient’s history of bringing such items to the hospital. If the patient is resistive, the local police service will be called.”

law. In the ordinary course, when illegal items are surrendered, it is not necessary to reveal the name of the person who brought the illegal item/substance to the hospital/program to law enforcement authorities. If the police want to investigate further, they can obtain a search warrant to obtain the information.



“Employees must report the existence of any illegal items/substances to appropriate Management/Shift Coordinator/Security Department personnel who will make arrangements to have the items/substances turned over to the police.”

Review Date: 2017-12-02 (YYYY-MM-DD)

“Illegal paraphernalia is any equipment, product, or material that is modified for making, using, or concealing illegal drugs or substances.”

“If the patient/client refuses to surrender illegal items they will be asked to leave the premises. Law enforcement may be called to assist if the patient/client refuses to leave the premises or the patient’s medical condition prohibits the patient leaving.”

Ensure that interactions with law enforcement agencies are consistent throughout the District and are compliant with Federal or Provincial statutes, such as *Personal Health*



## **PREScriber's Orders**

**NO DRUG WILL BE DISPENSED OR ADMINISTERED  
WITHOUT A COMPLETED**

## METHADONE ORDERS:

Starting  Immediately \*OR\*  on tomorrow's MAR

Date

**Discontinue all previous methadone orders and implement orders below:**

- methadone 30 mg (thirty mg) daily at 09:00  
numeric spelled out

methadone \_\_\_\_\_ mg (                 mg) BID at 09:00 and \_\_\_\_\_  
numeric spelled out time

methadone \_\_\_\_\_ mg (                 mg) TID at 09:00, \_\_\_\_\_ and \_\_\_\_\_  
numeric spelled out time time

methadone \_\_\_\_\_ mg (                 mg) QID at 09:00, \_\_\_\_\_, \_\_\_\_\_ and \_\_\_\_\_  
numeric spelled out time time time

methadone \_\_\_\_\_ mg (                 mg) PRN x 1 (one) dose per 24 hours  
numeric spelled out

methadone 10 mg (ten mg) Q3H PRN – maximum 3 (three) PRN doses per 24 hours  
numeric spelled out

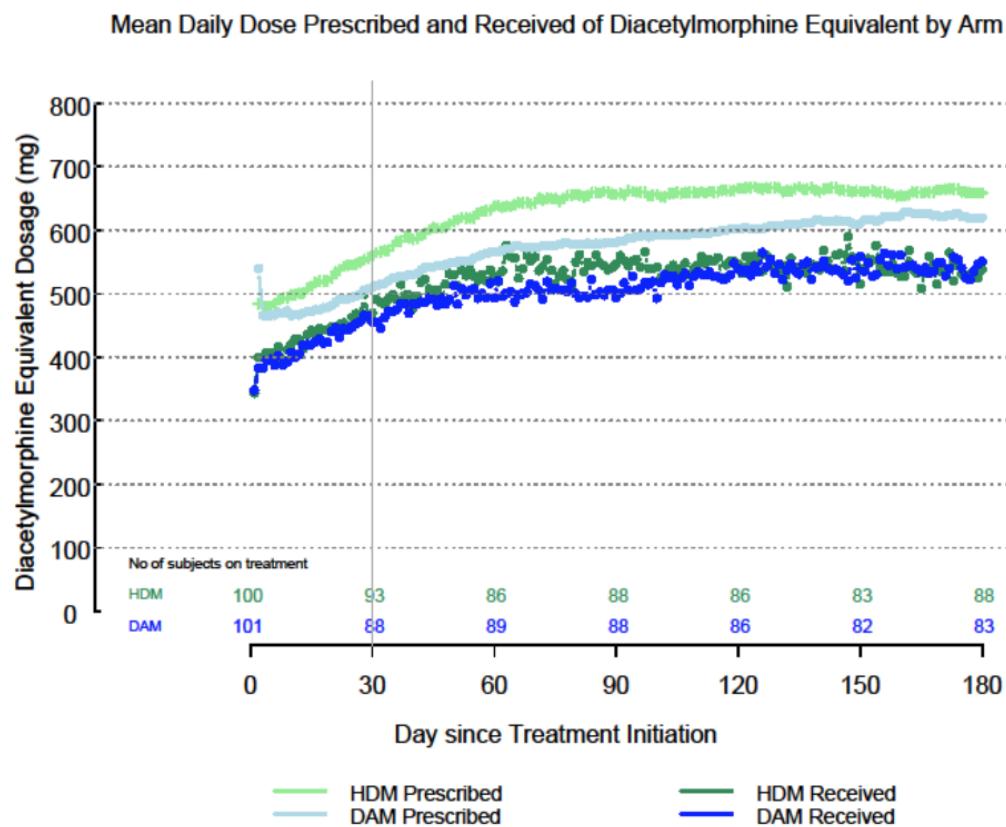
Hold methadone if patient is drowsy and not easily rousable

**Ensure at least 3 hours between all scheduled and PRN methadone doses**

Notify methadone prescriber STAT if methadone dose is held or missed for any reason

Contact methadone prescriber if patient is drowsy and difficult to rouse 3 hours post-dose

# Mean Daily Dose by Arm in the SALOME Study



Average daily-total dose received:

HDM = 261.18 mg  
(SD=104.02; range= 44.18 to 497.85).

DAM = 506.41 mg  
(SD=205.49; range = 51.00 to 933.15).

**WARNING!**  
VIEWER DISCRETION ADVISED  
This booklet may offend some viewers as it contains information  
that may save drug users' lives!

# SHARP SHOOTERS

HARM REDUCTION INFO  
FOR SAFER INJECTION DRUG USE



# FUCK SAFE

- SAFER SHOOTING
- OD'ING
- NEEDLE EXCHANGE
- & MORE!

# SHOOT CLEAN



Special thanks to: The Original "Sharp Shooters" (you know who you are), Scott F., Frank C., Kelly G., Matt J., Danny W., Butch, Sara, Anne-Marie, Cyndi, Raffi, Or Tim, Barb & Erin. Thanks, too, to South Riverdale Community Health Centre's COUNTERfit program.

LOOK INSIDE  
FOR INFO ON:  
• AVOIDING  
INFECTIONS  
• VEIN CARE

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Contact:

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Canada's source for  
HIV and hepatitis C  
information

CATIE Ordering Centre No: ATI- 70095  
(aussi disponible en français, ATI-70096)

Production of this publication has been made possible in part through financial contributions from the Ontario Ministry of Health and Long-Term Care (MOHLTC). The views expressed herein do not necessarily represent the views of our funders.



# Choosing a safer injection site

## Safer

**Arms:** Your arms are the safest places to inject. Use different veins every time you inject to help them heal.

**Back of hand:** The veins in your hands are fragile, so inject slowly. Give these veins extra time to heal.

## Try to avoid

**Legs:** Inject yourself lower in your leg before injecting in places higher on your leg. You could get blood clots. These clots can go to your lungs or heart and cause serious problems.

**Feet:** The veins in your feet are fragile. Give these places extra time to heal. If you have foot problems, do not inject yourself here.

**Breasts:** Try not to inject yourself in your breasts. Injecting into your breasts can cause blood clots that can cause pain and swelling.

## Dangerous

**Wrist:** Try not to inject yourself in the wrist because you could hit an artery or nerve. Your wrist is full of veins, arteries and nerves that are very close together.

**Neck:** Avoid the neck vein because it is close to important arteries. You could die if you hit one of these arteries.

**Groin:** Avoid injecting into the groin. It is very close to an artery. Hitting this artery is dangerous. If you get a big bruise after you inject here, get medical help right away.

**Penis:** Avoid injecting into the penis. There is a high chance it could become infected, causing serious problems.



Canada's source for  
HIV and hepatitis C  
information

1-800-263-1638 | [www.catie.ca](http://www.catie.ca)