What Patients Have Taught Me about Addiction, Homelessness, and Society's Obligation to Those Living in the Shadows

January 22, 2018

Editor's note: Dr. James O'Connell, President of the Boston Health Care for the Homeless Program (BHCHP) and Assistant Professor of Medicine at Harvard Medical School, contributed this op-ed as part of our Special Series on Addiction and Homelessness. Dr. O'Connell is the author of Stories from the Shadows: Reflections of a Street Doctor.

Serendipity has wreaked havoc in my career, often trumping carefully conceived plans. Four-year grants from the Robert Wood Johnson Foundation were given to the City of Boston and 18 other cities in 1985 in an effort to integrate the care of homeless individuals and families into the mainstream of each city's health care system. I was asked by Dr. John Potts, my Chief of Medicine at MGH, and Dr. Tom Durant, a longtime mentor, to delay a planned fellowship in oncology and accept a role as the physician with the new Boston Health Care for the Homeless Program. I was truly an accidental tourist with no experience in homelessness and ill-prepared for the burden of co-occurring medical, psychiatric, and substance use problems borne by this eclectic and vulnerable population struggling to survive without homes in the midst of abject and persistent poverty. My one-year diversion from my planned career path ignited my passion as the sheer complexity of caring for homeless persons challenged all of my clinical skills. I am still learning in that same role thirty-three years later.

In our new shelter and street clinics that summer of 1985, we were overwhelmed by an outbreak of multi-drug resistant pulmonary tuberculosis among dozens of

men in one shelter, most with alcohol use disorder and none with immunocompromise. Each required four medications each day for 18 months, a public health challenge that taught us that we always needed to be working as a team with our community and hospital partners. In early September, we saw the first person known to be diagnosed with AIDS while living in the shelters of Boston. During that first year, we cared for more than 100 homeless persons diagnosed with HIV/AIDS, most of whom had contracted the virus through injection drug use. This epidemic of AIDS, universally fatal in the decade before protease inhibitors (with the exception of rare long term non-progressors), was horrific and death lurked everywhere.

Substance use disorders (SUD) were intimately involved in the spread and immensely complicated the treatment of these two epidemics among homeless individuals. I became acutely aware of a gaping hole in my medical school and residency training. Dr. Timothy Wilens, a wonderful psychiatrist at MGH and currently Chief of Adolescent Psychiatry, and I were approached to be the co-medical directors of a new dual-diagnosis detoxification program in 1987. With funding from the Departments of Public Health and Mental Health, Andrew House was opened in a building adjacent to the 500-bed city shelter on Boston's Long Island. Run by Bay Cove Human Services, this remarkable program was the first in Massachusetts to serve those with co-occurring SUD and persistent mental illness. The Andrew House mission was to serve poor and homeless persons living on the edge of society, in marginal housing, in shelters, and on the streets. Tim and I had a steep learning curve as we learned safe approaches to medical detoxification. Most admissions in those early years were for uncomplicated alcohol detoxification, with only a few for opiates or benzodiazepines. AIDS underscored the need for better treatment of opiate use disorder, and we were asked to be co-directors of Bay Cove's Treatment Center, a methadone maintenance clinic then located on Lincoln Street in the Leather District. Neither of us had much experience with methadone but we soon witnessed the extraordinary effectiveness of this medication.

Admissions to Andrew House for heroin and other opiates, as well as cocaine, slowly rose during the 1990s and soon exceeded the number for alcohol. Parallel to this trend was a subtle but persistent rise in the number of individuals with polysubstance use disorders. We continually adjusted our detoxification protocols to optimize safe treatment for the simultaneous withdrawal from combinations of alcohol, heroin, benzodiazepines, cocaine, and other drugs. Our patients taught

us about the emerging use of creative "drug cocktails" on the streets, urging us to pay attention to the street value of commonly prescribed medications. One man, clean and sober for over a decade, walked me to Haymarket in 1998 and showed me a clear baggie labelled "Nirvana" containing four pills: oxycodone, clonazepam, clonidine, and promethazine. He explained that this $40 purchase assured a "heavy knee-bending sedation for 18 or more hours" and was the most sought-after purchase on the streets at that time. 'We are always one step ahead of our doctors!" I was bewildered as we contemplated this significant challenge that clearly presaged the widespread opioid epidemic that currently engulfs us.

A hallmark study published in 2013 by Travis Baggett and his colleagues at BHCHP and MGH showed opioid overdose to be the leading cause of death among Boston's homeless population from 2003-2008, almost a decade before the opioid epidemic became widespread across America. First, we had to acknowledge our collective failure to address opiate and other substance use disorders at BHCHP. Led by our intrepid CMO, Dr. Jessie Gaeta, many innovations have been implemented, including: a significant reduction in the number of prescriptions for opiates; naloxone (Narcan) training offered to all staff; Narcan offered to each person and partner with a narcotic prescription; board certification in Addiction Medicine achieved by more than a dozen of our doctors and NP/PA's; expansion of buprenorphine availability at our BMC and MGH clinics as well as one of our major shelter clinics; and SPOT (Supportive Place for Observation and Treatment) conceived and opened at our main facility at the corner of Massachusetts Avenue and Albany Streets.

SPOT was a response not only to the escalating number of overdoses occurring in and around our main clinic but also to the growing numbers of heavily sedated individuals in our lobby and waiting room. Individuals are anonymously invited into SPOT, where nurses and a physician monitor vital signs while a person recovers. The immediate objective is to prevent fatal overdoses, while the long term goal is earning trust and offering direct access to treatment.

SPOT has affirmed the lesson taught us by our patient in Haymarket 20 years ago. We know that 80% of the heroin deaths are due to fentanyl (and carfentanil), with most occurring soon after these powerful anesthetics are injected. We desperately need to explore every strategy possible to spare these tragic deaths and I do not want to divert our attention from that objective. But a second epidemic, largely hidden and perhaps more pervasive, is fueled by the creative

use of “drug cocktails” designed to cause marked sedation. One lens through which to monitor and understand these cocktails is the current street value of commonly prescribed non-opiate medications. During the past several years, the two most frequent and worrisome have been gabapentin and clonidine. For example, 800 mg of gabapentin (Neurontin) has the same street value as 1 mg of clonazepam (Klonopin), while clonidine (Catapres) sells for $1 per 0.1 mg. When combined with an opiate and/or a benzodiazepine (and often an antihistamine such as promethazine or hydroxyzine), these medications potentiate the sedation caused by opiates and benzodiazepines. As one anesthesiologist pointed out to us, this resembles a relatively common cocktail used for conscious sedation during surgery. We are again one step behind, as most of us have prescribed gabapentin and clonidine without understanding either the street value or the dangerous interactions with opiates and benzodiazepines.

I close with a nagging but poorly articulated concern. We know that the flexible and individualized continuum of care necessary for those caught in the throes of this opioid epidemic remains sorely lacking, particularly for those who have lived for years in shelters and on the streets. One patient of ours was housed recently after two decades on the streets of Boston. He managed to become clean and sober after he was housed with the help of buprenorphine and regular group meetings. Yet he soon relapsed, pleading with us that the stark reality of his life without family, friends, or job was too much to bear, and “getting high was much better.” We have come to view homelessness as a prism held up to society. Refracted are the weaknesses and failures of many sectors, including housing, education, justice, labor, welfare, commerce, and health. The permanent solution to homelessness will only come when society addresses the insidious determinants of disease attendant to poverty. Health and sobriety are optimized by the hope and opportunity created by a community of friends and/or family, stable and affordable housing, safe neighborhoods, and access to education and employment. We have our work cut out for us.

— James O’Connell, M.D.

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