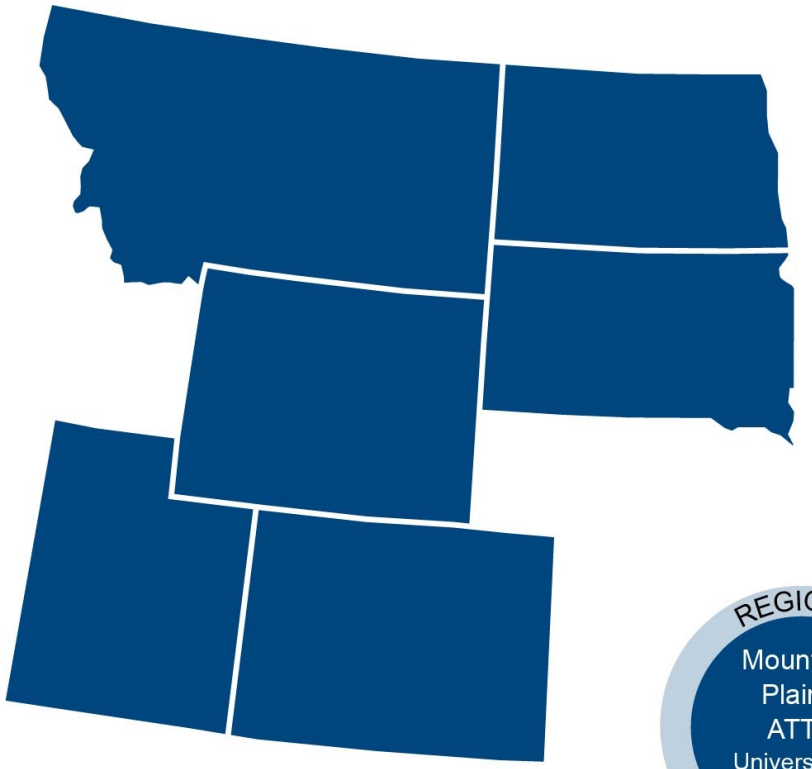
The Mountain Plains Addiction Technology Transfer Center

The Mountain Plains Addiction Technology Transfer Center (Mountain Plains ATTC) supports and enhances substance use disorder treatment and recovery services for individuals and family members throughout Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming).

We belong to the Technology Transfer Center (TTC) Network, a national network of training and technical assistance centers serving the needs of mental health, substance use and prevention providers. The work of the TTC Network is under a cooperative agreement by the Substance Abuse and Mental Health Service Administration (SAMHSA).



REGION 8
Mountain Plains ATTC
University of North Dakota

Twitter: @MT_Plains_ATTC
Website: https://attcnetwork.org/centers/mountain-plains-attc/home

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At the time of this presentation, Tom Coderre served as acting SAMHSA Assistant Secretary. The opinions expressed herein are the views of **Lisa Raville** and do not reflect the official position of the Department of Health and Human Services (DHHS), or SAMHSA. No official support or endorsement of DHHS, SAMHSA, for the opinions described in this presentation is intended or should be inferred.

The work of the Mountain Plains ATTC is supported by grant TI080200_01 from the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

The use of affirming language inspires hope and advances recovery.

LANGUAGE MATTERS.

Words have power.

PEOPLE FIRST.

The ATTC Network uses affirming language to promote the promises of recovery by advancing evidence-based and culturally informed practices.

ATTC Addiction Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

Evaluation Information

The AHTTC is funded through SAMHSA to provide this training. As part of receiving this funding we are required to submit data related to the quality of this event.

At the end of today's training please take a moment to complete a **brief** survey about today's training.

https://ttc-gpra.org/P?s=667586

Harm Reduction Increases Public Safety

First of Three-Part Series

https://und.zoom.us/meeting/register/tJcuduqorDkuGdEAJqG3ERwFqpvO25Eqc57K

Registration for April 13 and April 27 Events at Noon Mountain Time

Mountain Plains ATTC (HHS Region 8)

ATTC Addiction Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

SAMHSA

Substance Abuse and Mental Health Services Administration

Session Objectives

- An examination of the principles and evidence for the application of harm reduction strategies.
- The role of harm reduction programs in eliminating stigma and shame.
- Strategies to work cross-systems to advance harm reduction.
- Data from a recent survey of healthcare workers.

Welcoming Lisa Raville

Executive Director of the Harm Reduction Action Center in Colorado.

Administers Colorado's largest public health agency for people who inject drugs.

Has been successful in legislative efforts to expand harm reduction and is active in advancing policies to support harm reduction.

Mountain Plains ATTC (HHS Region 8)
ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

SAMHSA
Substance Abuse and Mental Health Services Administration

Harm Reduction

- Harm Reduction is Pragmatic
- Harm Reduction Respects Individuality
- Harm Reduction Focuses on Risks and Prioritizes Goals
- Harm Reduction ensures PWUD have a voice in the creation of programs and policies designed to serve them
- Harm Reduction Recognizes that Drug and Alcohol Consumption Exists on a Continuum
- Harm Reduction is Tolerant and Accepting
- Harm Reduction is about Empowerment
- Harm Reduction is NOT the Opposite of Quitting
- Other real-life examples: Nicotine gum, seatbelts, airbags, designated drivers, sand in a playground, housing first, condoms, etc.


12
11
Harm Reduction is no place for ego. It's a place to forget what you think you know and set aside your opinion, so that when you meet people where they're at, you can take the time to ASK THEM where they want to go.
-Dylan Stanley, Director of Community Outreach for Harm Reduction Ohio

Know the Racist Drug History (Very Abridged)

1800s

- AMA founded
- Opiates introduced to modern surgery
- Prohibition/temperance parties founded

1900s

- Temperance education becomes compulsory
- The Pure Food and Drug Act
- Utah passes the first state anti-marijuana law

1919-33: Prohibition

- Cigarettes are illegal in fourteen states
- Manufacture of heroin prohibited
- Formation of Federal Bureau of narcotics

1970s

- Comprehensive Drug Abuse and Control Act: Emphasis on Law Enforcement

War on Drugs Declared by President Nixon

- DEA established
- Alcohol, Drug Abuse, and Mental Health Administration established

Know the Racist Drug History (Very Abridged)

1980s

- Crack is first developed in the early '80s, devastating neighborhoods.
- Reagan signs the Anti-Drug Abuse Act of 1986
- Mandatory minimum penalties for drug offenses

1990s- Present:

- 1995 Crime Bill contributes to mass incarceration
- The U.S. Sentencing Commission releases a report that acknowledges the racial disparities for prison sentencing for cocaine versus crack. The commission suggests reducing the discrepancy, but Congress overrides its recommendation for the first time in history.
- President Bush - Record amounts of money allocated to drug war. Militarization of domestic drug law enforcement. While rates of illicit drug use remain constant, overdose fatalities rise rapidly
- Opioid prescriptions sales quadruple between 1999 and 2010

1990s – Present (Continued):

- President Obama supports policy changes reducing the crack/powder sentencing disparity, ending the ban on federal funding for syringe access programs, and ending federal interference with state medical marijuana laws
- Does not shift the majority of drug policy funding to a health-based approach.
- Marijuana reform gains unprecedented momentum
- President Trump calls for a wall to keep drugs out of the country, and Attorney General Jeff Sessions makes it clear that he does not support the sovereignty of states to legalize marijuana.
- The Opioid Epidemic is declared a national emergency.

People who Inject Drugs (PWID) Characteristics

- Further, stigma and misinformation surrounding PWIDs also lead to healthcare disparities for this population.
- PWIDs represent one of society's most heavily **stigmatized** populations.
- PWID health disparities are not dissimilar to other marginalized populations, such as racial/ethnic minorities, homeless people, and mentally ill populations.
- PWIDs experience disproportionately high morbidity and mortality from manageable infections, including viral hepatitis.
- Healthcare providers often have a misconception that PWIDs do not care about their health.

Who are PWID?

4 Main Reasons a Person Decides to Inject

Seeing someone inject- This takes the fear out of the act, the sky didn't fall, the cops didn't rush in, no one died, no big deal. We call this normalizing a behavior.

- Hearing people talk about the rush and other benefits of injecting- better, harder, faster etc.
- Feeling like the odd one out or that you're missing out: on a better high with a better drug experience, bonding with friends
- Learning that initially it is more economical to inject vs snorting or smoking

Source: Neil Hunt, United Kingdom, Break the Cycle

Fun Facts About Syringe Access Programs (SAP)

Reduction of injection-related diseases (HIV, Hepatitis C) and the risk for injection-related bacterial infections

- New York City SAP expansion: reduction in rate of new HIV infections from 4% per year to 1% per year.
- CDC: SAP's associated with 50% reduction new cases of HIV and HCV

Improvement of Public Safety

- In Portland, OR, improper syringe disposal dropped by almost two-thirds after the establishment of SAPs.
- In addition, SAPs DO NOT increase crime in the neighborhoods in which they are located.

Protection of Law Enforcement

- A study of Connecticut police officers found that needle stick injuries were reduced by two-thirds after implementing SAPs.

Taxpayer Money Savings

- People are living longer with HIV/AIDS; needles cost a dime.

Evidence-Based

- SAPs are based on rigorously tested best practices to treat chaotic drug use as a health issue, NOT a moral issue

Syringe Access Programming Results at Harm Reduction Action Center (February 8, 2012 – December 31, 2020)

- **11,118 unique clients to date! = largest SAP in CO**
- **170,576 + syringe access episodes**
- Average number of people represented per exchange**:** 3.0
- 81,686 (testing, substance use treatment, mental health, etc.)
- Overdose prevention: **4,900** trained, **2,238** lives saved.

HRAC PWID Behavior

Drugs injected most past 30 days (n=11,118)

3.3%= percentage of clients that inject steroids

Heroin: 52%

Methamphetamine: 52%

Goofball (heroin&meth): 16%

Speedball (heroin & cocaine): 11%

Cocaine: 8%

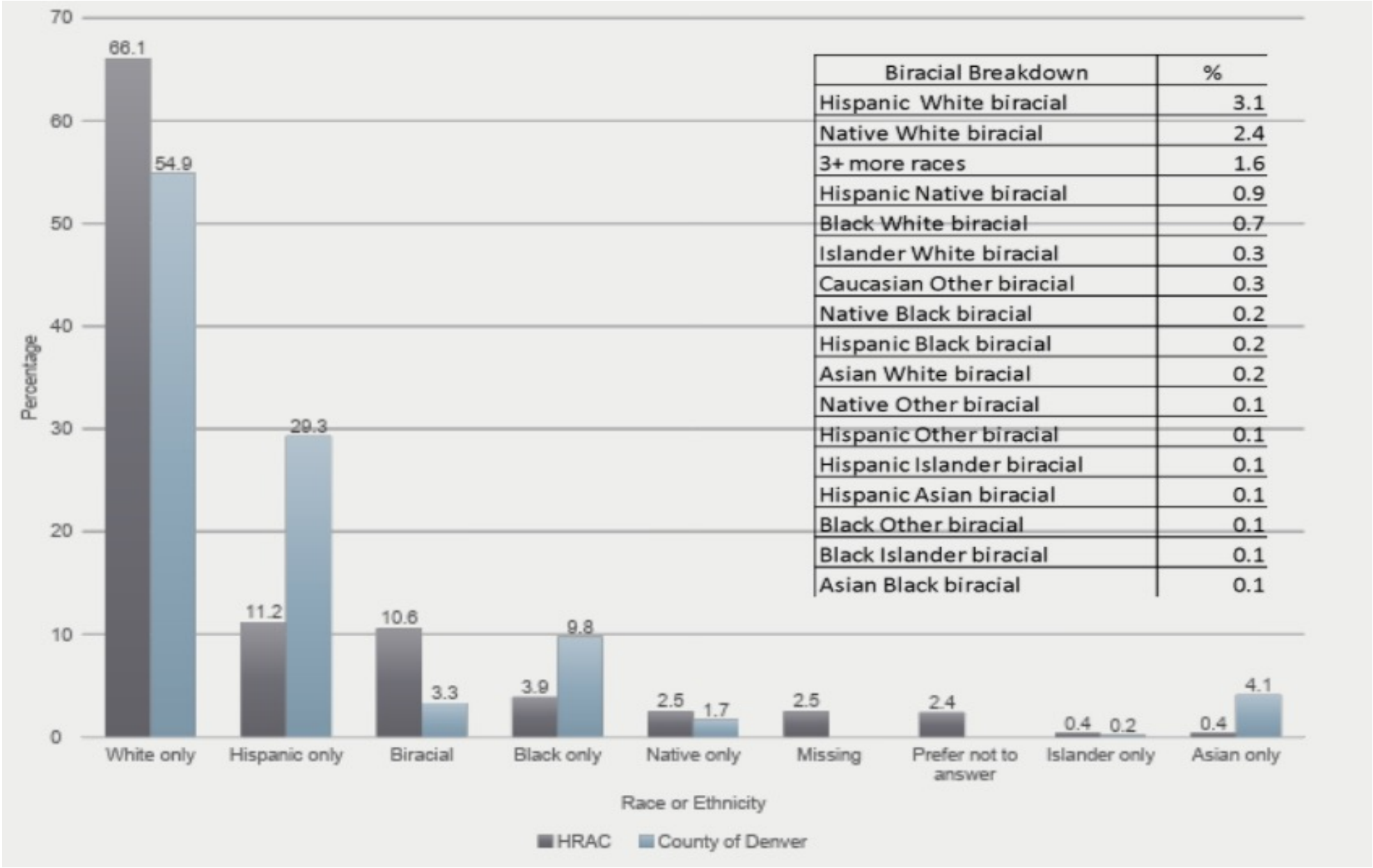
Pharmaceuticals (pills): 5%

SMOKING??

CRACK:
28% of participants surveyed had smoked crack in the past year…12% of them have **shared** a crack pipe in the past 30 days..

METH:
81% of participants surveyed had smoked meth in the past year…59% of them have **shared** a meth pipe in the past 30 days..

HRAC PWID Client Demographics



Biracial Breakdown	%
Hispanic White biracial	3.1
Native White biracial	2.4
3+ more races	1.6
Hispanic Native biracial	0.9
Black White biracial	0.7
Islander White biracial	0.3
Caucasian Other biracial	0.3
Native Black biracial	0.2
Hispanic Black biracial	0.2
Asian White biracial	0.2
Native Other biracial	0.1
Hispanic Other biracial	0.1
Hispanic Islander biracial	0.1
Hispanic Asian biracial	0.1
Black Other biracial	0.1
Black Islander biracial	0.1
Asian Black biracial	0.1

HRAC PWID in Denver (N=11,118)

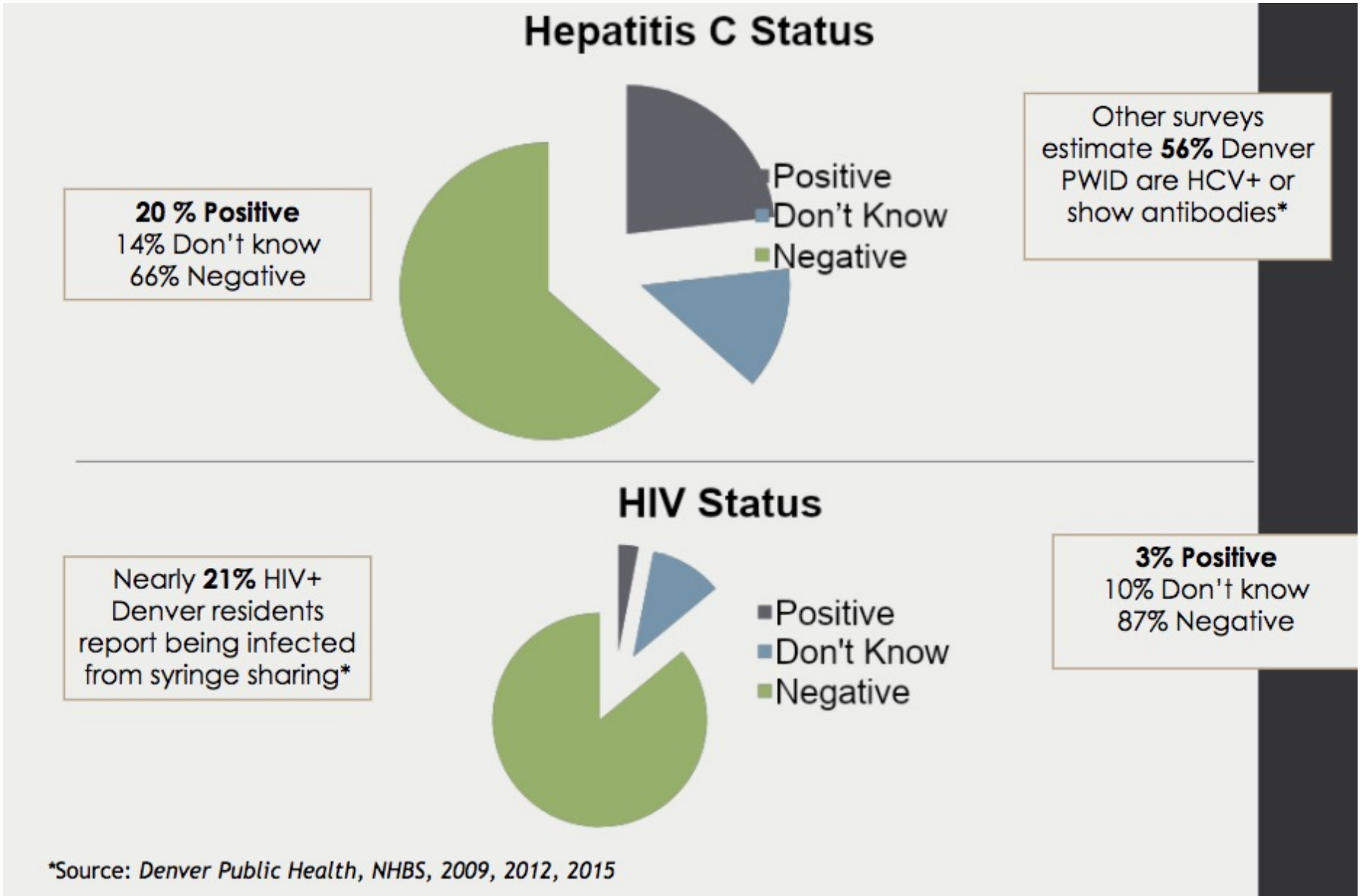
Percentage of clients whose first time is at an SAP: 90%

How did you hear about us?

74% said from a friend, followed by online (10%), outreach (6%)
referral (3%) Other (3%) Missing (4%)

34% had no health insurance at time of intake
3% had CICP, 51% had Medicaid, 2% had VA assistance, 7% had Private insurance, and 2% had “other” insurance

HCV & HIV status at intake



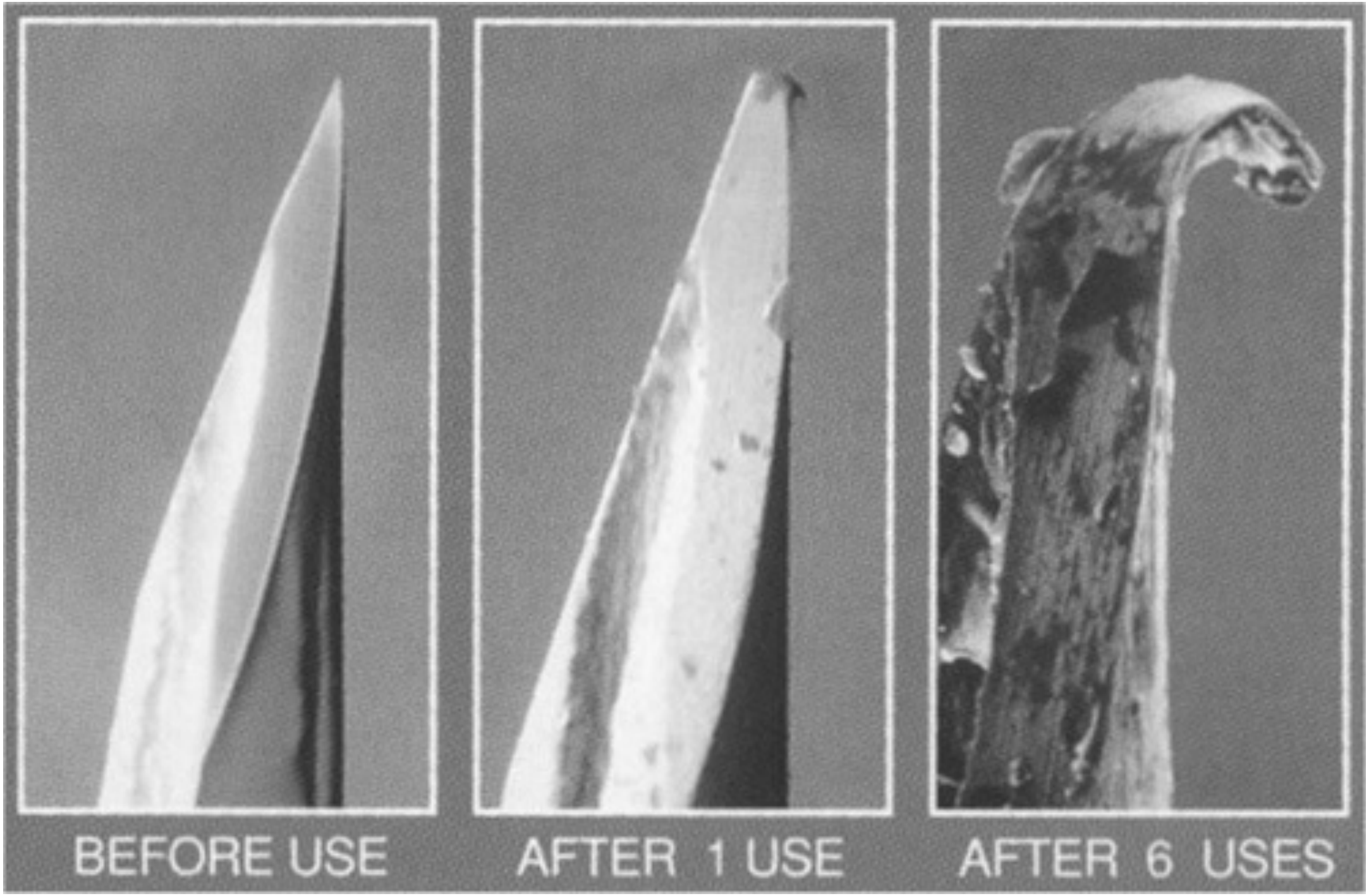
"After reviewing all of the research to date, the senior scientists of the Department [of Health and Human Services] and I have unanimously agreed that **there is conclusive scientific evidence that syringe exchange programs, as part of a comprehensive HIV prevention strategy, are an effective public health intervention that reduces the transmission of HIV and does not encourage the use of illegal drugs."**

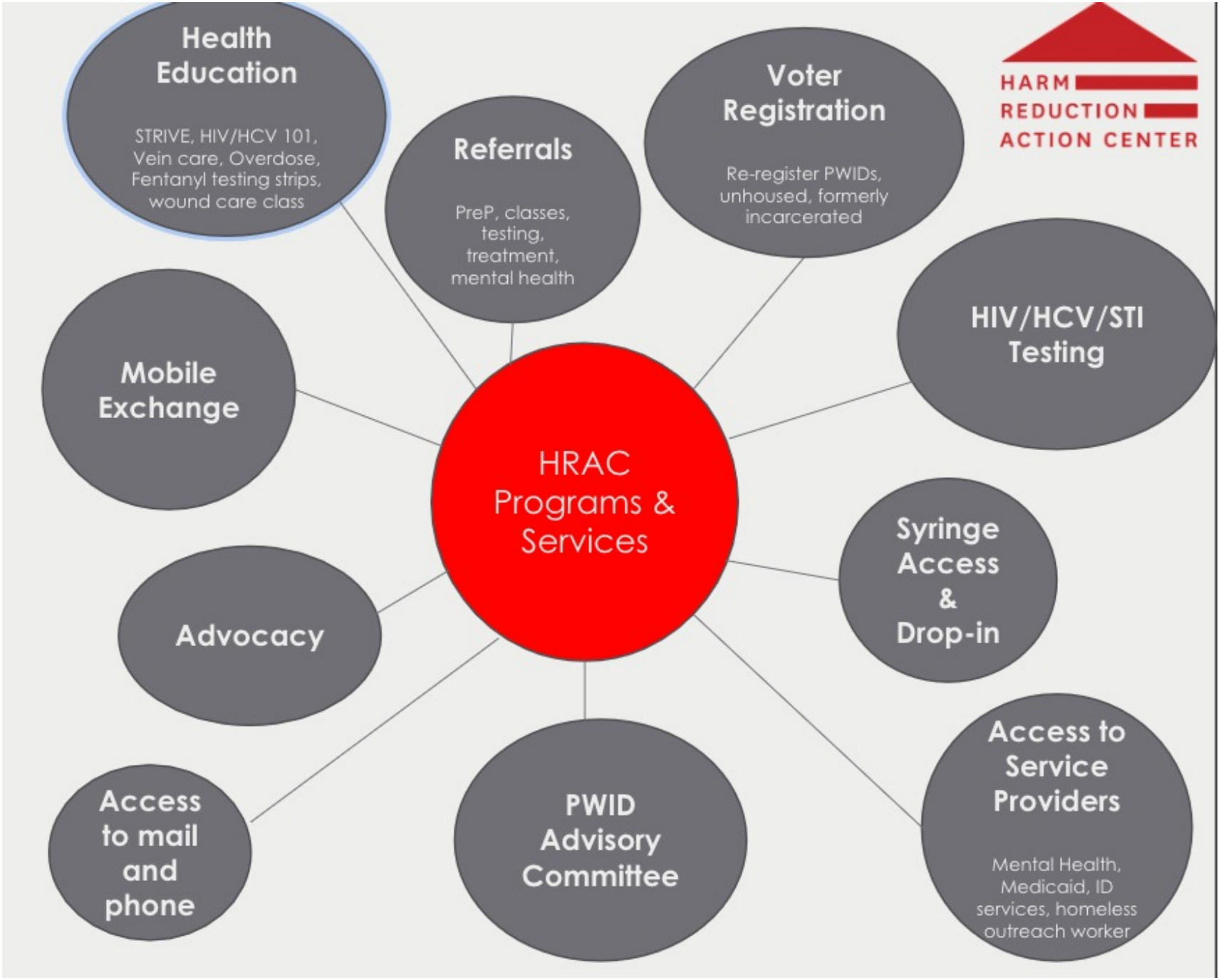
-- David Satcher, MD, Assistant Secretary for Health and Surgeon General – April 1998

The number of Coloradans with hepatitis C continues to climb, partly because the opioid epidemic has spurred a rise in people sharing needles and other equipment with infected blood. About 100,000 Coloradans were diagnosed with hepatitis C between 1993 and 2016, according to the Colorado Department of Public Health and Environment (CDPHE), although it is difficult to determine how many still live with it.

About 100,000 Coloradans were diagnosed with hepatitis C between 1993 and 2016, according to the Colorado Department of Public Health and Environment (CDPHE), although it is difficult to determine how many still live with it.

What we do know is CDPHE reported 41 new cases of acute hepatitis C in 2016, up 17 percent from 35 newly reported cases in 2011. Acute hepatitis C is a short-term infection that can, for some, go away without treatment.


BEFORE USE
AFTER 1 USE
AFTER 6 USES

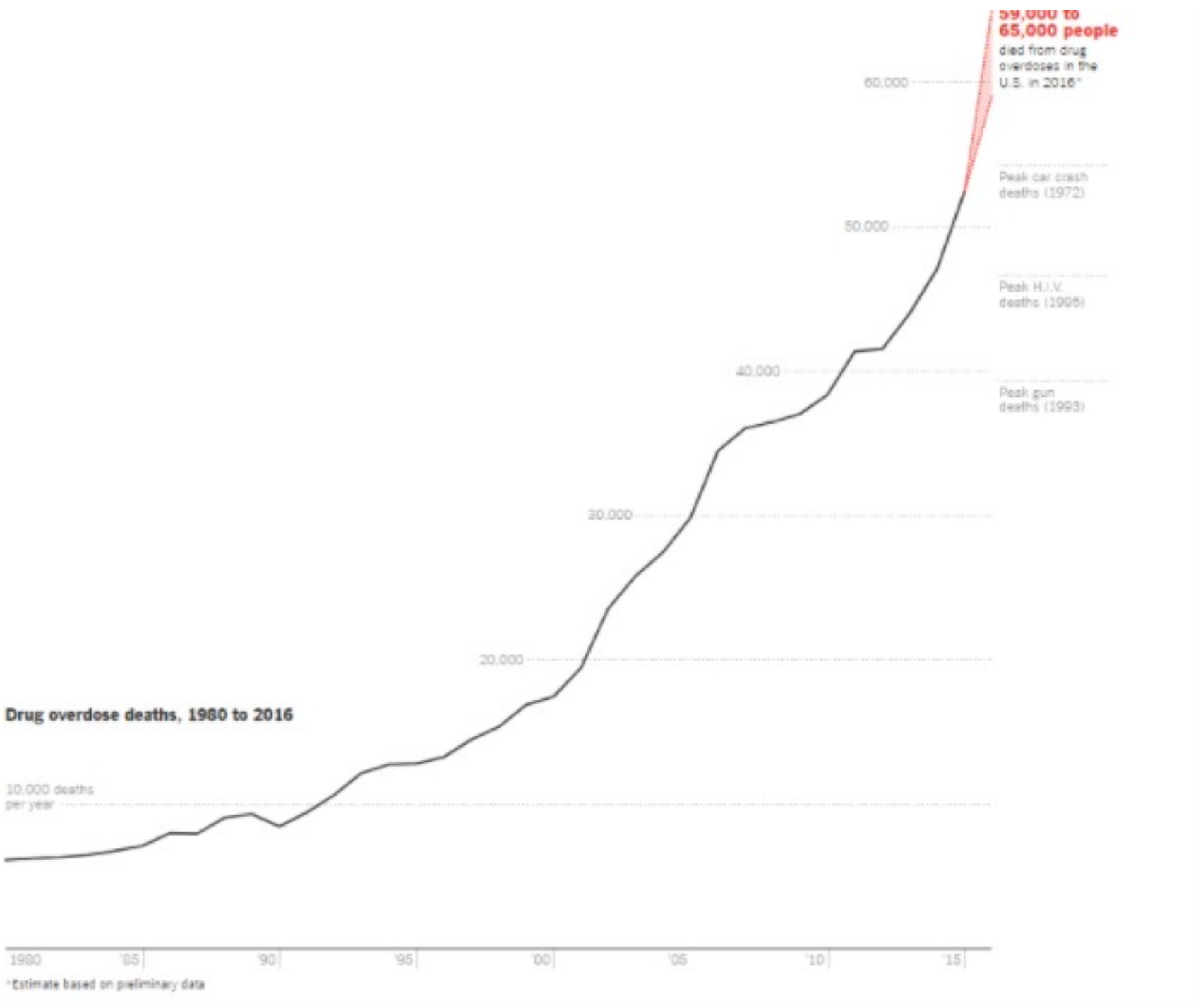

HARM REDUCTION ACTION CENTER
Health Education
STRIVE, HIV/HCV 101, Vein care, Overdose, Fentanyl testing strips, wound care class
Referrals
PreP, classes, testing, treatment, mental health
Voter Registration
Re-register PWIDs, unhoused, formerly incarcerated
HIV/HCV/STI Testing
Mobile Exchange
HRAC Programs & Services
Syringe Access & Drop-in
Advocacy
Access to mail and phone
PWID Advisory Committee
Access to Service Providers
Mental Health, Medicaid, ID services, homeless outreach worker

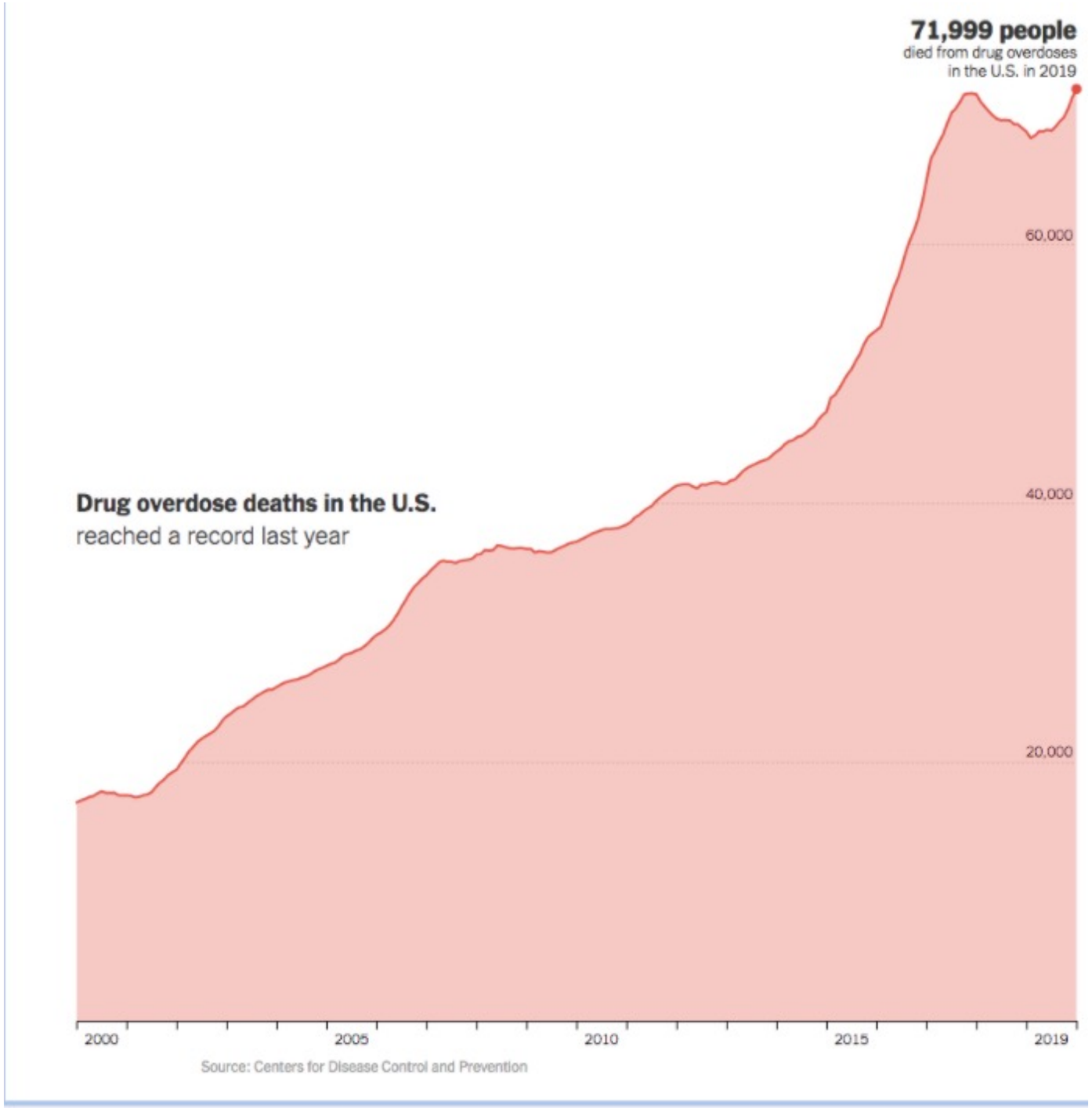

Capitol Hill United Neighborhoods
presents the
Award for
Creating a Safe
Neighborhood
to
Lisa Raville
Harm Reduction Action Center
January 11, 2018

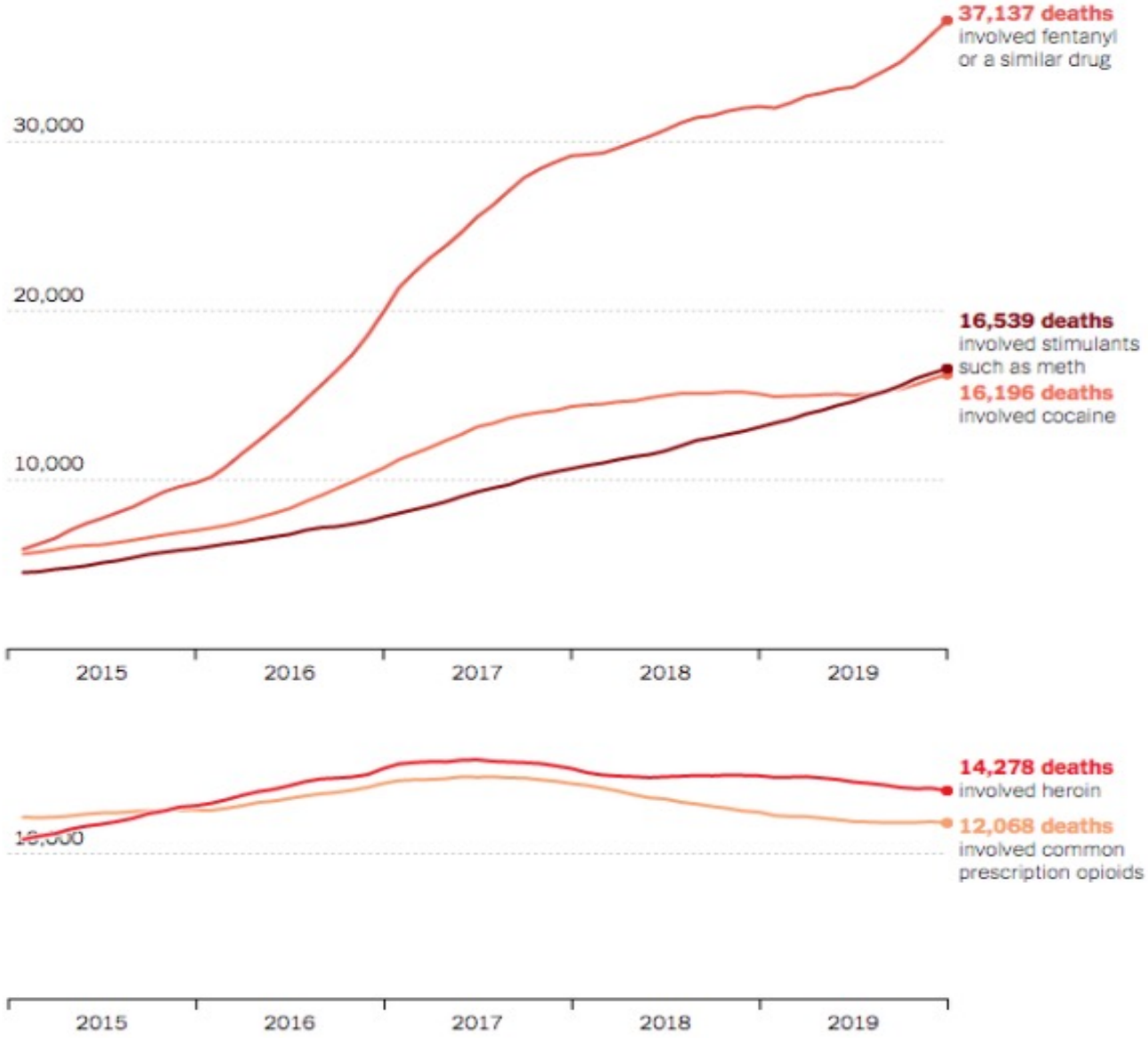
The Question of Enabling

“I got into harm reduction to enable people who use drugs. I enable them to protect themselves and their communities from HIV and hepatitis C and overdose. I enable them to feel like they have someone to talk to, someone who cares, someone who respects them and their humanity.

I enable them to ask for help and to help others in turn. I enable them to find drug treatment and health care, to reconnect with their families, to rebuild their lives. And I enable people who use drugs to take personal responsibility for their health and their futures. If that makes me an enabler, I’m proud to claim that term" -- Daniel Raymond, Harm Reduction Coalition (aka, the mothership)


59,000 to 65,000 people
died from drug overdoses in the U.S. in 2016*
60,000
Peak car crash deaths (1972)
50,000
Peak H.I.V. deaths (1995)
40,000
Peak gun deaths (1993)
30,000
20,000
Drug overdose deaths, 1980 to 2016
10,000 deaths per year
1980
'85
'90
'95
'00
'05
'10
'15
*Estimate based on preliminary data


71,999 people
died from drug overdoses
in the U.S. in 2019
60,000
40,000
20,000
Drug overdose deaths in the U.S.
reached a record last year
2000
2005
2010
2015
2019
Source: Centers for Disease Control and Prevention

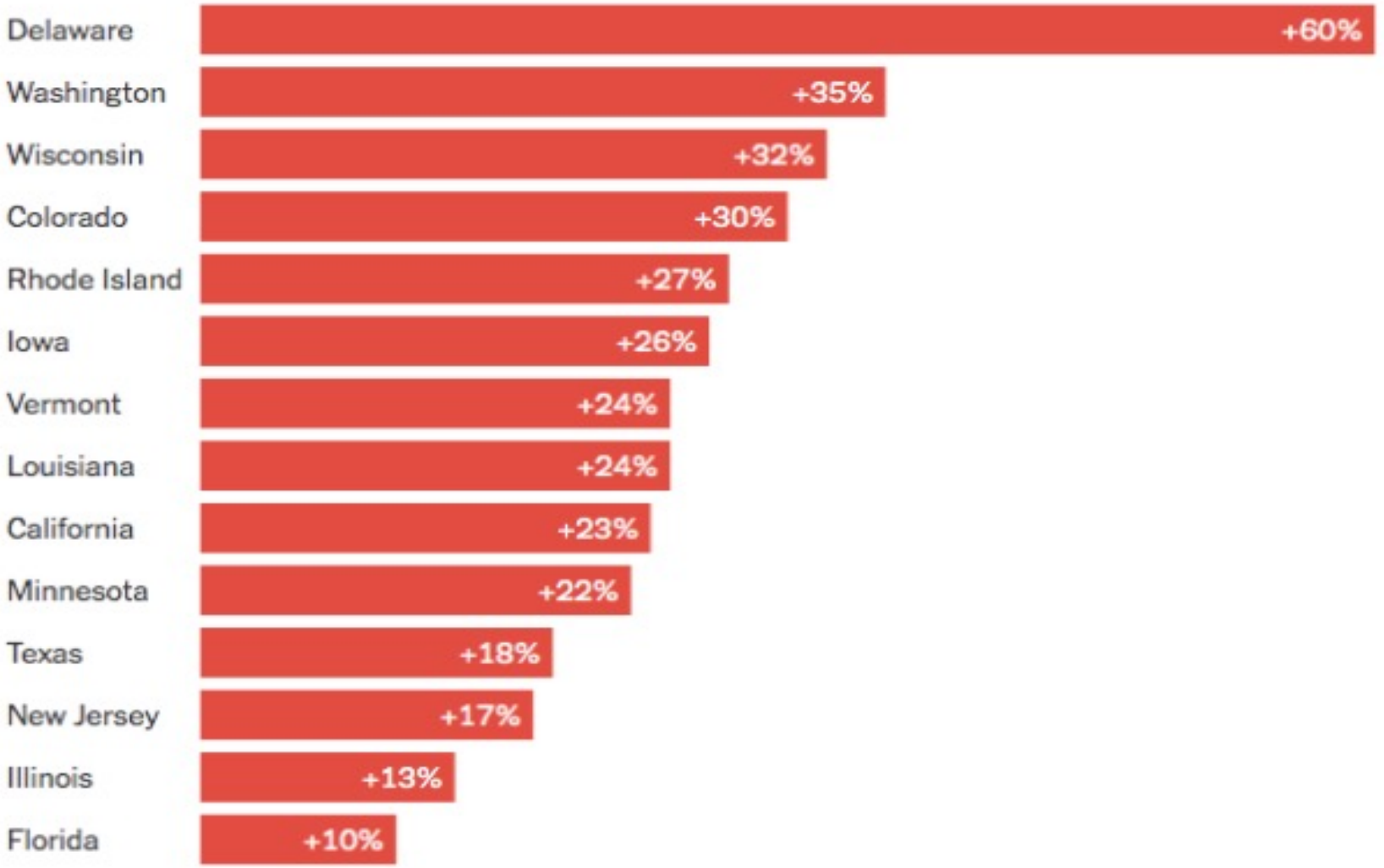


Categories are not mutually exclusive. Deaths often involve multiple drugs. A small portion of the increase in deaths attributable to a specific drug may be due to improved cause-of-death reporting.

Source: Centers for Disease Control and Prevention

Drug-related deaths have risen in 2020 in states across the country.

Increase in drug-related deaths from 2019 through the first portion of 2020.

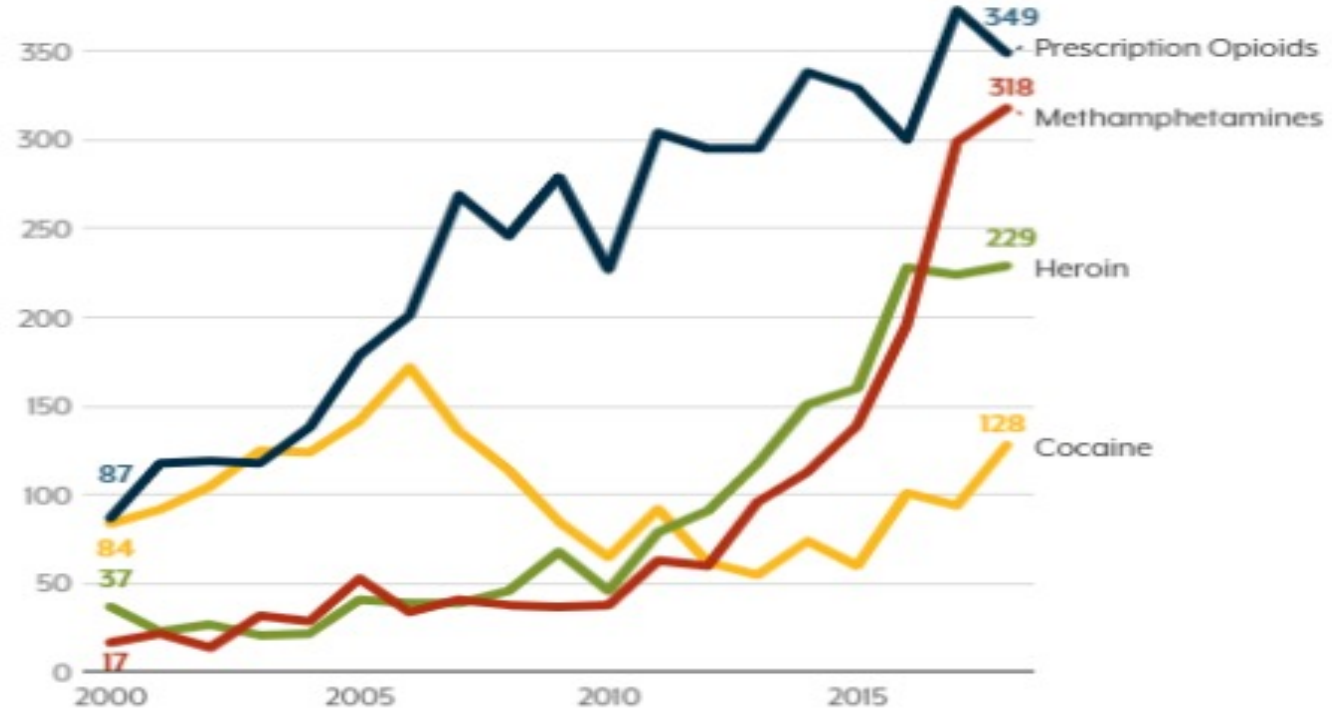


All data is provisional. Definitions of what counts as a drug-related death vary by state. Data for Arizona, California, Florida, Minnesota, Tennessee, Texas, Washington and Wisconsin includes only a subset of counties within each state.

Source: State and local health departments, coroners and medical examiners

Fentanyl contributed to 102 deaths in 2018, up from 81 in 2017.

Number of Drug Poisoning Deaths in Colorado by Drug Type, 2000-2018



Categories are not mutually exclusive (may total to more than 100% of total drug overdoses) or comprehensive (other drugs not listed).

Below: Otero County had the state's highest rate of drug overdose deaths per 100,000 people, 52.9, in 2018, followed by Rio Grande (52.1), Saguache (47.1), Prowers (41.4), and Las Animas counties

- *Sasha – Health Foods Grocery Store
- *Eric – Grocery Store
- *Rachel - coffee shop
- *Jesse - stair well of the parking lot for the 13th and Speer King Soopers
- *AJ - medical campus outside of their ambulance bay
- *Daniel - abandoned house in Cap Hill
- *Andrew - outside in a park
- * Amanda - under the bridge at 14th and Speer
- *Seth - lawn of an abandoned building in Cap Hill
- *Josh - abandoned car
- *Eddie - tent at a camp
- *Luke - tent at a camp
- *Will - abandoned building at 13th and Umatilla St
- *Trey - abandoned building in the Baker neighborhood
- *Joseph - field next to the I25 and Evans
- *Jack - car
- *Angelina – I25 viaduct
- *Tony – on the bike path 14th & Speer

Risks for Overdose- Prevention Strategies

- Change in quality of opioid
- Ask others
- Tester shots
- Change in tolerance
- After release from hospital, rehab, jail, illness
- Tester shots
- Mixing
- If mixing, use less
- Opioids first
- Using alone
- Leave door unlocked; call someone trusted

What are the signs/symptoms of an Overdose?

- Body very limp
- Face very pale
- Pulse (heartbeat) is slow, erratic, or not there at all
- Throwing up
- Passing out
- Choking sounds or a gurgling/snoring noise
- Breathing is very slow, irregular, or has stopped
- Awake, but unable to respond

REALLY HIGH	OVERDOSE
Muscles become relaxed	Deep snoring or gurgling (death rattle)
Speech is slowed/slurred	Very infrequent or no breathing
Sleepy looking	Pale, clammy skin
Nodding	***Heavy*** nod, not responsive to stimulation
Will respond to stimulation like yelling, sternal rub, pinching, etc.	Blue/grey skin tinge (usually lips/fingertips)
Normal heart beat	Slow heart beat

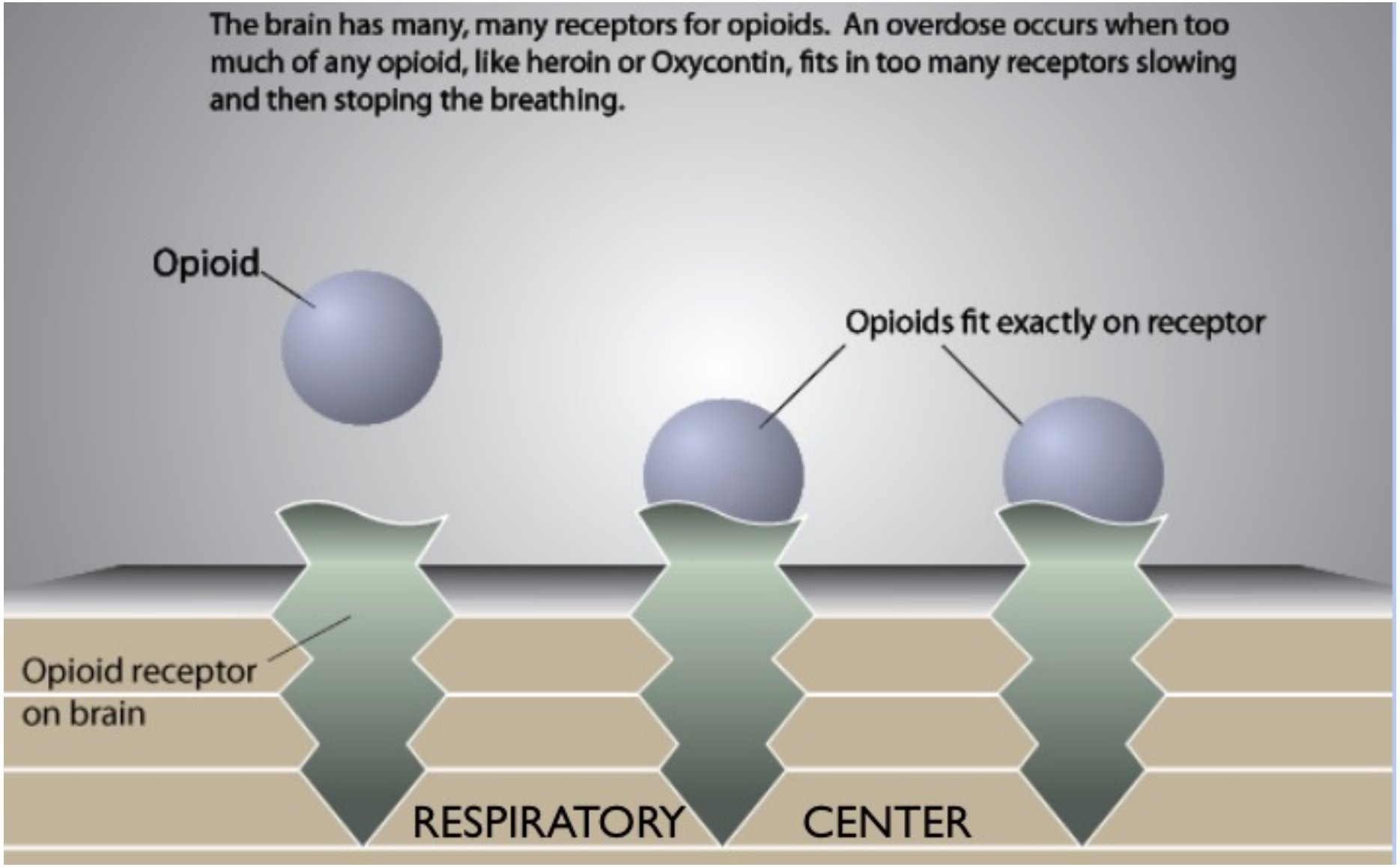
Opioid Overdose Deaths are Preventable

- We have the antidote: naloxone (Narcan)
  - Safe
  - Highly effective
- Paramedics use to immediately reverse effects of opiate overdose
  - Having available before paramedics arrive saves lives and decreases possibility of brain damage
- Community programs and first responders expanding access across the country

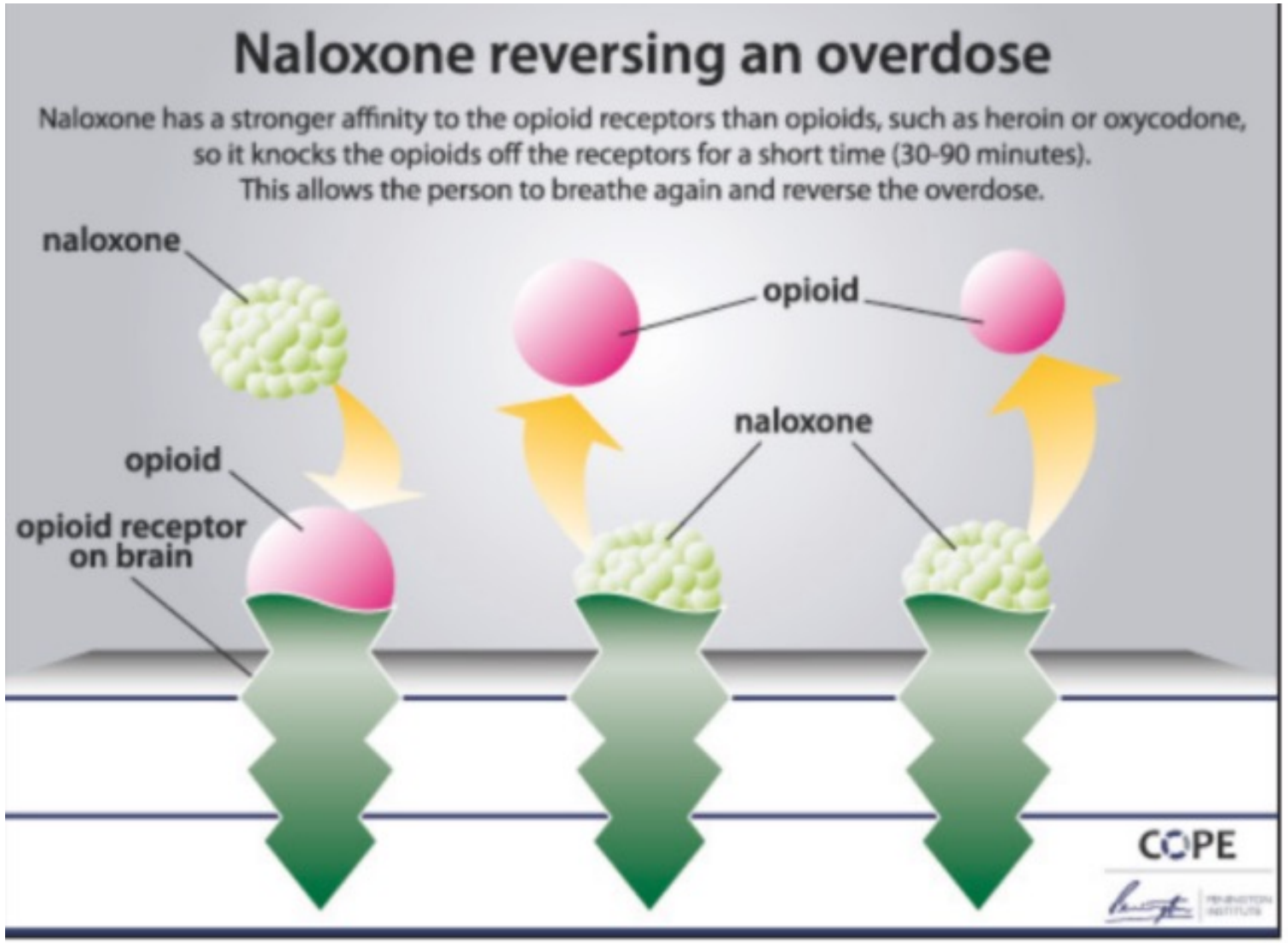
Naloxone- Evzio auto-injector, Intranasal, Injectable

- Opioid antagonist
- >40 years experience by emergency personnel for OD reversal
- Not addictive; no potential for abuse; no agonist activity
- Not a scheduled drug but RX needed
- No side effects except precipitation of withdrawal (dose-sensitive)
- Unmasking underlying medical problems
- Administered via intramuscular and intranasal routes in community programs

How it works


The brain has many, many receptors for opioids. An overdose occurs when too much of any opioid, like heroin or Oxycontin, fits in too many receptors slowing and then stoping the breathing.
Opioid
Opioids fit exactly on receptor
Opioid receptor on brain
RESPIRATORY CENTER

How it works



Source: Adapted diagram from *Guide To Developing and Managing Overdose Prevention and Take-Home Naloxone Projects* http://harmreduction.org/our-work/overdose-prevention/

Responding to an Overdose

- Are you alright?
- Are you ok?
- Pain Stimulus
- If no response call 9-1-1
- Rescue Breathing
- Naloxone
- Rescue Breathing

Training

Can be done by staff or pharmacists with standing orders

- Must include discussion of:
  - Risk factors for OD
  - Recognition of OD
  - Calling 911
  - Rescue Breathing
  - Administration of Naloxone

Response Myths

- Salt Water
- Suboxone
- Ice On Body
- Cold Shower
- Cocaine
- Milk
- Burning Skin
- Punching
- Slapping

Fentanyl Testing Strips

- Offered to all participants **at the syringe access table**
- Staff provides a **5 minute training** on how to use the strips
- Participants are requested to **return with their results**: which drug they tested, positive or negative, etc.

- **TRAINED**: 1,617 unique participants trained on how to use fentanyl checking strips.

Fentanyl Stats:

- *Self Reported Results Collected 6/14/18-5/14/20:*
- RESULTS: (n=2,092)
  POSITIVE: 42%
- NEGATIVE: 56%
  DIDN'T WORK: 2%

FINDINGS:

Of the 42% of test results positive for the presence of fentanyl or fentanyl analogues:

Drug breakdown of positive results:

Heroin: 45%
Meth: 34%
Goofball (meth and heroin): 13%
Polysubstance use (multiple drugs, not goofball): 5%
Other (cocaine, crack cocaine, other opioids/pills): 3%

Initial Findings From Pilot

FINDINGS:

- 99% of participants using strips report feeling that using a strip to detect fentanyl makes them feel better able to protect themselves.

- 90% of participants who reported positive results took some kind of action to protect themselves or others ranging from: using less, pushing their plungers more slowly or only part way, snorting instead of injecting, ensuring they had someone with them in the case of overdose, sharing results with a friend, and combinations thereof.

- 43% of participants with positive results reported either using less, or throwing out their drugs entirely.

    - Of the 24% of participants who report throwing away drugs (or throwing away their drugs in combination with other methods such as telling others about their results), 53% of participants who reported throwing away their drugs after a positive result also reported checking methamphetamine alone for fentanyl or fentanyl analogues, reaffirming the importance of the availability of fentanyl checking strips for stimulant and otherwise non opiate tolerant using drug users.

Senate Bill 14 for Third Party Naloxone distribution

- Senate Bill 14 passed in the Colorado Legislature in May, 2013. This bill allows medical providers to prescribe the lifesaving medication Naloxone—which reverses the effects of an opiate overdose—to 3rd parties likely to witness an overdose, including friends and family members of opiate users, and all homeless service providers. There have been 2,238 lives saved so far!

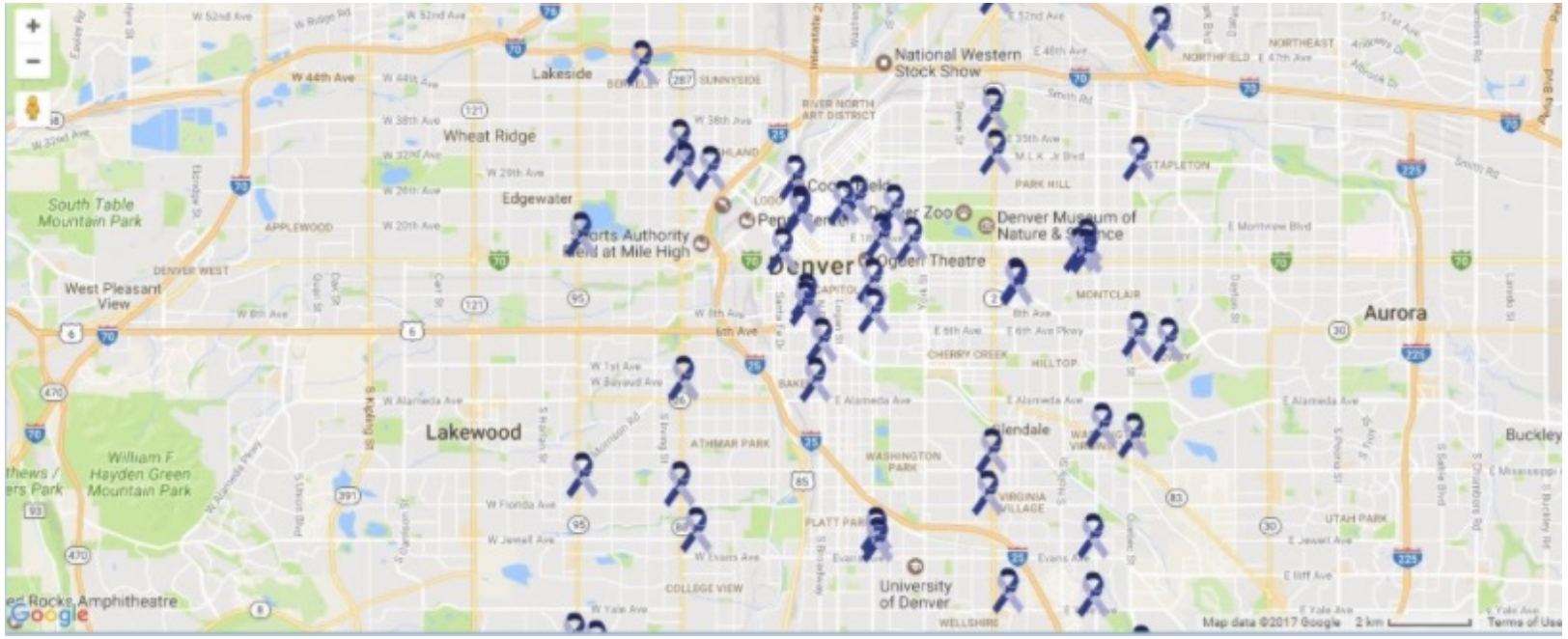
Harm Reduction Action Center - Denver

Denver Health & Hospital – Denver

University Hospital

Pharmacies & First Responders

- 470 pharmacies including Walgreens, CVS, KS, Rite Aid pharmacies, etc.
- 202 Police and Sheriff's Departments
- 6 county jails



Colorado Harm Reduction Legislation

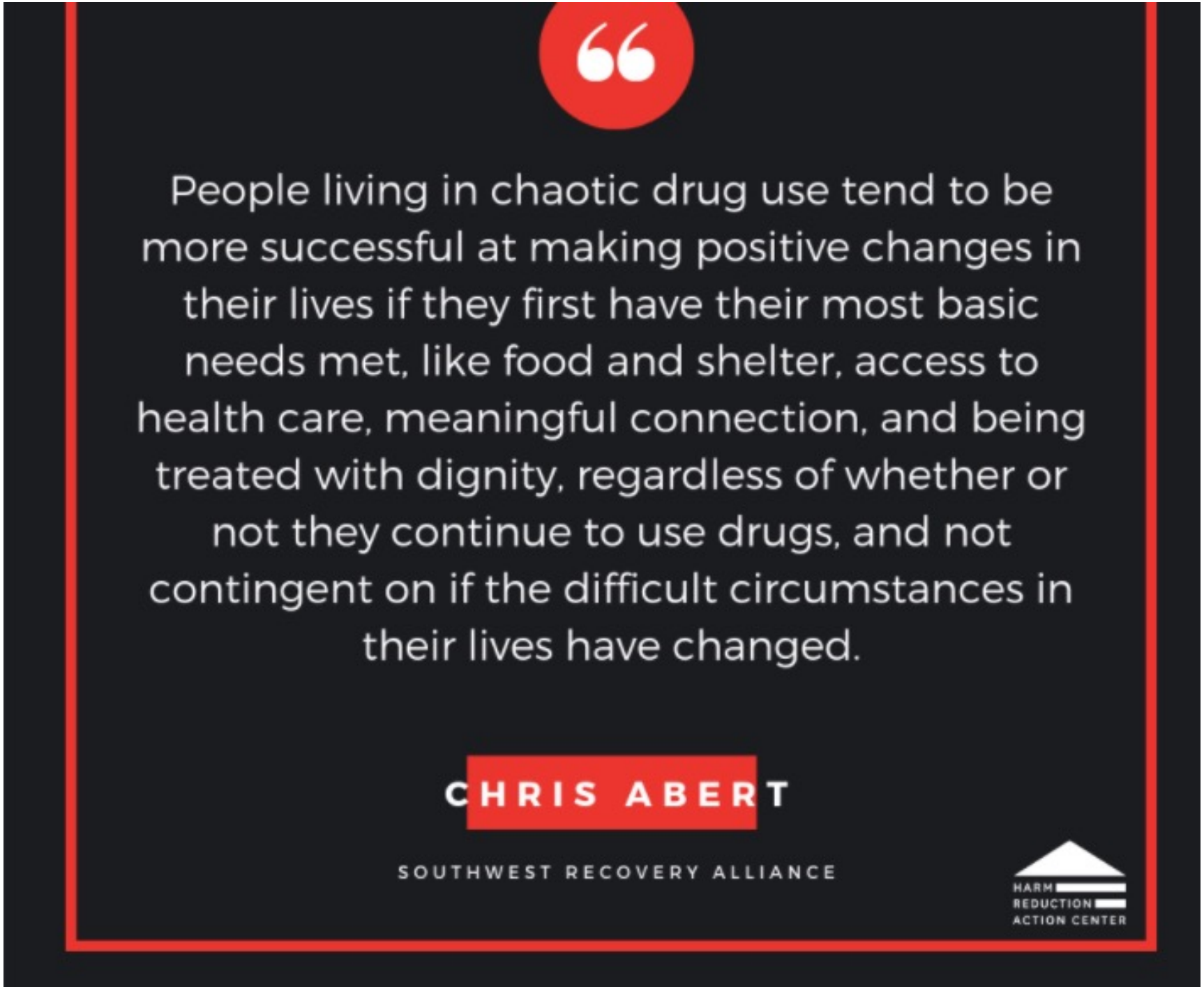
- Syringe Exchange – SB 10-189
- 911 Good Samaritan Law – SB 12-020 & HB 16-1390
- Participant Exemption – SB 13-208
- 3rd party Naloxone Access – SB 13-014
- Needle stick Prevention – SB 15-116
- Standing Orders with Access to Naloxone – SB 15-053

Safer Syringe Disposal Initiative

- Used syringes are discarded in public places around Denver. Improper disposal of bio-hazardous waste exposes city employees and the general public, to potential needle stick injuries. 1,500 were disposed between October 2015 – October 2016.

Barriers to proper disposal:

- Pharmacies can sell syringes but don't allow disposal
- Hours of operation for syringe access programs - limited
- Fear of ticketing, additional days incarcerated
- Difficulty disposing, public disposal access is rare
- Issue for homeless diabetics


People living in chaotic drug use tend to be more successful at making positive changes in their lives if they first have their most basic needs met, like food and shelter, access to health care, meaningful connection, and being treated with dignity, regardless of whether or not they continue to use drugs, and not contingent on if the difficult circumstances in their lives have changed.
CHRIS ABERT
SOUTHWEST RECOVERY ALLIANCE
HARM REDUCTION ACTION CENTER

- Overdose Prevention Sites are legally sanctioned and designed to reduce the health and public order problems associated with injection drug use. They enable the consumption of pre-obtained drugs in an anxiety and stress-free atmosphere, under hygienic and low risk conditions.
- Commonly, the purpose of OPS's are to reduce public disorder and enhance public safety, reduce overdoses, reduce transmission of HIV and hepatitis C infections, decrease skin tissue infections, and improve access to other health and social services.

Numerous peer-reviewed scientific studies have proven the positive impacts of SIFs. These benefits include:

- Increased access to drug treatment, especially among people who distrust the treatment system and are unlikely to seek treatment on their own.
- Reduced public disorder, reduced public injecting, and increased public safety.
- Attracting and retaining a high risk population of people who inject drugs, who are at heightened risk for infectious disease and overdose.
- Reduced HIV and Hepatitis C risk behavior (e.g. syringe and other injection equipment sharing, unsafe sex).
- Reducing the prevalence and harms of bacterial infections (e.g. staph infection, endocarditis).
- Successfully managing overdoses and reducing overdose death rates.
- Cost savings resulting from reduced disease, overdoses, and need for emergency medical services, and increased preventive healthcare and drug treatment utilization.
- Not increasing community drug use.
- Not increasing initiation into injection drug use.
- Not increasing drug-related crime.


Use Site
Supervised Use Site

Public Restrooms Become Ground Zero in the Opioid Epidemic

- Public bathrooms become clandestine epicenter of opioid crisis
- The new front line in opioid abuse fight: public restrooms
- Overdoses in public bathrooms are turning baristas and
- other service workers into unwitting first responders.

Jonathan Giftos, MD
@jonathan_giftos

Following

We need to play that game where we require politicians to finish every sentence denouncing supervised injection facilities with the phrase, “and that is why I think injecting alone in a McDonald’s bathroom is better.”

9:03 PM - 5 May 2018

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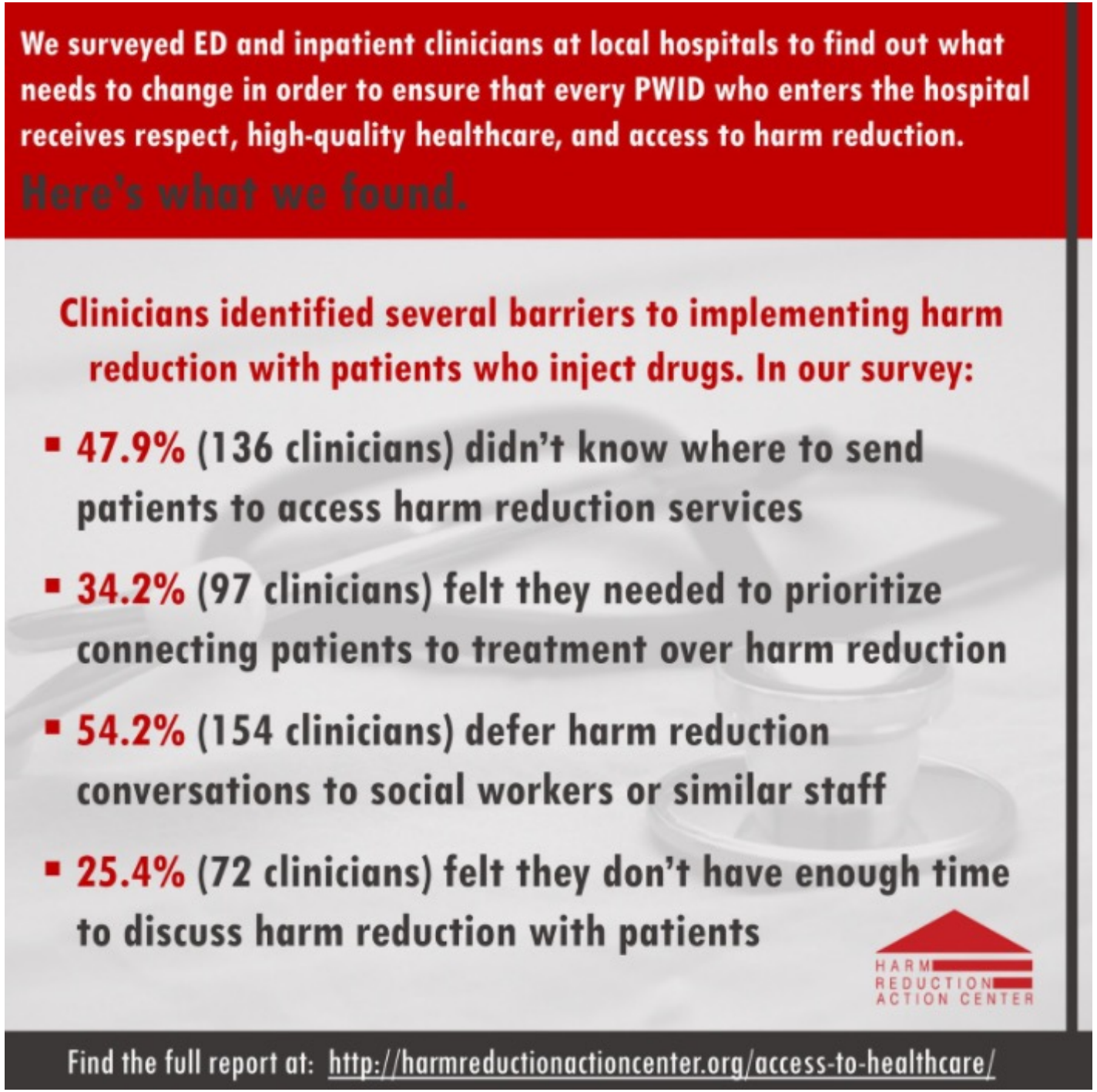
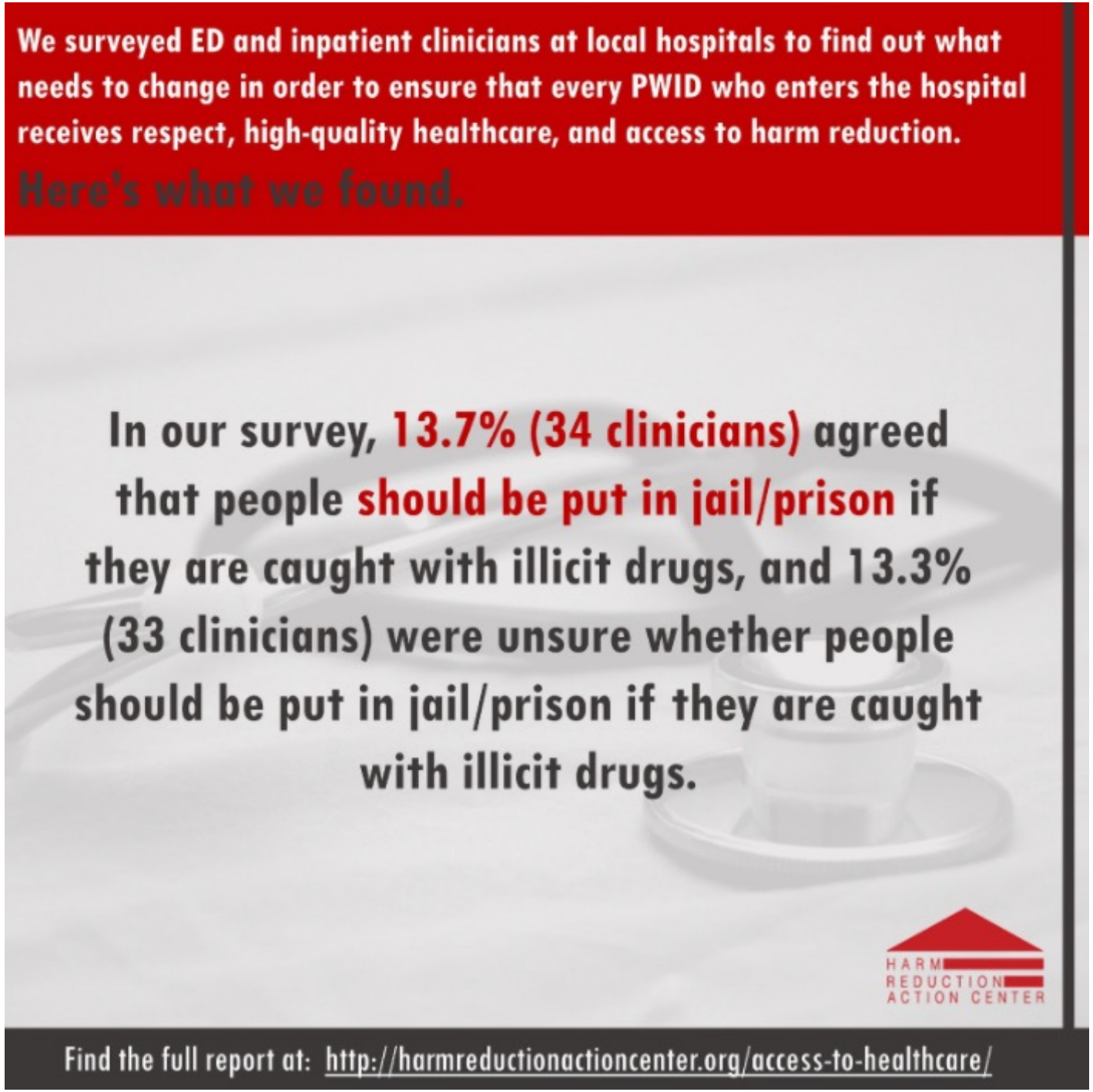
2020 Healthcare Provider Survey

In 2020, the Harm Reduction Action Center partnered with local medical professionals to develop and administer a survey of Emergency Department and Inpatient clinicians at local hospitals in the Denver and Aurora area. This survey was also reviewed by the People Who Inject Drugs (PWID) Advisory Committee.


We surveyed ED and inpatient clinicians at local hospitals to find out what needs to change in order to ensure that every PWID who enters the hospital receives respect, high-quality healthcare, and access to harm reduction.
Here's what we found.
Clinicians identified several barriers to implementing harm reduction with patients who inject drugs. In our survey:
47.9% (136 clinicians) didn't know where to send patients to access harm reduction services
34.2% (97 clinicians) felt they needed to prioritize connecting patients to treatment over harm reduction
54.2% (154 clinicians) defer harm reduction conversations to social workers or similar staff
25.4% (72 clinicians) felt they don't have enough time to discuss harm reduction with patients
HARM REDUCTION ACTION CENTER
Find the full report at: http://harmreductionactioncenter.org/access-to-healthcare/


We surveyed ED and inpatient clinicians at local hospitals to find out what needs to change in order to ensure that every PWID who enters the hospital receives respect, high-quality healthcare, and access to harm reduction.
Here's what we found.
In our survey, 13.7% (34 clinicians) agreed that people should be put in jail/prison if they are caught with illicit drugs, and 13.3% (33 clinicians) were unsure whether people should be put in jail/prison if they are caught with illicit drugs.
HARM REDUCTION ACTION CENTER
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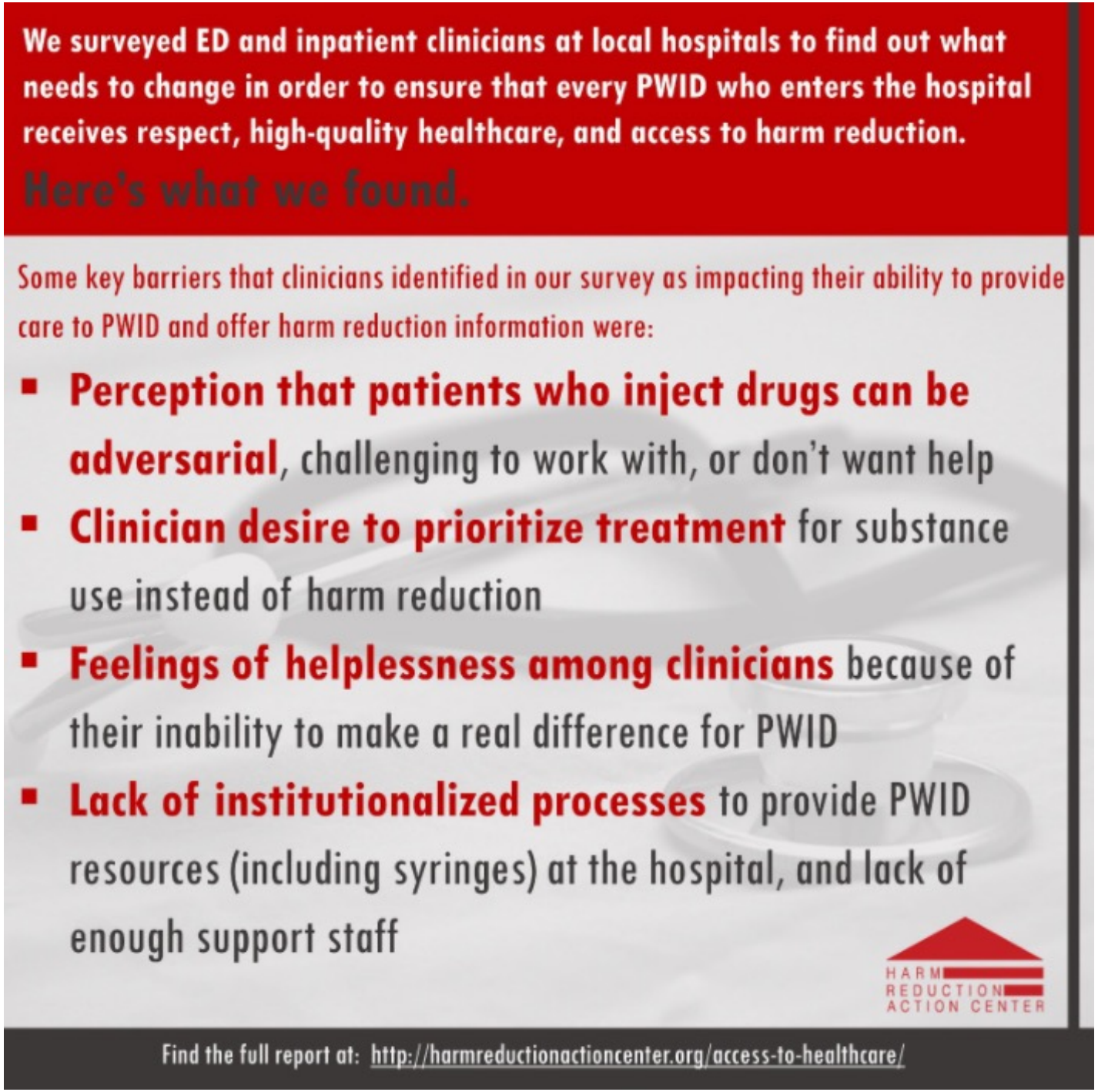
We surveyed ED and inpatient clinicians at local hospitals to find out what needs to change in order to ensure that every PWID who enters the hospital receives respect, high-quality healthcare, and access to harm reduction.
Here's what we found.
Some key barriers that clinicians identified in our survey as impacting their ability to provide care to PWID and offer harm reduction information were:
Perception that patients who inject drugs can be adversarial, challenging to work with, or don't want help
Clinician desire to prioritize treatment for substance use instead of harm reduction
Feelings of helplessness among clinicians because of their inability to make a real difference for PWID
Lack of institutionalized processes to provide PWID resources (including syringes) at the hospital, and lack of enough support staff
HARM REDUCTION ACTION CENTER
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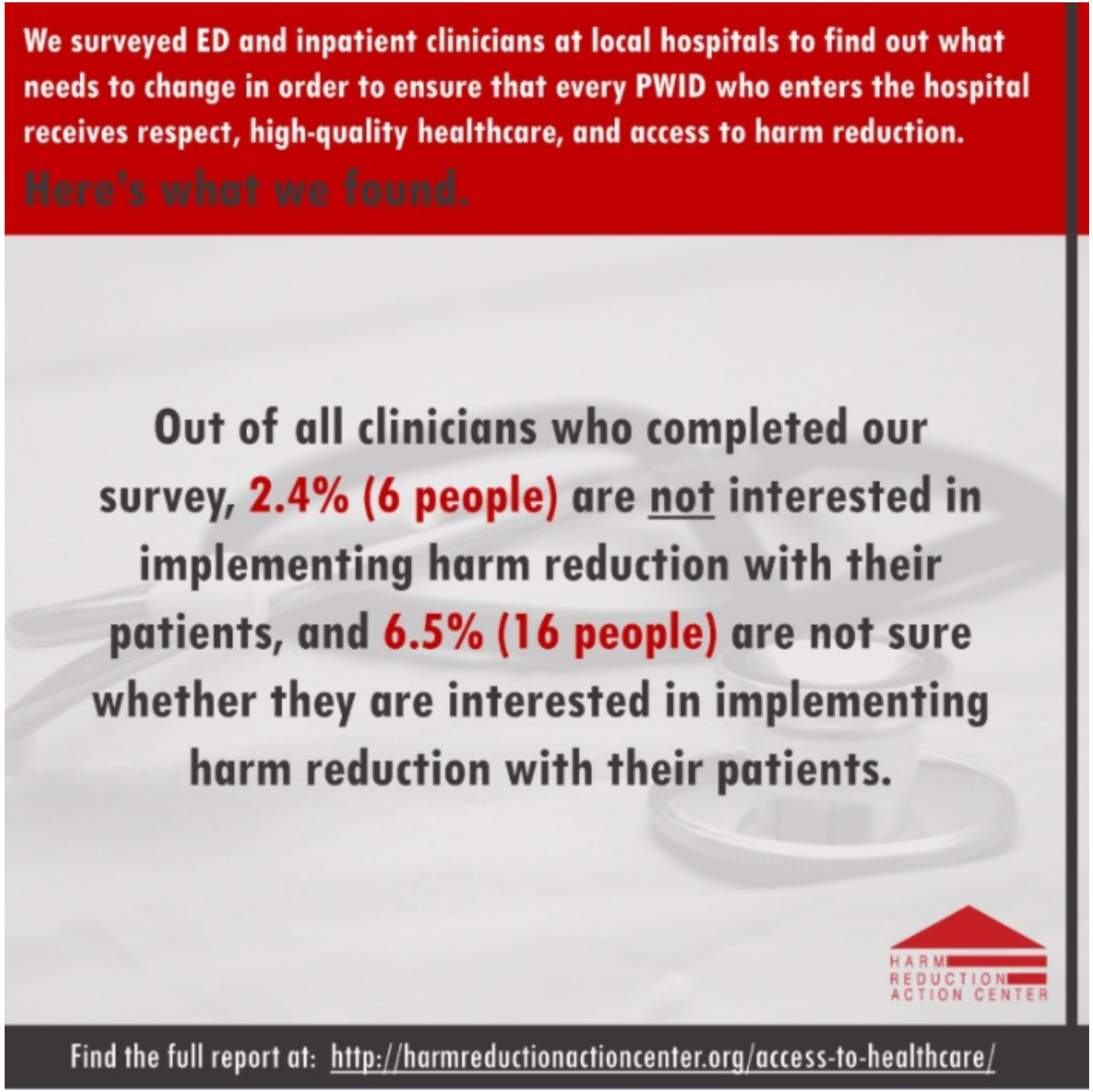
We surveyed ED and inpatient clinicians at local hospitals to find out what needs to change in order to ensure that every PWID who enters the hospital receives respect, high-quality healthcare, and access to harm reduction.
Here's what we found.
Out of all clinicians who completed our survey, 2.4% (6 people) are not interested in implementing harm reduction with their patients, and 6.5% (16 people) are not sure whether they are interested in implementing harm reduction with their patients.
HARM REDUCTION ACTION CENTER
Find the full report at: http://harmreductionactioncenter.org/access-to-healthcare/

Pitfalls in the Treatment of PWIDS

- Afraid of being warrant checked
- It is not uncommon for clinicians to assume that drug users don’t care about their health; such misperceptions are noticed by patients. Fearing this negativity and condescension, many drug users avoid the emergency department by trying to “doctor” themselves.
- Some providers automatically undertreat or minimize pain when they suspect drug-seeking behavior, or perform procedures (eg, abscess drainage) with inadequate anesthesia in order to “teach the patient a lesson.”
- Health care providers occasionally bring in other colleagues to gawk at patients without their permission. However, these insensitive “Look at the crazy thing this junkie did to herself/himself!” conversations are inappropriate.

Pitfalls in the Treatment of PWIDS

- Vague or unrealistic aftercare plans are futile.
- Long speeches and shaming life lectures about drug use can and should be replaced by educational information about risk reduction.
- Patients often overhear health care providers talking about them negatively outside of the room or behind a curtain. Assuming the patient can’t hear them, clinicians can be heard warning other providers about the “druggie” or “drug seeker.”

What would you like to tell doctors about people who inject?

- There are people who want and do quit drugs
- It's a different world for us
- Listen to us about the best veins to 'hit'
- Give more trainings that teach about IDU culture and special needs
- Use programs like a syringe exchange to connect folks to care
- Hospital 'human resources' should support healthcare workers that serve complex needs patients

- We are people, too
  - We just deal with things differently
  - We aren't immoral/bad people
  - I didn't intend to become an person who uses drugs
  - We deserve care and compassion
  - Need mental health care

Provider Attributes

- **Great/Excellent**
- Professional, friendly, kind
- Very gentle
- Asked caring questions
- Treated me with dignity
- Explained in detail
- Advice on HCV mgmt
- Didn’t seem judgmental
- Informative & concerned
- Go beyond to help

Fair/Poor

Lectured on life choices
From congenial to harsh
Refused to believe me
Curt/brusque
Seemed unconcerned
Ignored me
Discharged without help

- Lisa Raville, HRAC Executive Director, Lisa.harm.reduction@gmail.com
- Twitter: @HRAC_Denver
- Facebook & Instagram: Harm Rection Action Center

Thank you for joining!

Lisa's YouTube Video that will give you more information to share in your agency in a 12-minute view with TEDxMile High talk.
https://www.youtube.com/watch?v=fsC7epItHXI

Evaluation Information

The ATTC is funded through SAMHSA to provide this training. As part of receiving this funding we are required to submit data related to the quality of this event.

At the end of today's training please take a moment to complete a **brief** survey about today's training.

https://ttc-gpra.org/P?s=667586