Harm Reduction for Homeless Service Providers Transcript

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[Josh Leopold, he/him]
Hello everybody, thank you for joining the webinar this afternoon on harm reduction for homeless service providers. My name is Josh Leopold. I'm the senior advisor for health, housing and homelessness at the Minnesota Department of Health, and we're going to get started with the webinar now. So Katie if you want to go to the next slide.

Okay great, so just a few housekeeping items before we get started. Um, the first is that all the attendees joining right now, you are muted. And so if you have a question that you want to submit, there's, you can see there are three dots on the bottom right of your Webex screen, and if you click those, you can open up the Q&A panel and you can submit questions. And so you know, if they are, you know, clarifying questions, we can try to, um, address them as we're presenting, uh, otherwise.

If there are more kind of discussion questions, we are, we have reserved the last thirty minutes of the webinar for discussion, so we will address those questions that are kind of general importance and kind of need a longer discussion in the discussion section of the webinar. Also this webinar is being recorded, and we will post the recording and the slides on our website once they are accessible, they will have to go through a review process so it won't be immediately after the webinar but as soon as we can after the webinar the recording and slides will be posted. We'll also do a follow-up survey after the webinar for attendance, to get more information about you know how the webinar went and sort of people's interest in maintaining engagement on this topic and also potentially other webinars or kind of educational opportunities after the webinar. Okay, if we go to the next slide.

So the goals for the webinar today are first to help make some connections between people working in issues related to homelessness and people working in harm reduction and kind of, I know a lot of that has already happened organically, but to kind of help further make those connections. The second and probably most important is to kind of share resources on how we can best keep people alive and healthy, and we're going to be focusing today on harm reduction related to drug use, but a lot of these harm reduction principles are also very applicable to other aspects of life as well. And finally we really want to hear from you about current practices and where additional guidance and resources are needed. So there'll be a few points during the presentation where we'll do some polling questions and then we'll have opportunity to discussion to really get into it in more detail. Okay, next slide.

Okay, so this is the first polling question and you should see the response options on the right hand of your screen using Slido. So if you could just choose whatever, and if there might be some people attending who wear multiple hats, pick as many as you feel like best describe your line of work or advocacy. And we'll just give people a minute to answer.

[Katie Hill, she/her]
Make sure you please hit that send button once you're, once you've made your selections so that you can see the responses changing and view those coming in in real time.

[Josh Leopold, he/him]
Okay, great, so seeing a lot of, um, representation from supportive housing providers, which is great. Katie, let's go to the next slide.

Okay, so for the agenda today, I'm going to be doing an overview of homelessness and what we know from the research about drug related harms associated with people experiencing homelessness. Then Anna Bosch from MDH is going to be presenting on syringe service programs and harm reduction. Then Cody Bassett from MDH will be talking about naloxone, what it is and where to find it. And then Morgan Weinert from Minnesota Community Care will talk about harm reduction in health care and how they practice it. Then John Tribbett from Avivo will talk about how they practice housing first and harm reduction in their programs, and then we'll have the last thirty minutes or so of the webinar for discussion. Next slide.

Ok so to start, I just wanted to address the issue of stigma, because I think that's something that plays a big role both in the homelessness field and in the harm reduction field. And I know there are concerns like when we talk about homelessness and drug use together it can be kind of further stigmatizing and I know that that's a real concern, but I also feel like you know, we have a lot of people here from a lot of different areas of work and advocacy that you know really care about people experiencing homelessness and people who use drugs, and there's a lot of benefit in bringing people together and sharing strategies and making those connections and we will talk throughout the webinar about how we can do that in an inclusive and non-stigmatizing way. I also want to acknowledge that homelessness is not, was not caused by drug use or by drugs. Homelessness is an economic problem and that's you know, there's a lot of evidence to support that. For example, there's a recent book that just came out called “Homelessness is a Housing Problem” which looked at why certain cities like Seattle or San Francisco have homeless rates that are four to five times higher than other cities like Chicago or Cleveland. And they tested a lot of different hypotheses and so they looked at are there big differences in the number of people with substance use disorder or the number of people with severe mental illness, and the biggest factors that explain variation on homelessness rates was the median cost of an apartment and a rental vacancy rate. So what percent of rental units were available at any given time. So that's really what determines the number of people who are going to be experiencing homelessness in a community, but within those conditions we know that people with substance use disorder, people with mental illness, people with disabilities, people of color, LGBTQ people are more vulnerable to becoming homeless. So it's not to say it doesn't have any effect, but it is not the main cause of homelessness. And we also know that homelessness can be both a cause of substance use, but it can also be a consequence that substance use can affect how people use substances. Oh, and I got a question about who is the author of that book and so that is, the “Homelessness is a Housing Problem” is by Gregg Colburn and Clayton Page Aldern from the University of Washington. But anyway as I was saying, so we know that experiencing homelessness can affect how people use substances or whether they use substances, so we know we hear a lot about people who might use amphetamines to help stay awake or alert while they're experiencing homelessness or opioids to fall asleep while they're experiencing homelessness or to deal with some of the traumas associated with homelessness. So if we go to the next slide.

Okay, so now we want to talk about a report that we released at the end of January called the Minnesota Homeless Mortality Study. And this report was done with funding from the CDC Foundation and then the researchers were at the Hennepin Healthcare Research Institute’s Health, Homelessness and Criminal Justice Lab. And what they did is they looked at the Minnesota state death certificate records for 2017 through 2021. So that's anybody with a death in the state of Minnesota during that time period. And they merge that with the Minnesota Homeless Management Information Systems data, which captures information about people who use homeless outreach programs, shelters, day centers, transitional housing, supportive housing, during that same period of 2017 to 2021, and then they also combine that with a Minnesota census data to look at, to compare mortality rates for people experiencing homelessness with the state population. So if we go to the next slide.

So the three kind of principle findings from that study were first that the rate of death for people experiencing homelessness was three times higher than the general population. And the disparities were greater for American Indians, so for American Indian people experiencing homelessness the disparity was, mortality rate was five times higher than the general Minnesota population. And substance use related deaths were the most commonly cited cause of death for people experiencing homelessness, accounting for more than a third of deaths we saw during this time period, and the mortality rate for substance use related deaths was ten times higher for people experiencing homelessness than the general Minnesota population. So if we go to the next slide.

So that was really the motivation I think, or one of the big motivations for having this webinar was to share this information and talk about strategies for how we reduce those deaths. And so this chart is kind of a way to visualize that data, so that the mortality rates of the vertical axis shows the mortality rate, which is essentially sort of the number of deaths that we saw divided by the number of people in the study in the number of years we were following them. So the higher up something is in that vertical axis that means the more deaths we saw during that time period. So we see, the two main things were chronic diseases, so things like heart disease and then as I said the substance use-related deaths. And then the horizontal axis shows the disparities between, in the mortality rates, between people experiencing homelessness and the general population. And so we see, the further out something is on that horizontal axis, the greater the disparity. And so we see that the substance use-related deaths, which are circled, are both the most commonly cited cause of death and also where we see the greatest disparities compared to the general population. And if we go to the next slide.

So this is a visualization that looks at the substance use-related deaths based on what substances were involved based on the death certificate. And so the pink dots are the rates for the general population and the blue dots are the rates for the people experiencing homelessness and then that blue bar is the disparities, so the rate ratio of how much more common these deaths were for people experiencing homelessness. And so we see here that, you know, the most common type of substance use-related deaths was related to opioids and specifically fentanyl. And then we see a lot of a combination of deaths involving a combination of alcohol and opioids, or methamphetamine and opioids, or a little bit less commonly cocaine and opioids. And so if you're yeah, and I know that some people might have problems if they're not seeing the slides in color. So basically the dots further on the left are the general population, then further to the right are the people experiencing homelessness. If we go to the next slide.

So just quickly, I also wanted to share that in addition to the mortality study that we did, the health department also has something called the Minnesota Drug Overdose and Substance Use Surveillance Activity or MNDOSA system that looks at hospitalizations related to a drug overdose based on participating hospitals reporting data, and so if you go to the next slide.

We can see that from November 2017 through October 2021, the MNDOSA system captured 459 emergency department visits involving severe or unusual symptoms of substance misuse, and of those cases 29% were among patients experiencing homelessness. So this is something that we're seeing in a lot of our data, not just specifically the one mortality study. So I think I'm going to now turn it over to Cody Bassett. Oh no, sorry to Anna Bosch to talk about syringe service programs. Thank you, Anna.

[Anna Bosch, she/her]
Thanks, Josh. Hi all, thanks for being here today. My name is Anna Bosch, I use she/her pronouns, and I am the harm reduction program specialist within our Infectious Disease division at the Minnesota Department of Health Excellent. Next slide.

So I always like to start with the definition of what harm reduction is. It is both a set of practical strategies tools and ideas that are aimed at reducing some of the negative consequences associated with drug use, and it is also a movement for social justice that's built on a belief and respect for the rights of people who use drugs. And

most importantly, the movement of harm reduction is created by and for people who use drugs. So I always like to share that as a representative of the state, I am not the expert in harm reduction. People who are using drugs and who are taking care of each other are the experts. Next slide.

So to share a couple, and I'm going to go through these pretty quickly, a few of the principles of harm reduction. Harm reduction accepts drug use as a part of our world and chooses to minimize harms. It doesn't ignore that there are real harms associated with using drugs but acknowledges that there are safer ways of using substances – that there are some ways of using substances that are safer than others. It focuses on the quality of an individual's life and of a community and is always non-judgmental and non-coercive. Next slide.

And it absolutely includes and is led by the voices and insights of people who use drugs and acknowledges that the people who use drugs are the primary agents in reducing harms in their lives. And then certainly recognizes that all of these realities and some of the systems in our society that also cause harm really impact somebody's vulnerability, you know, to harms associated with using drugs and their capacity to effectively deal with particular harms. Next slide please.

So let's talk a little bit about syringe access and syringe services programs in Minnesota. So this is the CDC's definition of a syringe services program. So community-based prevention program that provides a range of services, you know, this isn't comprehensive of all the services they can provide, but it can include linkage to substance use disorder treatment, access to and disposal of syringes, vaccination, testing, linkage to care, and treatment for infectious diseases. I think in many ways this definition is limiting, and we'll talk a little bit more about that as we move on. Next slide.

So my section at MDH funds six of the many other SPPs in Minnesota to provide this wide range of services. So certainly it is not just syringe exchange, although that is important, a very important component of a syringe services program. But all of our SSPs provide rapid HIV and hepatitis C testing, as well as linkage to care. They provide education about overdose prevention, including not just safer injection practices, but safer use practices, depending on the mode of use. They provide the naloxone kits, overdose reversal kits, as well as training and education on how to use them, both for their participants – so the folks that are utilizing SSPs – as well as for all sorts of community partners. They provide sharps containers, both to community partners and participants, and always safe disposal of use syringes as well as many activities too community syringe collection and clean up. And then they just provide a huge variety of referrals to their participants. So referrals to medical, mental, and sexual health services, referrals to substance use disorder treatment and recovery supports. I listed these other things on the side as well. All of our syringe services programs are providing fentanyl test strips, so their participants can test the substances they're using for fentanyl, and many do make behavior changes related to the results of those test trips. They are providing wound care kits, and in many places on-site wound care for their participants, and safer smoking and snorting supplies as well. Next slide, please.

I always share this slide, which is from the Instagram page of this organization called Street Cats. A lot of, you know, many folks will talk about harm reduction with a little h and harm reduction with a big H. And so if you're looking at the left side, you know, harm reduction is absolutely these tools that folks can use to stay safe and alive, but it is so much more than those really pragmatic important tools. As you see on the right, harm reduction with a big H really is that movement for social justice, it is an act of love within community that's trauma informed, that is de-stigmatizing, that is accessible to all, et cetera. Next slide.

And I think one of, as we think about harm reduction with the big H, SSPs in particular and the staff that work there are creating trusted spaces where their participants can very authentically and safely discuss the conditions of their use. They're a trusted bridge to other services as well, and sometimes the staff and the volunteers that work at syringe services programs might be the only trusted service providers that somebody who is using substances will engage with. Most of our SSPs would say that far above any other means of advertising their services, word of mouth is the most important component. If folks don't trust the services and

the staff at a particular organization, they won't engage in the services that they provide. And many, if not most of our SSPs are engaging the participants they serve in the design of their programs as employees and as volunteers. And we see many anecdotal examples of folks who, you know, start connecting with an SSP to utilize the syringe exchange or to access the naloxone, and then continue on to volunteer as a secondary exchanger – so bringing syringes out into the community at-large and collecting syringes – as a naloxone distributor and things like that. Next slide, please.

So these are the six syringe services programs that our section, the Infectious Disease section at MDH, is funding for the next two years here. Harm Reduction Sisters and RAAN are based out of Duluth and the Duluth area, NorthPoint Health and Wellness is located on West Broadway in North Minneapolis, Clinic 555 in St. Paul, Native American Community Clinic on Franklin in Minneapolis, and then Southside Harm Reduction. Next slide, please.

This is not a comprehensive list of other syringe services programs. I'm sure that I'm missing some, or I'm missing some spaces that are centered in the provision of various tools of harm reduction in Minnesota. But certainly if you have questions or want to connect to a syringe services program or a harm reduction provider in your geographic area can certainly reach out to me. The next slide, if you want to go to the next slide.

Oh, sorry, there's another slide here. I'll touch on syringe services calendars that folks can access that is a more comprehensive list of providers in Minnesota and their location. This is some of the quantitative data from the SSPs, the infectious disease division funded from 2022 to 2022. I highlighted in yellow, I always like to highlight these points. If you look at the number of exchanges, so almost 30,000 exchanges and this is just six of the syringe services programs in Minnesota, that's 30,000 conversations that happened between people who use drugs and the staff or volunteers of an SSP. So thinking about that safe space to have those authentic trusted conversations, I always like to highlight that. And I know that Cody is going to talk a little bit more about overdoses. If you look at the right column, this is a vast underestimate but about 1,200 overdose reversals reported by participants directly to one of these six SSPs, utilizing naloxone that was acquired in an SSP. And some of them, I'll also track, you know, when you responded to that overdose, did you call 9-1-1 or EMS and the majority of those did not engage with calling 9-1-1, and so I think there's, you know, there's a large swath of overdose reversals or non-fatal overdoses that we are missing a lot of the data related to, if they're not engaging with an emergency room or EMS. Next slide please.

So SSPs are some of the best organizations that meeting people where they are, physically and mentally and emotionally. So many if not most of the participants of the SSPs throughout Minnesota are people experiencing homelessness. Some are really centered in directing their services specifically to people experiencing homelessness, but services are provided in many different ways: brick and mortar, on call delivery – you'll see folks walking down the greenway in Minneapolis with wagons full of supplies. Ice fishing tents, a lot of them organize larger pop-ups near encampments or other spaces where folks may congregate and pop-up these, these tents to provide services. Many have mobile units and some are just starting to utilize vans to go out and about, some are actually providing these resources via mail. And so many are also really open to coming to different service providers, whether that's like a particular hub or a shelter to provide various services. So again, don't hesitate to reach out to an SSP that might be located near you to see if they can meet some of your clients in different spaces. Next slide, please.

This is the calendar I was talking about. So this is a two-page calendar. The first page is the Twin Cities area, and then the second page is SSPs located in Greater Minnesota. It maps out the different, you know, services that the actual location will provide. It is updated monthly, and it is on the Rainbow Health website as well as we are getting, we are working on getting it uploaded onto the MDH website as well. Next slide, please.

I'll talk a little bit about, you know, why do we need all of these wonderful services? So next slide.

So a lot, you know, injection drug use can present some particular risks, associated or harms associated, you know, with drugs, including – I always like to clarify too, it's not the act of injecting drugs that may present, you know, present a risk for infectious disease, it is the lack of access to a sterile syringe for every time that somebody may inject, that is presenting a risk for infectious disease transmission And then it also presents a higher risk for overdose, wounds, and other bacterial infections. So this is data related to admissions to treatment for substance use disorder, so these are folks that are being admitted to treatment. But from the decade between 2009 and 2019, we saw over a 330% increase in injection drug use in Minnesota, with the introduction of synthetic fentanyl to our drug supply. It also is prompting more frequent injections for people who do inject drugs due to an earlier onset of symptoms of withdrawal. Next slide, please.

A little bit about infectious disease transmission. About 75% of U.S. cases of hepatitis C are related to injection drug use, or more specifically sharing of syringes or supplies. The majority of new cases of hep C in Minnesota are linked to that as well. In 2021, 22% of hep C tests conducted at the six SSPs were reactive. About 11-12% of new cases of HIV in Minnesota reported injection drug use, and we are currently responding to two different outbreaks in Minnesota of HIV that are disproportionately impacting people who inject drugs and people experiencing homelessness, as well as American Indian/Alaskan Native communities. These outbreaks are, there's one outbreak in the Hennepin/Ramsey County Metro area, and then another outbreak in the Duluth area. And then I think Cody will touch a little bit more on overdose rates, but you know, we truly are seeing an overdose epidemic. Every year we're seeing increased rates of fatal and non-fatal overdose in Minnesota, Next slide, please.

Some of the benefits of SSPs. And I say this with a caveat, these benefits, I list all of the potential benefits, it certainly depends on the audience that you're talking to, you know, which benefits they may see as most important. Certainly in my heart, that safe space that non-stigmatizing, non-judgmental space for people who use drugs as one of the most important benefits. But areas that have an SSP are associated with less syringe litter, that's a common concern within many community spaces. SSPs are providing safe disposal of syringes and community syringe collection. Quite a few law enforcement officers over the course of their career will experience an accidental needle stick, and then areas where there are SSPs reduces needle stick injuries to law enforcement by 66%. SSPs are not associated with any increased crime in the areas that they serve. Next slide, please.

And SSPs are not associated with an increase in substance use, and in fact, they're associated with a reduction in using drugs. So when someone has access to an SSP, they are 50% less likely to acquire HIV or hepatitis C. They are five times more likely to enter treatment for substance use disorder. That is not the end goal of harm reduction or syringe service providers, but it is, you know, folks that have access to those spaces to be able to transparently, you know, discuss their conditions of use are five times more likely to enter treatment via referrals. And then folks that have access to an SSP are three times more likely to reduce or stop injecting drugs altogether. And a lot of SSPs are providing tools and discussion around, you know, prompted by participants around a transition from injection to smoking as a harm reduction tool in and of itself. Smoking or snorting or other modes of use. And folks that have access to an SSP are more likely to connect to other avenues of care, including primary care. Next slide, please.

That's it. Thank you, and feel free to reach out to me anytime really. Lovely to share this space with you. I'm happy to answer questions at the end and offline as well. Thank you very much.

[Cody Bassett, he/him]
Hi everyone. My name's Cody Bassett. I'm with the injury violence prevention section at the Minnesota Department of Health. I'm mostly just going to talk about where you can find naloxone today and just a little bit about it as well. Next slide, please.

So naloxone, I'm sure a lot of you are already familiar with it. You know, it's also known as Narcan. That's a brand name. It's a potentially lifesaving drug. It can reverse an opioid overdose, and it can be administered as an injection or a nasal spray, more commonly intramuscular injection. So, when a person administers the naloxone during an opioid overdose, what that naloxone does is it disables the opioids harmful effects on the receptors in the brain and temporarily – keyword temporarily – reversing that opioid overdose. It's only effective in the event of an opioid overdose and it's otherwise harmless. I could give myself an injection right now and nothing would happen. Anyways. Next slide, please.

So don't really have much in the way of information, but we have the pretty much the basics right here. We're seeing annual increases and overdoses at a statewide level, nationally. Increased availability of fentanyl is part of that increase. You know, it's 50 to 100 times more potent than morphine. We had in Minnesota a record setting number of overdoses, Anna mentioned it earlier proximately 1,200 I believe. I don't believe 2022 is available quite yet. And just to sort of expand on it too, you know, as far as numbers go like as a whole, the state is kind of on the lower side as far as nationally goes, but at this point in time to our knowledge in the injury and violence prevention section, Minnesota has the greatest race rate disparity in the nation. American Indian are 10 times more likely to experience overdoses, African Americans are four times more likely to experience an overdose. Both of those in comparison to White populations. So, you know, overall that's really just to demonstrate that overall like looking at the state comparison to other states may not be concerning or as concerning; however, when you really dig down into the numbers and dig down into, you know, the trends, such as the one I just mentioned, you know, there are definitely causes for concern. The report that came out earlier that is a prelude to this public meeting, You know it's, there are definitely populations that are facing some serious inequities when it comes to drug overdose. We're also seeing increases in overdoses in Greater Minnesota, versus the Metro. So I could go on and on, but unfortunately I do not have the slide in front of me. Next slide, please.

And this slide I like to keep around. Don't really worry about it. It's more background as far as naloxone access in the state. In 2016 we have the sessions law. Basically it made it easier for folks to go to a pharmacy and they could, what they basically do is they create a prescription on the spot and they can prescribe that naloxone to you. 2020 there was further legislation that loosen that protocol, that requirement even more for pharmacies. So what was happening was they actually had to seek out a prescriber of record or the Minnesota Department of Health was one for a while, but now since 2020 that has since loosened. And then now even, I didn't have a chance to update this slide, but now there's even discussion on the federal level of making a naloxone an over-the-counter. We have no idea where that's going to go, I just wanted to mention it that it might be happening sooner or later. It definitely seems like the FDA at least approved to the idea, but it still has more hurdles to go. Next slide.

You know, what I was just saying like where to get naloxone, you know, right now as I mentioned, like those participating pharmacies are definitely an option, but I'm going to go through a quick list here of options as well where to find naloxone in the state. Next slide, please.

So the first one we have to talk about is there's a naloxone finder that the Minnesota Department of Health in partnership with a few other organizations, such as the Board of Pharmacy and a couple of the, let’s see, and a bunch of the nonprofits in the state who are all kind enough to let their info be shared on there as well. So it’s on knowthedangers.com. It's called in the Naloxone Finder, you simply click on it. You can go to the next page.

This is kind of a demonstration. So, the image on the right is what it looks like, there's over 800 locations listed in there. Pharmacies that are known to have naloxone protocols, syringe service programs, other harm reduction groups, the Steve Rummler Hope Network, naloxone access points are listed in there as well. All you have to do, you enter an address or a zip code and you can find the nearest location. You can even filter it to, like the ones that I have listed there under “Over 800,” the three different ones you can filter by that, you can set a 20- mile radius or a 5-mile radius. So, depending on what you're looking for you can, you can find it. Next slide, please.

And this, I'm going to talk about some groups there. These are state-funded partners, so they're not all directly funded by MDH, some of these are funded by DHS. Naloxone is kind of a mishmash as far as funding goes in the state, but what the important information for you, at least on this call is, so for like organizations that are seeking training and education – naloxone and other naloxone-related resources – the Rural AIDS Action Network and Steve Rummler Hope Network are two of the larger organizations, you can see there focuses right there. So Rural AIDS Action Network tends to focus on the Greater Minnesota, Steve Rummler Hope Network tends to focus on the Metro, but I believe they're also statewide as well. Not sure why it says Metro, but I believe there statewide. If there's anyone from Steve Rummler please correct me in the comments, but next slide please.

And then there are additional state-funded partners. I wouldn't, they do distribute naloxone, but this is more I would recommend, like, if you're going to refer clients out, this would be like, you know, recommendation for an individual. So Anna already mentioned a number of groups. There are some syringe service programs on this list. There are, and then they all have sort of different specialties, but you'll see for example Southside Harm Reduction there. They operate out of South Minneapolis. They're, they have a very Metro-heavy presence. There's the Native American Community Clinic, Hue Man group, Northpoint, Ka Joog, Red Door Clinic, and Lutherans Social Services/Street Works. They all have populations they like to focus on, but they also distributing naloxone as they work with those groups as well. So yeah, they can be referred to those groups, and then I think next slide.

And that's pretty much all I have. Sorry, I wanted to make it nice and quick for everyone. Thanks.

[Josh Leopold, he/him]
Thank you, Cody. So we also have a couple of more polling questions just to get, take the temperature of the room and see what attendees are doing regarding providing naloxone, and so the choices here are: Yes, we provide naloxone, and it's specifically for staff to have available or to distribute; Yes, we provide naloxone both to staff and to clients or consumers of our program or services; No; Not sure; or Not applicable if you're not in a kind of customer or client facing type of organization. So just click whatever you feel like best describes your situation and then hit the submit button. We'll just give it a minute for everyone to get their responses in. Great, and then, or let's see we've still got a few coming in. So alright, and then Katie, let's go to the next question.

Okay, so the next question is if any of the following are barriers to offering naloxone in your organization, and so choose all that apply here. One is lack of knowledge about naloxone or how it works, uncertainty about where to get naloxone, costs, lack of training opportunities, staff hesitance, or concern from leadership about liability or other risks. So just choose any and all that you feel apply here. Okay, well it seems like we've, I think got responses from most people, if you still are waiting get that response in. And I am going to turn it over to Morgan.

[Morgan Weinert, they/them]
Awesome, hello everybody. I have more slides than I do have time. So I'm going to try to go through this pretty quickly. I'm the medical director of the co-located sites at Minnesota Community Care. We're the largest FQHC in Minnesota, providing services regardless of the ability to pay. The clinics that I, the clinic that I mainly work at is the downtown clinic, which is co-located with St. Paul Catholic Charities', excuse me. St. Paul Opportunity Center. We also have a clinic Union Gospel Mission, and we also do a lot of outreach work in collaboration with Radias, People Inc, the county. And something that I'm really proud of is the work we do around harm reduction in our clinic. So that's what I'll talking about today. Next slide.

I'm going to leave these, slides are going to be available to look at in the future, so I'm not gonna really dwell on them, but I do like this kind of spectrum of psychoactive substance use visual that talks a little bit about how we can kind of conceptualize substance use, and when it maybe is beneficial versus what it might become problematic or chronic dependence. And this isn't, I just want to point out that this is not placing like goodness

or badness on any of these. Many of us use drugs for beneficial reasons all the time, like any of the medications that you might be prescribed, some people smoke weed because it makes them feel a little bit more calm. Like there's lots of reasons that people use drugs prescribed or otherwise. Casual/non-problematic use, like sometimes people go to the bar for happy hour with their co-workers. It's not impacting their health or social life, but then sometimes it can get into a place where it's beginning to negatively impact people or the people around them. And often that is when in health care – when we are working with folks to help in whatever way we can in those harm reduction efforts – to help bring them to a place where they are able to feel a little bit more control of their use. Next slide, please.

And then again, not going to go super deep into this cause it's big, but this is a another really great visual that talks about the different reasons people might use drugs. And again, I think this helps kind of normalize it or give us a little bit more insight into why people are using. I want to shout out to Josh and Anna, who both I think said this in their slides as well, especially in people experiencing homelessness, we see folks using because it maybe is helping them stay alive. So we hear a lot folks are using stimulants like cocaine and methamphetamine to stay a week because they don't feel safe if they fall asleep. A lot of folks with chronic pain disorders will use opiates to feel like they can function and get around. So just kind of keeping that stuff in mind. And again, I think it's important to remember that this chart applies to everybody, it's not just people expressing homelessness. We all use substances for a lot of different reasons. Next slide, please.

I was asked just to kind of run through real quick some of the common drugs. This is, to be specific, what we see most in Saint Paul and Ramsey County, but I think it's pretty common for a lot of cities. We categorize drugs as stimulants, depressants, and then “designer drugs” or hallucinogens. The common stimulants we’re seeing in Ramsey County are cocaine and methamphetamine. The common depressants we see are opiates and benzos. Stimulants meaning that it stimulates your central nervous system, so it gives you energy, it helps you stay awake. Depressants being it depresses your central nervous system, so those are things that make people feel a little bit more sleepy and relaxed. But what we're seeing is because of the way that drugs are being produced and distributed, and those changes are definitely in direct relationship to the way that they're being policed. We're seeing a lot more fentanyl and other kind of adulterants that are being put into to the drug supply. So the one that everybody is really talking about right now is fentanyl, and this little image here kind of shows you how much fentanyl is, like the far-right vial shows the amount of fentanyl that is equal to the far-left vial which is the amount of heroin. So that amount of heroin and fentanyl are like equal in their potency. So a very little amount of fentanyl goes a very long way, and it's being cut into substances – fentanyl is an opiate – and it’s being cut into substances like methamphetamine and cocaine and other things, and so people are buying one drug expecting a certain effect and they're getting hit with fentanyl. And that's why one of the reasons that we're seeing an increase in the number of overdose deaths is that people are using a drug and getting a different result than is expected. So just something to kind of keep in mind. We're seeing lots of other things right now. The other big one is xylazine. We're seeing a lot more of that in the drugs supply too, which is actually an animal tranquilizer. So it's not an opiate and doesn't respond to Narcan which is a whole other issue that I won't go into detail today. But again, just trying to show you the different types of drugs and how, despite the fact that folks might be like a stimulant user or a depressant user, because of the poisoned drugs supply, we're seeing all sorts of things getting mixed into other drugs. Next slide, please.

The next few slides are just gonna talk about the different substances that we see, when to get help, and then also some of the ways that we encourage safer use at our clinic. So cocaine like I said is a stimulant, so it's making people feel more alert, often causes kind of euphoria and confidence. Physically, it's increasing heart rate and blood pressure, can cause eyes to dilate or get bigger, and can make people sweat more. It can be smoked, taken orally, snorted, or injected. And you can see that little, the table on the bottom right-hand corner. It kind of shows you the different ways, the different onset of actions at how long it takes somebody to feel high from the drug and how long they will feel high from the drug based on how they take it. And I think that's important just to understand why people might choose different ways of taking a substance. When to get help for folks who are using cocaine, the person is non-responsive and that's going to be the same for all of

these substances. If a person is unresponsive, you should get help. Agitation and delusions that are life threatening to them and the people around them. Chest pain or tightness, especially with stimulants. Sometimes people can get heart stuff like heart attacks or arrhythmias. Folks that use it for a long time can end up getting like chronic heart failure – congestive heart failure, excuse me. And then extreme shortness of breath. Next slide, please.

These are pipes that are used to smoke cocaine. In our clinic people often refer to them as stems, some people will call them love roses because they're advertised in gas stations as little roses to give your partner. You can keep a lookout for them next time you're in a headshop or a gas station. And then you can see the little like filters at the end of the one, the picture on the left. We hand out those at our clinic as well, and we hand these out in our safer smoking kits for folks who use cocaine, so they have their own clean unbroken glassware that they can use to smoke. We also a hand out mouthpieces to cut down on people getting their lips cut. Go ahead and go to the next slide.

Methamphetamine again is a stimulant, so it causes a lot of the same things that cocaine does. Methamphetamine releases dopamine at much higher rates than like any other substance. So people tend to feel really really good when they use it. And chronic use can make it so people have a hard time feeling good if they're not using it, and that I think is really important to keep in mind. It's not an easy drug to stop using. So a lot of times we just say, oh you can just stop using like you should just quit, just go cold turkey or whatever. But for some people like this is literally the only thing that makes them feel good, makes them feel like they'll be able to accomplish stuff. So I like to just kind of help people conceptualize that if you can imagine just like all the joy being sucked out of your life except for if you could do one thing, and then being told you can't do that one thing. People get it's not easy. It's not an easy thing to stop. And I'm saying this as a person who's never used drugs but relying on the expertise of the patients that I work with who are able to tell me like the only time I feel like myself is when I'm using this drug. So really kind of sitting with that for a second and thinking what that really means. When folks use meth sometimes, and this is the same with cocaine but we see it a little bit more with the methamphetamine, they can kind of appear manic, so talking really fast, agitated, unable to sit still. And sometimes if folks are using long enough or use enough, it can cause delusions or psychosis. We often in the clinic, we'll see people who feel like they have an infestation of bugs in their skin, which you can imagine is really distressing. So that's something to help kind of people feel calm. It doesn't necessarily, like the thing you don't want to do is say that's not happening to you, that's not real. But just acknowledging that for them it feels real, so helping people feel calm, get to a space where they can feel a little bit safer. Again, meth can be eaten, injected, snorted, smoked, or administered rectally. And then same thing to get help for cocaine, but adding seizure on there. When people use too much, sometimes they can have seizures, and using too much stimulants we call it over-ramping and that is definitely something they have to go to the hospital for. Next slide, please.

Oh, for some reason, my slide with the bubble on it wasn't there. But for safer use of methamphetamine, we hand out bubbles. They're like, they look like the stems except for they have a little bubble at the end for safer smoking of meth. And then opiates is again a depressant, so causing pain relief, sedation, it calms down the nervous system. Opiate use can cause pinpoint pupils. So instead of pupils being really big and blown out, they get really small and tiny, even if there's a lot of light in the room. They can decrease heart rate and breathing rate, sometimes people can nod off, so they look like they're sleeping and some folks will go in and out of consciousness, like semi-consciousness and being awake. It can be used orally, snorted, smoked, injected, or used via rectum. For opiates the thing that causes overdose is your breathing basically gets so slowed down that you just stop breathing. Often one of the signs of that is blue lips because they're losing the oxygenated blood going around. Also gasping or snoring or not breathing. So if you see somebody breathing, but they're not breathing normally or they're breathing irregularly or snoring, that would be a good reason to intervene. And then again somebody being non-responsive. Next slide, please.

And then I won’t go too much into this because it was talked about in the syringe exchange program, but we hand out kits very similar to the one in this picture that allow people to inject more safely and focus on avoiding

bloodborne pathogen exposure. We actually do nurse-led visits at our clinic where patients sit down with nurses and are taught how to clean their skin before injection, are taught like what veins to avoid, and how to identify an infection. Go ahead, next slide.

And I also want to shout out to Anna for talking a little bit about this, but harm reduction was founded by people who are using drugs, it's something that we really need to give credit to people who use drugs for being the people who founded and finally got public health on board with, so I like to separate public health harm reduction – which is a lot of what I've been talking about and even the other folks from MDH – and the liberatory harm reduction, so that's harm reduction where people who use drugs and people who are actually involved in, like street economies are helping keep each other alive. We've been doing some research and some surveys and some focus groups with our clients who use drugs, and the things that I'm learning that folks do are totally like mind blowing and eye-opening and stuff that we can't as health clinic encourage, like we can't be the people who like push those harm reduction methods into the world and it also wouldn't be appropriate for us to do it. It's amazing that these communities are caring for each other, are really keeping each other alive, and like we have to give credit to the fact that our clients are responding to overdose, to the overdoses of their friends. They're getting their friends to the hospital, it's really amazing stuff. And then all of the stuff we buy is from smokeworkspipes.com, all of our glasswork. So if you're looking for a place to buy, I really recommend them. They also do like kind of sit-downs with organizations and will help them buy the right stuff for their organization if that's something that you're feeling a little bit overwhelmed by. The only other thing I just wanted to say is we're not a syringe exchange, we definitely hand out syringes, but just the constraints of our clinic system we're not able to like really truly not have low barriers or no barriers to handing out harm reduction supplies, but if you are kind of in a similar situation as a clinic or another organization that can't just do a pure syringe exchange and you have questions about how to do it differently, you can feel free to email me. Which I just realized my email is not in here, but maybe Josh can send it out when he sends out the slides. Next slide, I think that's it. Yeah, thanks.

[John Tribbett, he/him]
Alright, good afternoon everyone. My name is John Tribbett, and I am the service area director at Avivo – one of the two service area directors in Avivo's Ending Homelessness Division. Go ahead, next slide.

And so let me tell you a little bit about Avivo. I'm sure many people that have heard of our organization if you haven't, we are a 501(c)(3) nonprofit located in Minneapolis. We have three large divisions, a chemical and mental health division, an employment division, and the ending homelessness division. Next slide, please.

So the Avivo model, and certainly the Avivo model is not something that we invented. It simply is us combining a lot of best practices that we've learned from the community. As everyone on this call I'm sure is aware of, this work only happens through relationship not only with the people that we are supporting but with one another as we work together, and people who are using drugs and people who are experiencing homelessness and all those best practices come together to really define some of the work that we're doing. And so what I'm going to talk about in a brief bit of time is to try to give a big picture and hopefully some details about how you can actually go about integrating harm reduction into your homelessness services. And certainly one of the important things and I just want to reiterate what's probably been said several different times already is that we learn from one another, and harm reduction is really a conversation. It's a set of principles that are applied in many different forms and certainly there are some standard things that occur often in different environments using harm reduction, But really, it's a flexible and adaptive responsive model. So in terms of the housing model and what we offer and work towards at Avivo is really a full continuum of services that look at working with and serving people on the street when they're staying in places unfit for human habitation. And so that can be an encampment, that can be in abandoned buildings, garages, vehicles, just about anywhere and everywhere where you might find people that are staying outside. We also operate Avivo village, which is a 100-room, some people call it a tiny home shelter, but really it's more accurately described as a tiny SRO shelter, which means everyone has their own individual room equipped with a bed. When people move in, everyone is provided with

naloxone and equipment to safely dispose of any equipment that they may or may not be using. And it's focused on really permanent housing. I'm gonna talk a little bit more about that later on. And then we also operate site-based housing, including two locations in St. Paul that are High Fidelity to Housing First & Harm Reduction and then scattered-site housing. We have a variety of programs that are funded through different subsidies and housing support throughout the metro area. Alright, next slide please.

So goals. Goals of harm reduction, certainly one of the good things about a presentation like this is knowing that you're excited to hear from the prior four presenters because I've been listening with open ears to the great information that's already come out. And so there's a lot of things that people have talked about in terms of the goals involved with harm reduction. At its most fundamental, rubber-meets-the-road place, it's really keeping people alive. People who use drugs who die as a result of using drugs can't be housed, they can't recover, and they can't find their way into flourishing in their life in a way that's meaningful as they define it. And so within our agency really we talk about integrating harm reduction throughout the agency to a point of saturation, we're not there yet we are working to do that, and that means not only having things like naloxone available to staff and to participants, but also really having that framing of that mindset of harm reduction, of meeting people where they're at with compassion and dignity just really permeating everything that we do. And then, of course it does include making sure that everyone has the training, the techniques, the skills, both for participants and staff. And then offering opportunities for flourishing, which really you know they can be somewhat tangential, but actually not. I mean it's part of that harm reduction, it's not when you get to a certain point of safer or more stabilized drug use, then your life begins, you get to have opportunities for flourishing. But really providing opportunities for people to have meaningful connection to themselves and others through, whether it's group activities to art, through whatever it is that that they define in their own lives. Next slide.

Alright, so harm reduction does not mean anything goes. Oftentimes people say, you know, harm reduction… you're just giving needles to people so they can go out and get high and they do whatever they want. It absolutely does not mean anything goes, in fact, a well structured housing program or a shelter program is going to provide a lot of guardrails. We don't have a lot of red lines, we have some red lines, but mostly we have guardrails that really help people be supported within those spaces in a way, because harm reduction is not only geared towards helping the individual to remain safe, but the community that lives around them to remain safe as well. Next slide, please.

So I'm going to just talk briefly here about Avivo Village as one example, due to lack of time, of the different programs where we do harm reduction. Avivo Village was created in partnership with White Earth Nation. We are serving a target population of Native American individuals, which as talked about earlier has some of the highest disparities in terms of negative impacts of drug use as well as homelessness. We are not a native-based organization, we don't know what we don't know. And so when trying to serve people, we get out of the way and we try to learn what we need to learn in order to be more effective in the way that we do serve and support people. Next slide.

So this is a quick view. This is towards the end of our construction, but as you can see Avivo Village is built up of separate little pods which have individual rooms. We have for larger sections and I'll talk about some of the why of that in the structural space in just a moment. So next slide.

So harm reduction, what is it? It's a process of normalization. The goal is to say, "I need some naloxone" is as boring and as normal as "I need some shampoo." We want that sense of harm reduction to just be basic, normal, part of how we go day to day. Next slide, Please.

So I'm going to talk through these very quickly. If you have further questions, if they come in, I can certainly talk in more details. One is thinking about the physical structure of the environment, and certainly there's going to be some limitations depending on where your housing program is. But for instance at Avivo Village, we were able to get a variance on the bathrooms. There are individual bathrooms that are used. There is about this much

space – probably not a very good – probably about three or four inches of space at the bottom of doors. The doors indicate whether the room is locked or unlocked. The light is a motion sensor light. And so all those things combined to let us know that if there was a bathroom that was occupied, the light was out, that somebody is potentially having a medical condition which might be an overdose. And so we are able to easily check to see if there's an individual in there that's having some type of distress. We've created the structure of the village itself as a way so people can easily move around and check rooms. And we have a common area at the front, which certainly could be reflected in a front desk area, for instance, in a site-based housing program, where there's just an opportunity to build a relationship and see people on a day-to-day basis to get just a baseline of how people are doing in the day. So a lot of ways to think about how to be creative there. Access to naloxone. Naloxone is handed out to residents, it's handed out to other participants, staff is all trained. Naloxone is literally just kind of sitting around just like you might see pens sitting on a desk somewhere. Safer use supplies again are available, including condoms and other safer supplies. We have a fairly rigorous overdose protocol, for instance at Avivo Village, we have reversed in a little over two years 96 overdoses successfully, which is telling of the degree to which there is, the opioid epidemic has really really impacted people staying outside. So we have roles that are clear, we do role plays, there's a variety of trainings that we do around those things. And then critically we make sure that we're doing debriefs with staff, because certainly for some staff once they've been around for a while, they're seasoned, these things are less adrenaline producing, but certainly when people are first responding to overdoses they can be quite traumatic. And so, again, those role plays, debriefs are really critical. Again, ongoing training in a variety of formats and really making sure you have access to, your program participants have access to medical support. And numerous people I could give a shout outs to, but we work in partnership with many many people in the community, NAAC, many of the street outreach teams, Healthcare for the Homeless, and we have people coming in from Hennepin County to do all of variety of STI, syphilis, HIV, hepatitis A, B, and C testing. In fact since October of last year, we've tested 71 people. And so all, really that wraparound comprehensive holistic support for people. And then really making sure that people as part of that harm reduction continuum, if they choose to do something like medically assisted treatment, if they want to go towards a full blown abstinence-based recovery process, whatever that looks like we want to make sure that people have the tools and the access points available to them as easy as readily and as low barrier as possible. Next slide, please.

Okay, so harm reduction is hard work. If you've been doing this work in any capacity, you know that. There are a lot of challenges, and I believe Anna had this slide or had this principle up from National Harm Reduction Coalition, which if you haven't been to their website I'd strongly encourage it, there's a lot of great resources there. Drug use does not, harm reduction does not attempt to minimize or ignore the real and tragic harm and danger that's associated with illicit drug use. We like to think about our work as not in any way, shape, or form promoting drug use, we are associated with treating a medical condition that takes time, creativity, and it's dealing with human beings with all the variability. And so some of the key things that we work with sometimes or we have challenges that we run into are staff buy-in. Some people do struggle with the harm reduction model and so there can be a lot of time that needs to be spent sort of working with people and not being judgmental. We try to create that parallel processing where we're meeting our staff where they're at and certainly helping them then move along in the continuum them as we, as they think about how to approach the work. Staff burnout, the moral injury in the face of suffering, it's continuous. We are working in these systems that are the legacy and continued ongoing realities of racism and injustice. And as a product of that is the day-to-day interaction with individuals that are being deeply deeply impacted by these symptoms or systems, and symptoms as a result of that, which can create very challenging spaces for staff. So giving people time and space to really work through that, talk about that, owning that, acknowledging it. Security and safety – and I want to just caveat here, I'm not talking about, usually almost never is it the individuals themselves that are the participants in these programs, it's the unfortunate reality of predatory behavior that can go on around people that are involved or have to access illicit drug supplies. And some of the people that are in those environments can produce danger and safety concerns, and so just being cognizant of that. And then really building that level of trust with people so that they understand that our staff are safe. They are people that they can talk openly to,

and just really working with people again and again and again to let them know that who they are right now, today, without any changes in their life is absolutely 100% the most beautiful that they can be. This work is ultimately about love, but through a bunch of practical strategies. So that's all I have.

[Josh Leopold, he/him]
Great. Thank you, John and Morgan and Anna and Cody. So thank you everybody who attended. As I mentioned in the chat, we'll be sending out the slides and the recording, and then we'll also be sending out a follow-up survey to learn more about people's reactions to the webinar and also suggestions for, you know, where to go from here. Alright, bye.

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