STUDIO TEAM PROPOSAL

GOING BIG ON THE HARM REDUCTION CENTER

To fairly test the potential of a Harm Reduction Center (HRC) as an alternative to a more traditional treatment center, it will be important to properly resource the pilot. Instead of repeating the half-measure mistakes of the past, let's make a big bet on a better future. This proposal sketches how a comprehensive range of offerings — delivered reliably — would make the Center a trusted source of services and care.

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SEED – Support, Embrace, Empower: Differently

When emergency departments were designed decades ago, they were to be effective, efficient, and compassionate. They were designed to deliver care and save lives for people presenting a wide range of medical crises.

During this time, individuals with behavioral health, substance use disorder, or an overdose crisis were a small fraction of the patients seen in the EDs. That fraction has skyrocketed, to almost one third of those presenting in emergency rooms currently. Unfortunately, this has come at a cost. EDs have needed to upgrade their standards for behavioral care to handle the increase in substance use and overdose cases. Staff are not adequately trained nor is the environment designed to support these cases. As a result, many people working in the ED experience burnout. While some are trying to solve this issue through incremental improvements, things have gotten worse. Marginal improvements have been prioritized over creating a space and system dedicated for this new and growing need.

It is time to redesign our emergency response. Rhode Island is well positioned by its size and recent legislation to create one comprehensive Harm Reduction Center. Recognized by patients, first responders and providers as the first and primary destination for effective, efficient, compassionate care and treatment for those with behavioral health, substance use disorder, or overdose crisis — all in one place. A "hub" for care that is fully comprehensive and known by everybody in the Rhode Island community as the place to go to be cared for.

A true harm reduction center in Rhode Island would be unique compared to what is currently available. It would put the focus on the people in the space, the space itself, and access.

Governing Design Principles of the Harm Reduction Center

- All-in, not a constrained version
- Not constrained by insurance
- Diverse from the door
- Peer presence
- Community-led
- In the community and easy to get to
- Well-informed neighbors around the site

Personnel

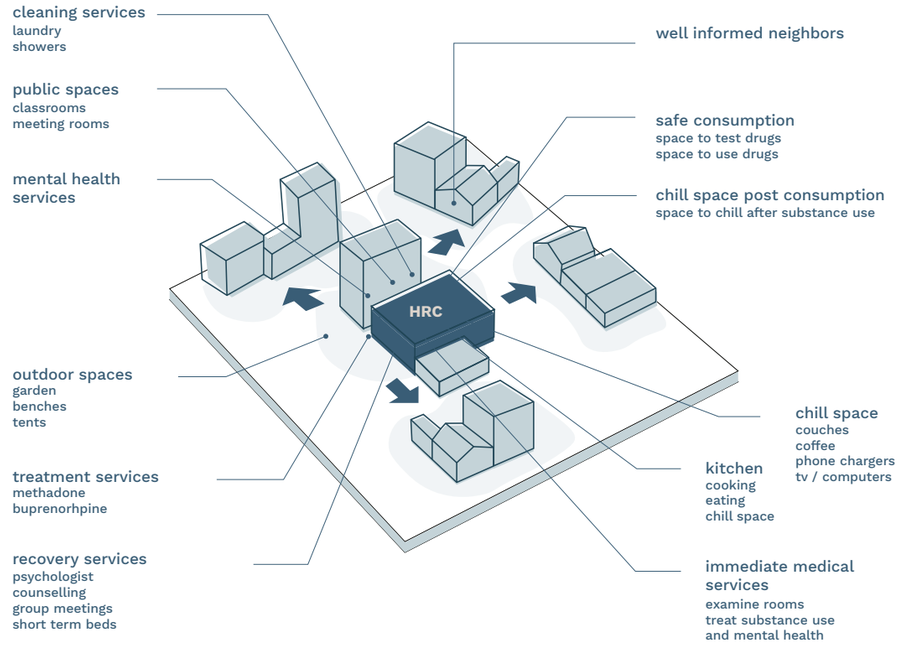
- Director
- Safe Consumption Manager
- Basic Needs Coordinator
- Nurses
- Security
- Attorney
- Insurance specialist

People

"Diverse from the Door"

- Staffed by people who are specifically interested in caring for this population and want to work in this space.
- Staff would also be hired and trained differently: working, learning, and caring alongside people with lived experience.
- Mental and physical urgent care services will greet people who enter the HRC, with physicians, advanced providers, and registered nurses, all trained in trauma informed, patient centered care.
- Goal to employ 50% people with lived drug use, addiction, and recovery experience so that this community, those employed, and those seeking care can see their potential as they access the care.
- A key success factor would be the presence of navigators, peer recovery coaches, and caseworkers to help link folks to the next steps. These are the people who build trust and inspire the changes that need to occur at a client and community level.

Conceptual Diagram of Harm Reduction Center Services



Space

A strong harm reduction center in RI would be a comprehensive mental health services facility with spaces equipped to provide support for harm reduction, behavioral health, and substance use disorder and would include:

- A safe consumption site, managed by nurses, with lifesaving equipment (ie. narcan/ oxygen) on standby, along with fentanyl testing supplies.
- Mental health support, counseling services, treatment and recovery services, immediate medical services.
- Our linkage to patients will be multi-pronged, with the Crisis Assistance Helping Out On The Streets (CAHOOTS) pipeline being a key component. Instead of routing subacute mental health/substance use cases to the hospital, they would come to the Harm Reduction Center, where they can be assessed and treated in a softer, slower, way. A lower tech way, thus saving healthcare dollars.

In addition to a safe consumption site and the mental health urgent care, there needs be space dedicated to community growth and the provision of basic human needs:

- Classrooms, meeting rooms, hang out space for people to gather, to learn, to engage in activities.
- Showers, laundry, light meals, warmth, air conditioning, clothing, etc.
- Bathrooms for "As you Are," Men, and Women
- Computers (Facebook, LinkedIn access), phones, and chargers
- It's only when these basic needs are met, that people can actually begin to work on the less tangible, more lasting self work.

Access

To succeed, people must come to trust that the HRC will be there for them when they need it. Every barrier to access is a chance for someone to veer off the pathway to recovery.

Location is critical.

- Needs to be centrally located in an area where there is demand.
- Easy access to public transit. Studies are available that can help determine ideal locations - the 02907 study done in 2020, the Village study done in 2019, and others. This is what should drive site selection, not politics and optics.
- Where there can be a client flow: built alongside a robust mental health, first responder model, something like CAHOOTS. Then there would be a flow of patients to the center. This would help decompress overburdened hospitals.

Reliability is vital.

- Clients should have at least 12 hour access every day to most non-emergency services.
- Clients should have 16 to 24 hour access to safe consumption site and triaged care.
- No one should be turned away with no next step.
- Patients can walk in or be escorted in by loved ones and receive care. Referrals from ERs and clinics, or direct referral from the on-site safe consumption space.

Who to treat.

Medical vs Behavioral Health vs Substance Use Disorder. Finding the right line.

- Where you decide the cut off of 'who gets treated here vs sent elsewhere' defines how responsive you can be.
- Many behavioral health sites send people to EDs if there is any medical component. If the cut off is not, "Is there a medical component?" that opens things up.
- The HRC should be able to see people with medical/urgent care needs. What, exactly, is the threshold for sending someone to an ED with specialized facilities? Need to decide.
- The size of the space will determine its service offerings.

Criteria for intake.

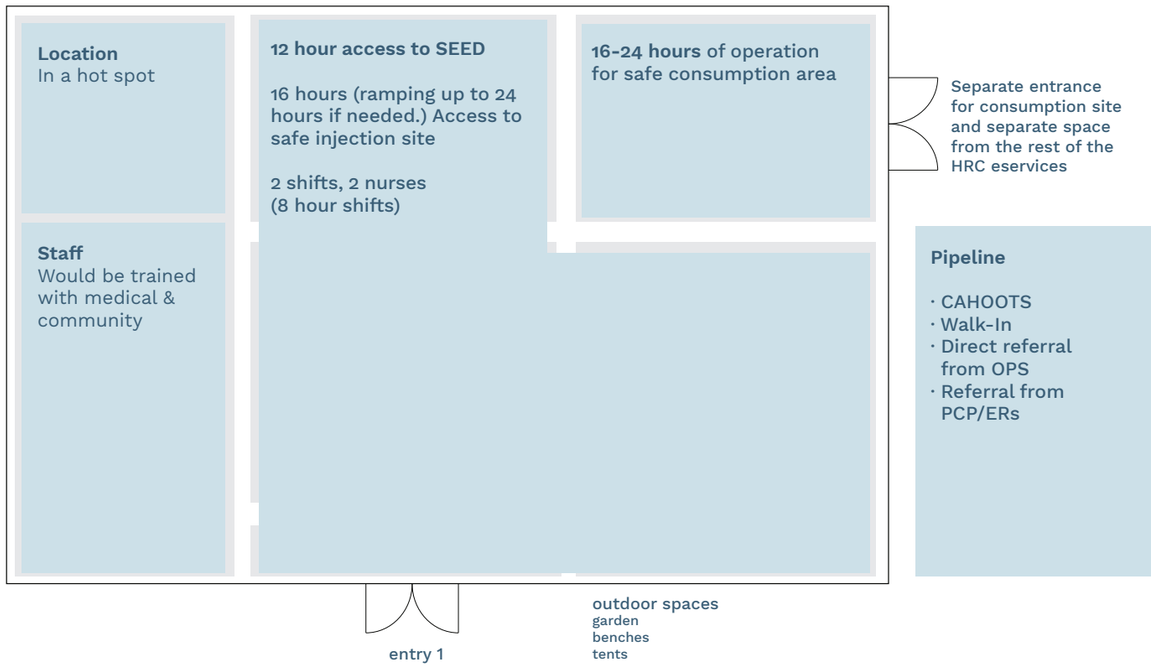
- Simplify admissions processes and paperwork.
- Immediate data intake upon entry.
- Overdose Prevention Site (OPS): people need to be able to walk in 'sober' to use (they have to be able to sign in).
- Harm Reduction Center: No severe high risk cases - these would go to the hospitals. No heart, no airway, no stroke, vitals within a range. Partner with EMS or CAHOOTS to identify these parameters.
- Determined by staff at intake:
  — Different triage.
  — Centralized, on-hand urgent care: IV fluids, comfort related drugs, and supportive services.

Funding

- To decouple the individuals from the finances, this program must be funded by a diverse combination of grants, reimbursements and other income streams.
  — Opioid Stewardship fund ($5million a year)
  — ARPA Fund (RI foundation)
- How much would a comprehensive HRC cost? Is $6 million enough?
- The shift in resource demand may mean this is budget neutral? Meaning that the costs here could save on costs to EDs and emergency services. Need to discover if making the shift = saving costs.

Spatial Use Diagram

Conceptual Diagram of Programmatic Elements



Discussion and Insights

- **Visibility:** Should the HRC be discrete or highly visible? How far from the street to the door? Is it embedded in something or a stand alone space?
- **Location ideas:** North Main street in Providence? Near broad street? Next to the Open Door Health Clinic? (or some other clinic space)? Buy the land across the street from the Armory on Parade st.? The Armory (meets hotspots, transportation access, but is it too big)? Does it have satellite locations?
- **Size:** Safe Consumption space: ~1,000-1,500 sf? Harm Reduction space- ~3,000 sf? (See Spatial Use Diagram for service offerings.)
- **Virtual:** Does the HRC have a website that provides information to the public?
- **CAHOOTS:** Connecting with CAHOOTS model: What's the capacity of 911? Medical v. non medical? 911 needs to have the capacity and training to triage people, transport people (exclusively rescue right now), reimbursement considerations (need a legislative exception: transport, reimbursement, destination).
  — In parallel with HRC, implementing both at the same time
  — Taking people out of ER and putting them into HRC
  — Taking people out of 911 cars/ambulances, and into CAHOOTS van
  — When are we going to see the results of the implementation of HRC and CAHOOTS?
- **Data:** Relevant data will be crucial to determine the scale of the space, and to guide decision making of location(s).
- The HRC needs to be designed comprehensively for a wide range of people and services. If this is done piecemeal, it will end up being designed too narrowly, not staffed appropriately, and won't be successful.
- Oftentimes, harm reduction centers are designed solely for medical purposes and use, but it will be just as important for the HRC to be a safe place for the community to do things together.
- The HRC needs to be seen as a "hub" in the community — so that people who have a history with addiction and those new to dealing with addiction — know to come to it.

Tyrone Mckinney

As a person who lived in the challenging decisions of life, I have had the privilege of occupying two sides of the coin.

On one side, I was living through addiction, being in prison, three types of abuse, mental incapacity, lack of family support, and the words, "No," or, "We Can't."

The other side is of greater education (school), resume building (work), interest in community, and participating in decision-making processes, being a person at the table. Because that's what I feel today. I'm finally at the table.

If I could build something, it would be an idea of empowerment for the community, embracing an approach to mental health and substance use. We need something great to offer our community. They cry daily for change. The bad decisions they are forced to make dictate the need for a state-of-the-art center.

For once in *ourstory*, let's begin looking at what works. Put the passion back into action and put a display of energy into the community to reach the people this project is yearning for. While we have one more meeting, someone is going to die in these streets. Someone is going to unintentionally hurt an employee who is trying, just trying. Someone is not going to get what they are standing in line for. This project belongs in the community, for the community.

The hours of meetings are far too long. The signing of any papers is far too slow. Let's break some ground, somewhere mutual, stop talking about things and just dare to walk...finally or for once. That's as big as it gets!

Dreamers are hopeful ones. And they're the ones who hope for something possible. Not the architects, not the politicians, and not the donors. They are the ones that brick-laid the words, "No," and, "That's Not Possible." So we hope that with this proposal, we can finally get people to start standing up, laying down bricks and getting things done for the community by the community.

— Tyrone Mckinney