Ethical Issues in Inner City Health

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Conflict of Interest

I receive an administrative salary from the Royal Alexandra Hospital Foundation (via Alberta Health Services).
Objectives

• Discuss the implementation and role of the Inner City Health and Wellness Program at the RAH
• Highlight some key ethical issues encountered during the first year of the program
  – Who should have access to detailed substance use and social risk information?
  – What is the role of harm reduction in an acute care setting?
  – Is it acceptable to reduce patient choice in order to improve compliance?
Background

• EICHREN was established in 2008 with a generous grant from the Royal Alexandra Hospital Foundation

Key Initiatives:
  – Needs Assessment and Satisfaction with Care Survey of Homeless and/or Substance Using Patients Presenting to the ED
  – Towards Patient-Centered Addictions Care Study
  – Inner City Health Elective
  – Discussion Groups
Key Lessons from EICHREN

• Many patients presenting to the RAH with substance use related concerns and/or unstable housing are trying to reduce their alcohol and drug use
• Our patients are interested in accessing additional addiction, housing and mental health related services at the RAH
• Patients who present to the ED with a substance use related complaint and are unstably housed are more likely to be admitted and are frequent ED users
A New Model of Care
The Royal Alexandra Hospital’s Inner City Health and Wellness Campaign
Inner City Health and Wellness Program

Mission:

To provide patient-centered, evidence-based and holistic care for our patients with an active substance use disorder and/or those dealing with social inequity.
Guiding Principles

1. The team will take its direction from the needs of the community that it serves.
2. All activities will be driven by the philosophies of reducing harm, respect and empowering people to make healthy choices.
3. The team and its activities will be culturally competent and will focus on relationship building and trust.
4. A broad definition of health (including physical, mental, emotional and spiritual) will be used to define outcomes.
5. Research and educational initiatives will be action-oriented and widely accessible.
Goals

1. Identification
2. Evidence-based addictions management
3. Improve social determinants of health
4. Maximize communication
5. Link to primary and community based care
6. Education
7. Research
Core Team Members

• Clinical Team
  – Physician
  – Nurse Practitioner
  – Social Worker
  – Addiction Counsellor
  – {Peer Outreach Worker}

• Education Team
  – Education Coordinator

• Research Team
  – Scientific Director (via partnership with the School of Public Health); Associate Scientific Director
  – Research Assistants

• Administrative Team
  – Director
  – Assistant Director
  – Administrative Assistant
The Addiction Recovery & Community Health Team
Hospital-Based Multidisciplinary Treatment

- Development of standardized intake and assessment procedures
- Comprehensive, evidence-based addictions management
  - Treatment of complicated intoxication and/or withdrawal
  - Initiation or maintenance of opioid agonist therapy
  - Harm reduction supplies and overdose prevention
  - Counseling, motivational interviewing, relapse prevention, treatment referrals
  - Identification and shared management of co-morbid mental health conditions
- Interventions to Maximize Social Determinants of Health
  - Housing, income support, ID
- Health Promotion activities
  - STI/BBV screening, PAP smears
Transitional Care

• Transitional Clinic
  – Follow up of active addiction-related issues
  – Ongoing withdrawal management
  – Bridging to opioid agonist program
  – Follow up of tests performed in the hospital
  – Addiction counseling

• Urgent, next day appointments are available for patients discharged from the ED
Key Partnerships – Healthcare

• Primary Care Providers
  – Boyle McCauley Health Centre, East Edmonton Health Centre
  – PCNs and some interested physicians in the community

• Addictions Care
  – Addiction Services Edmonton, ARC, MOAT, George Spady, Opioid Dependency Programs

• Community Agencies that Provide Healthcare
  – Hope Mission, Herb Jamieson, WEAC, Streetworks, HER pregnancy program, Women’s Health Options, community pharmacies and others
Key Partnerships - Housing

Housing First Collaborative Project

• Prescreening and referral to housing first from the hospital
• Exploration of transitional housing upon discharge
• Prioritizing high risk patients for access to housing
Key Partnerships – Environmental Public Health

• Screening tool for safe and adequate housing developed with environmental public health

• Ability to refer to Vulnerable Populations Program Coordinator to explore safety, tenant rights prior to discharge
Key Partnerships - ID

- Partnership between Alberta Health Services and the Government of Alberta
- Can store ID at the repository and/or use the repository as a mailing address
Key Partnerships – Human Services

• Homeless Transition Coordinator works with ARCH to coordinate access to programs
• This pilot is meant to support homelessness initiatives and enables us to maximize income and other supports

✔ Income Support
✔ Barriers to Full Employment
✔ Assured Income for the Severely Handicapped
✔ Office of the Public Guardian/Trustee
✔ Persons with Developmental Disabilities
✔ Child & Family Services
✔ Family Supports for Children with Disabilities
✔ Homeward Trust
✔ Housing First Agencies
Key Partnerships - Community

AAWEAR (Alberta Addicts Who Educate & Advocate Responsibly)

• Inpatient visits from those with lived experience (addictions, homelessness and much more)

CEASE

AA / NA
Hours

Full team available regular working days from 0800 to 1600.

Physicians available by phone until 2100 and available for urgent medical consults in the evenings and on weekends from 0800 to 2100.

Single point of contact – one pager number – 780.445.2902.
ARCH Team Consults

986 unique patients seen
- Patients are seen either as inpatients, in the ED, or in the clinic
- Many patients seen multiple times in multiple settings

Referral Source:
- 50% from Medicine
- 18% from ED
- 16% from Surgery
- 9% from Hospital Medicine
- 2% from Lois Hole
- 5% other
Who are our patients?

63% are male
Median age is 45 years
45% are Aboriginal

Drug use:
• 72% high risk alcohol use
• 77% smoke cigarettes
• 31% use opioids
• 45% use stimulants
• 31% use marijuana
• 29% have injected drugs in the last 6 months
• 17% have had an unintentional drug overdose in last 6 months

65% report a history of mental illness
40% screen positive for depression

42% are homeless

Income:
• 57% receive income assistance
• 17% no income at all

18% have no medication coverage

ID:
• 48% do not have valid photo ID
• 49% do not have an AHC card
Interventions and Treatments

Half of the patients needed 5 or more (maximum of 19) interventions from the ARCH team

- 88% received at least one substance use intervention
  - 74% brief intervention
  - 48% at least one withdrawal/intoxication/pain intervention
  - 44% at least one addiction treatment referral

- Among opioid users, 41% received at least one opioid agonist therapy intervention

- Among tobacco smokers, 39% received at least one smoking intervention
Interventions and Treatments

- 44% received at least one intervention to assist with social stabilization
  - Among unstably housed patients, 24% received at least one housing intervention
  - Among Aboriginal patients, 19% received a referral to an Aboriginal Cultural Helper
  - Among patients with no ID, 15% received at least one ID intervention
  - Among patients with no income, 18% received at least one income intervention

- 53% received at least one health promotion intervention
  - 42% were screened for infectious diseases
  - 9% were booked for a follow-up appointment in the ARCH clinic
  - Among patients without a primary care provider, 30% received a referral
Research Arm

**Process Evaluation**
- Examines how Arch Team functions:
  - Monitors program implementation
  - Measures patient perspectives on care
  - Assesses clinical care team effectiveness
  - Internal and external stakeholder perspectives

**Patient Outcome Evaluation**
- Measures Arch Team impact on patients:
  - Substance use stabilization
  - Chronic disease prevention
  - Attachment to primary care and other community supports
  - Income support
  - Housing
  - Reduced LAMA, hospitalizations, ED visits, etc.

Research Arm
**Short term patient outcomes**

- Decreased substance use-related risk behaviours
- Stable alcohol intake
- Stable drug intake
- Uptake into treatment
- Uptake into ODT
- Stable tobacco intake
- Prevention of STIs and unwanted pregnancy
- Primary care attachment
- Reduced leaving against medical advice
- Reduced leaving without being seen
- Valid ID
- Alberta health care coverage
- Medication coverage
- Outreach worker attachment

**Medium term patient outcomes**

- Treatment completion/ODT stabilization
- Decreased ACSC presentations to ED
- Decreased ED presentations
- Decreased EMS activations
- Increased continuity of care
- Reductions in trauma and injury
- Reduced hospitalization
- Increased housing stability
- Income support

**Longer term patient outcomes**

- Decreased substance use
- Decreased alcohol use
- Decreased tobacco use/tobacco cessation
- Improved health and wellbeing
- Housing/Social Stabilization
- Decreased criminal victimization
- Decreased criminal activity

**Inputs**

- Physicians with expertise in addiction medicine
- Nurse practitioner
- Social worker
- Addictions Counsellor
- Transitional clinic
- In-hospital consultations
- RAHF funding
- Institutional support
- Oversight committee
- Community partnerships
- Community Advisory Committee
- Education Advisory Committee
- Research Advisory Committee
- Clinical Advisory Committee

**Activities**

- SBIRT, MI, and counselling
- Substance use treatment liaison
- ODT initiation & maintenance
- Withdrawal/Complex pain management
- Harm reduction education, liaison, & supplies
- Tobacco cessation counselling & NRT
- Health promotion services
- Sexual health & prevention services
- STIBBV screening
- Primary care linkage
- Government ID applications
- Tax filing
- Health care/Medication coverage applications
- Housing support and liaison
- Income support applications
- Community services liaison

**Outputs (# of)**

- Brief interventions for alcohol/drug use
- Detox referrals
- Addictions counselling referrals
- Treatment referrals
- Peer support referrals
- Treatment applications
- ODT starts
- ODT prescriptions
- Withdrawal management interventions
- Acute pain management interventions
- HR education sessions
- HR referrals
- HR supplies distributed
- Naloxone kits distributed
- Overdose prevention sessions
- NRTs prescribed
- Tobacco cessation counselling sessions
- Health promotion counselling sessions
- Outpatient medical interventions
- MH therapist referrals
- Contraception prescriptions
- STIBBV screens
- Primary care referrals
- Gov’t ID applications
- Gov’t ID issued
- Alberta health care coverage applications
- Medication coverage applications
- Housing referrals
- Income support applications
- Community services referrals
- Outreach worker referrals
- Aboriginal cultural helper

**LOGIC MODEL**
Research

• Patients are being enrolled into a longitudinal cohort study
  – Follow-ups occur at 6 and 12-months along with administrative data linkage in consenting patients
  – Includes an economic analysis

• Additional funding has also allowed us to begin enrolment of a control group in Calgary
Educational Activities

• Harm Reduction Training

• Grand Rounds
  – Held quarterly, next one January 18, Robbins Learning Centre at 0800 “Six Ways to Improve Health and Reduce Substance-Related Harm in Edmonton”

• Inner City Health Elective

• Patient Education Sessions

• Standardized approach to alcohol withdrawal and development of a managed alcohol program
# Ethics in Substance Use Disorder Treatment

<table>
<thead>
<tr>
<th>Concept</th>
<th>Application</th>
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<tbody>
<tr>
<td>Autonomy or self-determination</td>
<td>A patient in the medical ICU for her fifth admission for an upper gastrointestinal bleed in 1 year refuses admission to an inpatient addiction psychiatry unit.</td>
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<tr>
<td>Beneficence</td>
<td>An addiction therapist is counseling a patient from a rural area whom must travel several hours to the sessions. He believes it is in the best interest of the patient to be admitted to a residential program, which is restricted to patients who have failed outpatient treatment. The therapist advocates for the patient’s admission.</td>
</tr>
<tr>
<td>Nonmaleficence</td>
<td>A patient who has ADHD and methamphetamine dependence asks his psychiatrist to prescribe a stimulant so he won’t self-medicate with illicit drugs.</td>
</tr>
<tr>
<td>Justice</td>
<td>A patient who has cocaine dependence who has failed outpatient treatment several times is denied admission to a long-term residential program because his insurance company states it is not clinically indicated.</td>
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<tr>
<td>Respect for people</td>
<td>An Iraq veteran who has PTSD and chronic pain from an intermittent explosive device requests a refill of his opioids 2 days early and is told he is a “drug addict.”</td>
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<tr>
<td>Truth-telling</td>
<td>A nurse on a geriatric ward is abusing opioids and promises she will enter monitored treatment if her nurse manager does not report her to the nursing board.</td>
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**Abbreviations:** ADHD, attention deficit hyperactivity disorder; PTSD, posttraumatic stress disorder.

Confidentiality

53 year old female admitted with pneumonia, stimulant use disorder, active involvement in the sex trade

28 year old male admitted with endocarditis due to injection drug use; regularly injecting opioids prescribed by his family physician

57 year old male admitted to ICU with an unintentional heroin overdose; runs a successful Edmonton business
Confidentiality

• Stigma – “a negative social value associated with a personal attribute that has consequences in thoughts, emotions and/or behaviors”
• Adversely affects the well-being of people who have an addiction even after recovery
• Large segments of society view individuals with substance use disorders as unpredictable, dangerous and responsible for their circumstances

Confidentiality

- Confidentiality rules and regulations are typically stricter and more protective
- Encourages patients to discuss their substance use and its consequences honestly to facilitate accurate diagnosis and effective treatment
- Competing ethical demands – ethical principles apply to both the individual patient and society

Be proactive

- Counsel patients at the beginning of assessment around the limits of confidentiality and who will have access to the information they are about to share
- Report only the minimal amount of information required to external agencies with written, informed consent
Thoughts ...

• Is consent required for the ARCH assessment to become part of the patient’s electronic medical record?

• Should access to that part of the medical record be restricted?
Harm Reduction in Acute Care

24 year old female admitted with multiple septic joints; recurrent bacteremias with different organisms

36 year old male admitted with an epidural abscess found injecting in his room

36 year old male admitted with left foot infection, severe alcohol use disorder, multiple episodes of leaving AMA
Harm Reduction

Harm Reduction is a comprehensive, just and science-based approach to drugs. It represents policies, strategies and services which aim to assist people who use legal and illegal psychoactive drugs to live safer and healthier lives. All drugs have both positive and negative effects. Substance use is a personal choice that may affect one’s health and legal vulnerability, and recognizes that people use drugs for many reasons. Reduction of substance use and/or abstinence is not required in order to receive respect, compassion or services. It is clear that most people who use substances do not experience problems, but in some circumstances, substance use can become dependent and/or chaotic. Harm Reduction enhances the ability of people who use substances to have increased control over their lives and their health, and allows them to take protective and proactive measures for themselves, their families and their communities.

Streetworks, 2015
HARM REDUCTION FOR PSYCHOACTIVE SUBSTANCE USE

ALBERTA HEALTH SERVICES

DOCUMENT #
HCS-33

INITIAL APPROVAL DATE
October 28, 2013

APPROVAL LEVEL
Alberta Health Services Executive Team

INITIAL EFFECTIVE DATE
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SPONSOR
Addiction and Mental Health

REVISION EFFECTIVE DATE
N/A

Population and Public Health

CATEGORY
Health Care and Services

NEXT REVIEW
October 28, 2016

If you have any questions or comments regarding the information in this policy, please contact the Clinical Policy Department at clinicalpolicy@albertahealthservices.ca. The Clinical Policy website is the official source of current approved clinical policies, procedures and directives.

PURPOSE

- Alberta Health Services is committed to harm reduction as one approach when working with individuals that use psychoactive substances.

- To offer direction in program planning and service delivery within the organization built on the principles and evidence base for the practice of harm reduction.

- To encourage and facilitate joint harm reduction strategies and partnership initiatives between Alberta Health Services and community agencies.
Hospitals as Risk Environments

• Patients with substance use disorders are seen in the ED and are admitted to hospital significantly more often than the general population
• Face multiple barriers to accessing health care
• One of the populations most likely to be discharged from hospital against medical advice

Hospitals as Risk Environments

“A key finding of this study is that patients who use illicit drugs characterize the health care system as unsafe…”

Hospitals as Risk Environments

Structural vulnerability – social arrangements embedded in the organization of society render particular populations disproportionately vulnerable to harm

Everyday violence – normalization of suffering within any particular context due to the contextual forces that render it invisible

Hospitals as Risk Environments

• Complex pain and withdrawal untreated

• “drug-seeking”

• Surveillance, searches

Hospitals as Risk Environments

Abstinence only policies, inadequate pain & withdrawal management, negative stereotypes

Inability to practice harm reduction, involuntary discharge

Increased morbidity and mortality

Harm Reduction in Acute Care

• Focus on reducing harm may be a more ethical approach

• When abstinence is not possible, it is not ethical to ignore other available means of reducing suffering

• It should not be easier to access evidence-based health interventions in the community than in the hospital

Figure 1  Conceptual model to promote patient-centered care for people who use drugs (PWUD)

Thoughts …

• Is there an ethical imperative to incorporate harm reduction into acute care? How do we do this?

• Should hospitals offer safe injection services?
Limiting Choices

33 year old woman admitted to hospital with pelvic inflammatory disease, 12 weeks pregnant with an opioid use disorder

45 year old man with discitis being discharged on oral antibiotics, currently receiving po opioids as part of a harm reduction approach in hospital
Informed Consent

• Patients with substance use disorders – unless it can be established otherwise – ought to be presumed capable of understanding and consenting to treatment regimens

• Need to provide information in a manner that enables the individual in question to make a choice for him/herself

Capacity

• People with severe addiction may have extremely diminished capacity to choose other priorities over substance use even in the face of severe consequences.

• Autonomy, although operative in the early stages of the disease process, may become reduced.

Fig. 3. Model proposing a network of interacting circuits, disruptions in which contribute to the complex set of stereotypic behaviors underlying drug addiction and chronic overeating: reward (nucleus accumbens, VTA, and ventral pallidum), conditioning/memory (amygdala, medial OFC for attribution of saliency, hippocampus, and dorsal striatum for habits), executive control (DLPFC, ACC, inferior frontal cortex, and lateral OFC), motivation/drive (medial OFC for attribution of saliency, ventral ACC, VTA, SN, dorsal striatum, and motor cortex). Nac, nucleus accumbens, interoception (Insula and ACC), and aversion/avoidance (Habenula). (A) When these circuits are balanced, this results in proper inhibitory control and decision making. (B) During addiction, when the enhanced expectation value of the drug in the reward, motivation, and memory circuits overcomes the control circuit, favoring a positive-feedback loop initiated by the consumption of the drug and perpetuated by the enhanced activation of the motivation/drive and memory circuits. These circuits also interact with circuits involved in mood regulation, including stress reactivity (which involves the amygdala, hypothalamus, habenula) and interoception (which involves the insula and ACC and contributes to awareness of craving). Several neurotransmitters are implicated in these neuroadaptations, including glutamate, GABA, norepinephrine, corticotropin-releasing factor, and opioid receptors. CRF, corticotropin-releasing factor; NE, norepinephrine. Modified with permission (Volkow et al., 2011).
Thoughts ...

• Should options be limited in the best interest of the patient?

• Do the neurobiochemical changes associated with substance use justify restricting treatment options?
Thoughts ...

- Is consent required for the ARCH assessment to become part of the patient’s electronic medical record?
- Should access to that part of the medical record be restricted?
- Is there an ethical imperative to incorporate harm reduction into acute care? How do we do this?
- Should hospitals offer safe injection services?
- Should options be limited in the best interest of the patient?
- Do the neurobiochemical complications of substance use justify restricting treatment options?
Summary

• The ARCH Team at the RAH is delivering patient-centered, evidence-based care for patients with active substance use disorders and/or those patients dealing with social inequity

• Care of these patients can be complex and raises ethical issues around confidentiality, harm reduction and patient autonomy
Questions?

Thank you!

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