Combating the Opioid Crisis: Addressing Stigma
Public Health Live!
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TRANSCRIPT

Moderator Rachel Breidster: Hello and welcome to Public Health Live. I’m Rachel Breidster and I'll be your moderator today. Before we get started, I'd like to ask you please pull out your online evaluation at the end of the web cast. Continuing education credits are available for a limited time after your take our short posttest, and your feedback is helpful in planning future programs. I also want to let our planners and presenters of Public Health Live do not have any financial arrangements or affiliations with any commercial entities whose products, research or services may be discussed in this activity. And no commercial funding has been accepted for this activity. As for today's program, we'll be taking your questions throughout the hour by phone at 1-518-402-0330 or via e-mail at phlive.ny@gmail.com. Today's program is titled, “Combatting the Opioid Crisis, Addressing Stigma” and our guests today are Allen Clear, the director of the Office of Drug User Health at the New York State Department of Health AIDS institute, and Robert Suarez, a community leader with the Peer Network of New York and VOCAL-NY. Thank you for joining us.

Moderator: So good morning, thank you both for joining us today.

Allen Clear & Robert Suarez: Thanks for having us.

Moderator: Yeah I’m looking forward to the discussion. So, Allen to get us starred today, would you mind reviewing for us what the objectives are of today's program?

Allen: Yeah, people use drugs are one of the few populations that we deem acceptable to stigmatize, as if stigma is going to help them. So we're going to look at the role stigma plays in their lives and the way it impacts health of people who use drugs negatively and as we talk through this, there will be ideas and suggestions as to ways we can improve addressing stigma and maybe undoing some of the stigma that impacts people who use drugs.

Moderator: Excellent. Thank you. Let’s start by talking about why is stigma part of the conversation around addressing the opioid crisis?

Allen: We're in the midst of an opioid crisis. In this country, and in New York a lot of people are dying unnecessarily and a lot of people experience nonfatal overdoses. And if it was simple enough that we would just provide medication or drug treatment or something or health care, then we could undo this. But stigma overlays this and it keeps people out of the system out of our communities out of our families and it delays people getting the help and support that they need.

Moderator: To make sure we’re all on the same page, could you talk about how you define stigma to frame this conversation?

Allen: Yeah as you can see from the slide here, we quote from Corrigan the idea that we discredit people for who they are and what they do. And we make sure that they are different from us because if they are different from us, then easier to deny them help and deny them services. And drug use is a socially disapproved status for people because of the criminalization of people who use drugs and we’ve
had this as an ongoing social norm for the last 100 years. And we need to move past this idea that people who use drugs are criminalized or pathologized.

**Moderator:** And Robert, does this perspective resonate with you as well?

**Robert:** It does. One of the things I wanted to make sure we're absolutely clear about is that people who use drugs are human beings.

**Moderator:** Yeah and I think that's a big part of the message that we're trying to illustrate in today's show. So can you talk to us, Robert, about how pervasive is stigmas impact on people who use drugs?

**Robert:** It is very widespread when it comes to our criminal justice system, when it comes to medical facilities, any institution or just, it's just widespread. We need the make sure when we talk about ending stigma, we talk about ending it from the bottom up. Housing, education and so many other things.

**Moderator:** So a pervasive idea when we're looking at the whole picture. Now, Allen, what do these forms of stigma mean functionally, for a person who uses drugs?

**Allen:** I'm going to on to the slide that people can see in the audience, but there's different levels of stigma. There's the way we stigmatize individuals. There's stigma by association. So if you want to open up a homeless shelter or something like that people want that out of the neighborhood even though it's necessary. You tell people, enough times that they are not worthy, they internalize that. So there's an amount of self-stigma. And institutional stigma, which we use to keep people down. So the federal ban on the funding of the needle exchange which we’ve had since 1988. When we know how to stop the spread of HIV and you still can't use federal funds to supply syringes, that's a form of institutional stigma. If you want to break this down into differences in danger and discrimination we may want to move to the next slide. We want to keep people away from us so we push them away. They are different from us. So if they are not us it is easier to, you know, to not allow them into our world. They're dangerous people. How often do we see, where drug use surfaces and your interaction with law enforcement, they're somehow dangerous. The people who use drugs are dangerous to us. Then we can openly discriminate when we do that, to keep people down, keep them different. Keep them out of our housing. Keep them out of our neighborhood. And as Robert says everyone is a human being that uses drugs; people that use drugs are us.

**Moderator:** I think that's an excellent point that you made. The idea that if we separate ourselves from people, it makes it so much easier to dehumanize or create that idea of danger and criminalization. So how is stigma reinforced through its impact on people's lives?

**Allen:** It's one of those cycles isn't it. We stereotype people, give them names. Give them majority of names. And once you being to do that you being to layer those roles on people. You then limit what their expectations are for those people. You limit how they interact with us. By doing that, you limit the opportunities. You can get drug tested for working in a pet store when you probably need to take drugs to work in a pet store sometimes and that kind of thing. And again, and then it becomes internalized and reinforced. So if people feel they are inadequate, they won't try or they won't show up. Oh, I’ve got an excuse here and that just goes around and around.

**Moderator:** Robert, from your perspective, what are some of the labels that people who use drugs deal with?

**Robert:** One of the things that starts the stigma rolling is the word ‘addict’. So from that word, you have the criminalization, the dehumanization, villainization. Just a wide range of other things that just keep
people from moving forward. It's important that when we talk about people who use drugs, as I said I’m going to continue to go back to this, that we talk about them as human beings which helps in much of the stereotype that has to do with people who use drugs. One thing I want to make very clear is that people who use drugs are the most brilliant, gifted, blessed individuals on the planet. They should not be discounted. Putting labels on individuals, I can't say enough about how damaging it is. So, moving forward and past that is the best thing I can do.

**Moderator:** If I could ask you a follow up question, I’ve heard people describe themselves as addicts. Can you say more about the harm in that particular label to help people and myself to understand?

**Robert:** So people will choose to describe themselves as they do. For the most part, we want to try and help individuals understand that the word ‘addict’ is for many, it's a hurting, and it’s hurting kind of thing. Now people who describe themselves as addicts are individuals for the most part who come out of that treatment program, abstinence based treatment program. We want to make sure we don't take away anything that has to do with abstinence based treatment programs because abstinence based treatment programs and harm reduction in many works hand in hand. There's a time when individuals come around to see it. Okay, so I’m starting to understand where you're coming from with that word, ‘addict’ and how it follows through with so many other things like the criminalization and the dehumanization aspect that the word ‘addict’ holds.

**Rachel:** Thank you so much for that. Now Allen can you tell us more about consequences that occur as a result of drug related stigmas?

**Allen:** I mentioned the way that people internalize the stigma and when you feel a lack of self-worth and it impacts your mental wellbeing, it impacts your self-esteem. So basically, when you have poor quality of life, it means your interactions between you and your world become diminished. You become diminished as a person, but also your interactions are less than healthy. Your interactions are less than positive, you go in with a negative attitude. And you get, like we were talking about the cycle before, you end up with a diminished set of services and care. And you feel less worthy at the end of that interaction when you interact the medical system or the health care system or social services system. It’s something that really affects your mental health and wellbeing.

**Moderator:** I think that's the perfect segway to my next question for you, Robert, talking about how people internalize that stigma. So how does that influence the ways that people who use drugs then go on to interact with the health care systems?

**Robert:** It has a huge impact. For the most part, people who are trying to seek medical attention in the health care system, they are stigmatized because of just who they are, not being human beings, but being an ‘addict’. That carries over to saying that you are not going to receive the same quality of health care or treatment that others would. So in some ways, I equate that to an individual who may have diabetes. Who takes a bite that donut and then their doctor talking to them and how you need to manage your sugar more. But when it comes to a person who is a user, and they go and have pain from a broken arm or many other different things and a doctor say, I can't treat you with a painkiller that I would treat anybody else with because you're a user. That just puts people off from wanting to go and receive any kind of quality health care because they're already stigmatizing. They know they're not going to get the same treatment others would.

**Allen:** Which is why we often mention that people go in and need adequate pain relief. People are looked upon as people who are drug seeking and what people do is they have very logical responses to that- that they exaggerate maybe what it is that's wrong with them or they tell a different story because their experience is they are not going to get the care they actually came in for, so they will try and
manipulate the situation to get what they need. And so then people get that reputation for you know, not telling the truth, when in fact the system does not deliver to them what they actually need.

**Moderator:** So it becomes sort of a cycle that the system isn't delivering so people exaggerate their claims and the system says we can't trust these people because they exaggerate their claims and it keeps spinning. So it's the system that begins the problem. So Allen, what are some overarching principles you would say we should keep in mind about people who use drugs?

**Allen:** Obviously we're talking about people who use drugs and stigma, but people are not their drug use. Drug use is an aspect of something that people do. But it doesn't, it's not the totality of who they are. They are full human beings who happen to use drugs, which happens to be something that's criminalized. We have this thing too, it's very hard to disclose drug use and it's very hard to disclose for this particular reason. That we assume a certain amount of harm that's associated with drug use when that is not in fact, a fact. People use drugs in all kinds of different ways, for health reasons, for fun, to cover up pain, for self-medication. But even within thinking that way, people can vary the way they use drugs. You can use one drug for one thing and another drug for another thing. It's a sense of relief for a lot of people. So we can't define people by what we imagine the drugs are that they are taking.

**Moderator:** Sure, absolutely. And I just want to remind our viewers that you can email questions for our speakers at any time during the web cast to phlive.ny@gmail.com or you can call at 518-402-0330. Robert, now shifting back to you say is important to tell providers that they need to change in order to better the needs of people who are using drugs?

**Robert:** Right, so this is a really important question. We need to show that individuals who use drugs are, for the most part not planning their own health care treatment, but they are a part of it. So we want to make sure the providers are providing an availability to have an interactive conversation with individuals so that the provider and the individual who are using drugs are working together when it comes to helping them reach their goals within their drug treatment. So it's important that providers have an understanding of how to talk to individuals with that nonjudgmental approach. With that humanistic approach. As someone who, we would want you to be a part of what's happening to you and giving the individual an opportunity set their own goals when moving forward with treatment.

**Moderator:** So advocating similar to what we would say to any other patient. We should be engaging the person and having a dialogue. And getting the person invested in their own treatment plan.

**Robert:** Once again, it's important to remember that People who use drugs are not these lower class people that they are sometimes thought of. They are human beings and they are capable of making sound decisions given the opportunity to.

**Moderator:** Thank you. Allen, in the programs that are supported by the health department, do you provide specific guidelines to providers on strategies to address stigma and how can providers learn about these different strategies and what they can be doing to better meet the needs of drug users?

**Allen:** I think the office I work for we're all about, you cannot separate out the support that we give to programs from an anti-stigma initiative. We're about serving people who use drugs. We expect that the people and the organizations we fund are going to be wanting to see people use drugs because we want them brought in, and given the care they deserve and that care that they need. So perhaps in our policies and procedures we will make that perfectly clear. But also in the health department we have begun an effort to develop stigma free health care for people that use drugs. So we've just gone through the first cycle of working with a core set of providers to look at what they have going on within their system, within their individual practices or their health care facilities to ensure that when a person who uses
drugs comes into that program, they get the best quality welcome that they can expect. And then the best quality services. I think that what we end up too is a much more satisfied workforce because you feel like you're doing something good rather than pushing people away and people begin to change and check their own attitudes within their office and can begin to think about the positive things they're doing for people.

**Moderator:** Excellent, I think everything you're talking about in looking at ways to reduce stigma, I think we're introducing the concept of harm reduction. I wonder if you can talk to us about what we mean about harm reduction and how that comes into play.

**Allen:** Yeah as you can see from the slide so if the organization called The Harm Reduction Coalition so a lot of this is from the work that we developed there. It's a set of ideas and strategies of working with people who use drugs that accepts that someone is using and they're going to use without an expectation that they're going to stop using in the short-term. Maybe they'll never stop. Maybe we can help them move to a place where they're going to want to reduce their drug use. So it's basically working with that person you know, in the situation that they're finding themselves right now. At the same time, you can't separate out a person's situation from a bigger societal goal which has been to prosecute a war on drugs for people. So this is very much, a harm reduction is a social justice cause. That we want to write some of the wrongs people have experienced over the last definitely forty years and where you can say over the last 120 years. And the interventions that the stuff we do actually reflects their genuine lives because I think too often we set ourselves up with our goals for someone to achieve. And if they don't achieve them, they have failed, rather than our system failing. I think we do that quite frequently with people who use drugs. So drugs are layered on top of all kinds of conditions. Whether it's poverty. Whether it’s mental illness or race and community. You know, we use drugs as tool to keep control on different folks. We use it as a monitor and surveillance system. All of those things play into the larger health care system or the larger mental health system, or whatever system it is, you can't have this the way we've addressed drugs in America, without having it play out in all different scenarios.

**Moderator:** Absolutely. Thank you so much for sharing all of that information. I think that's a really valuable perspective and framework to provide for this conversation. We recently visited with project Safe Point in Albany to learn more about harm reduction and reducing stigma. Let's take a look.

**Stephanie Lao, MSW:** Project Safe Point is the local harm reduction program. The work we do is really centered around working with individuals who are either actively using drugs or have a history of drug use. The work specifically centers around engagement and working with people along this continuum of change. Really harm reduction is about employing strategies that are going to lead to some kind of behavior change. So this work is you know a lot of it is based in human services. But it's also about recognizing that there's a public health component. You know, providing syringes is about preventing the transmission of HIV and Hepatitis C. And so that’s obviously something that impacts individuals but it certainly impacts our community.

**Samara Gabree, NP, AAHIVS:** Our program was designed to increase access to the meditation that we know prevents people from dying. Buprenorphine is medication to treat opioid addiction. It has traditionally been difficult for patients to access. And so our program was designed to allow access to treatment in a very nontraditional way. The requirements are you stay engaged with us. You come to appointments as needed and you be honest with us. You let us help you. And many times if somebody's still using, the engagement is “Okay, how did you use?” “Did you use safely?” “Do you need syringes?” There's no mandatory groups. They need to see me once in a while. Usually, it's great. We have up to an hour long session where it's focusing on just talking with the person. Getting to know them. We focus on the positives. Yesterday, I had somebody and she did use one day. And I said well you have six days that you didn’t use. Six out of seven isn’t bad. Some of the traditional programs focus on the negatives.
You have a positive tox screen. You used that day and they focus on that. Our program is designed to help encourage and empower patients to focus on the positives of the success they do have.

**Stephanie Lao:** The small victories equal success. So a lot of times, when people think about work with individuals who use drugs that somehow, the only marker for success is if that person stops using drugs. And that's not what harm reduction is about. Harm reduction falls on this continuum and so, you meet somebody all the way over here and they have a willingness to come to our mobile unit. That is success. The fact that they showed up is a success. They walk away with a Narcan kit, that's a success. That person is now educated about the risks of overdoses, has the ability to revive somebody. We've educated them about the 911 Good Samaritan law. So each little bit that's offered, each little opportunity is in my mind, a success.

**Moderator:** Now, Stephanie from project Safe Point talked about the continuum of change and opportunities that harm reduction encompasses. What more can you tell us about the key points you should focus on?

**Allen:** First of all, New York state has done a really good job at promoting harm reduction programs and supporting harm reduction, probably better than most other states in the U.S. we've had harm reduction here since the late '80s and syringe exchange has been legal and supported since 1992. So, for us to support programs that have the goal of genuinely wanting to interact with people who use drugs, we should praise that. We should think about how positive that is. And we've had an enormous impact as well, in terms of transforming the HIV epidemic. Because back in the early '90s, the HIV epidemic in New York State was driven by people who used drugs and New York State supported those efforts to reduce HIV among people who used drugs and we reversed an epidemic. We rarely think about that. We were the HIV and injection drug use capital of the world. And when we say that, we have to think this was people who use drugs that reversed the epidemic. When people think about people use drugs not being capable of doing anything, that's actually a no. When you provide health care in a setting that meets their needs in a stigma free environment, they will respond and we've seen that in New York State because we reversed an epidemic. So Naloxone, we'll talk about opioids here a little bit. You can reverse an opioid overdose by using Naloxone in a timely fashion. And that's something that we rolled out. Again, it's another, New York State has done really well in rolling it out through many, many different outlets in New York State. But again, that was another initiative that started by people who use drugs who were passing Naloxone on to each other through the harm and reduction programs to save the life of someone who was right there in front of them because they were on the scene of a drug overdose and it's grown from there. We often forget where these things come from. So, understanding how an overdose occurs and how you respond and how you recognize it and how you help someone to come out of an overdose is important and you need to know where you can get Naloxone. You need to know where you can get it on weekends. You can get it at pharmacies now. But so the Good Samaritan law also is something that protects the caller from too much over intervention from law enforcement on the scene of an overdose. Then Stephanie Lao talked about project Safe Point, which is one of our great programs in New York and what we've done is we've enhanced some of those programs to become drug user health hubs, where as opposed to where we think of syringe exchange as being a disease intervention, to stop the spread HIV or stop the spread of Hepatitis C, we want to have people looking at the whole person. Which these programs do, but we've sort of named it now and we've said you're a drug user health hub. And we're supporting you, and we're drawing people in who wouldn't ordinarily receive services at the syringe exchange program. Or having people reach out to law enforcement, emergency departments, and families when they're struggling to find what to do and what help they can go do. They can go to a health hub. We want to create that system of health care that works with people who use drugs. It's based upon what they need. We feel very often we know what a person who uses drugs, what they need. And maybe they need that, but u maybe they're not ready for that. So you base it
around what their most immediate needs are. And maybe that's getting Naloxone, maybe that's getting syringes. If you give someone what they want, they'll come back and talk to you further.

**Moderator:** Excellent. Thank you for sharing that. And in that vein, Robert, talk to us about ways that individuals or organizations can improve their cultural competency and their interactions with people who use drugs. One of the things Allen touched on is this idea of disease intervention to a health hub and even shifting the language. What are some of the thoughts you want to share on this topic?

**Robert:** I want to back up quickly and go back to Naloxone. I want to make sure it's clear when it comes to Naloxone, that people understand this. It's a medicine. So I know that there are a lot of individuals who are afraid sometimes because they're not sure if it's an overdose that someone is suffering from. So it's really important for people to know that Naloxone does absolutely nothing expect block receptors. So if a person is having a heart attack and you're not sure if they're having an overdose, and you give them Naloxone, you will do nothing to that individual that will harm them in any way at all. So moving on to your question, so, I love giving these little stories. So one story that I want to talk about is it has to do with Seattle, Washington. Within the community of Seattle Washington, there's a district called the U District or the University District. And within this district there's a restaurant within that community. And this community embraces individuals who use drugs. And they embrace them in way they treat them as human beings. I heard this story about this couple who had visited the restaurant and who were -- they were seated by the window and there was a group of individuals who were outside walking by. And just sitting down and they were drug users. And the comment that came from this couple were “Look at those individuals outside. They were just right outside the restaurant. You can tell they're drug users. Look at them. Why don't these addicts just walk past the restaurant?” And there was another couple who were in the restaurant, who were visiting the establishment often who said and turned to them and said, “We don't do that here. We don't talk about our community members in that way.” And it was the restaurant owner who came out and embraced these individuals and asked these individuals, “Are you guys alright? Would you guys like some water or a sandwich or something like that?” These are many ways in which organizations and communities can work towards not just ending the stigma, but embracing harm reduction. It’s also important to know that when it comes to harm reduction, a lot of people just don't understand and people find it hard to sort of embrace harm reduction for what it is. And that is embracing harm reduction with a true and absolute nonjudgmental approach. When we say nonjudgmental, it goes to the core of what we do as harm reductionists. It doesn't matter what you use. Or how you use it. We want to make sure you're alright. In many communities, and in many organizations, that should be resonated over and over and over again. We look at you as a life, a human being and want to make sure you stay alive. Until one day when you decide to make the healthy choice or choose something different.

**Moderator:** And I think to do that, right, one has to sort of set their own agenda aside. That's big part of what you're talking about. I might want you to stop using tomorrow, but I need to put that aside and say what do you need right now? Water? Or painkillers to deal with your broken arm that you referenced.

**Robert:** Exactly. When we start to understand it's not us to who wants, who wants to do better for that individual or who wants better for this individual, but giving that individual an opportunity to better for themselves. By asking them, what is it that you need? Whether that's housing. Whether that's medical attention. Whether that’s just an ear, someone to talk to. Begins that process of accepting an individual for who they are. A human being.

**Moderator:** Excellent. Thank you. Now, an example of a program that's embedded in the community is Chatham cares 4 U, led by police chief, Peter Volkmann. It's impact is currently being evaluated by Dr. Tomoko Udo, at the University of Albany’s school of public health. Let’s take a look.
Peter Volkmann, Police Chief: once we start judging certain parts of our community and decide not to help, we are going down a slippery slope. Who is anybody to come in and say you're not worthy. Everyone's path to begin their recovery we found from Chatham Cares 4 U, is different, but we have found is people are voluntary coming in, asking the police for help. How could we say no?

Peter Volkmann: Chatham is a little village of about one and a half square miles. A couple thousand residents. Just one of those quaint little villages in New York State that are just a nice walk. I've been in law enforcement for over 33 years. Retired from down in Westchester County. Moved up here. Was asked to become the chief of police about four years ago and during that time is when there was a huge spike in deaths from opioids. It was about two and a half years ago when we started having community forums. I realized that the war on drugs wasn't working. At about that time, I received an e-mail about this little police department in Gloucester, Massachusetts that took a different approach. Of putting it out that if anyone is looking for treatment, we'll help you get treatment. They're not in trouble with the law, they're just people walking in, saying I immediate help, I’m ready for treatment, and I’m ready for recovery. I was like, who would come in and say I'm a heroin addict to police. Who would ever admit that to the police, it's totally illogical. It shouldn't work. Announced to the community in 30 days I was going to start the PARRI program, based out of Gloucester, Massachusetts. And anyone can walk in and well help you find a treatment. For 30 year, we've been trying this war on drugs to stop the supply. And insanity is doing something for 30 years and expecting a different outcome. If we can't stop the supply completely, why don't we try to lower the demand? I realized I had no information. I think this is going really well, but I can't prove anything. That's when I had someone from U Albany School of Public Health who had me contact Dr. Udo.

Dr. Tomoko Udo: I have three related projects going on. One is with the police Department. I am helping them evaluate and implement their police divergent program. Compared to the state statistics, they're getting more young adults also more female compared to the state average so we're trying to understand why and that's another thing I’d like to look into. They had over 200 participants who got referred to the treatment program. And again, around 70% of people were referred to the treatment program, within 24 hours. That statistic is really amazing because a lot of people have to wait for several weeks on average.

Peter Volkmann: What makes us work is that we get when somebody from point A to point B. When somebody is ready for recovery, we know that window of opportunity is time limited. So the important thing as soon as they come in, say I’m ready for recovery, whatever reason that caused this, they're ready, we have to get them into treatment.

Dr. Tomoko Udo: We're trying to interview people afterwards and ask the questions, “Why did you go in?” and also, “How you're doing?” “Do you recommend the program?” And most of the time, if we are able to reach people and feedback is very, very positive. And they're likely to report they're not using.

Peter Volkmann: I think if we start looking at this as a public health crisis, that every police station, every fire house, every library, every school, every government building is a safe place to come to say I need help. We're going to start making a dent in it.

Moderator: So we just saw a very exciting example of a program that's meeting people where they are. Did you have something you wanted to share about your perspective on the law enforcement role?

Allen: I think law enforcement sort of critical actors in this. A very long time ago, I ran a syringe exchange program and I used to know everyone who used drugs on the lower east side in New York City. And we were not fond of the police in particular, but then I realized over a period of time that all the other folks who knew those who used drugs on the lower east side, were the police. They're social
actors in this. If we're going to move the dial on drug user, the people who use drugs, if we're going to change our approach to drugs in the country, you cannot discount law enforcement. We need to work and accept that they are part of this conversation. We just recently did a study where we interviewed, this is the New York State Department of Health, and we interviewed law enforcement who had administered Naloxone to people who were overdosing more than once and in New York State. Outside of the city, law enforcement are very often the first people on the scene, and they are the first responders. So they come across people who are overdosing quite regularly. It broke down into two different camps in terms of who were responsive to the person who had overdosed. Those who were the most compassionate, those people that law enforcement officers went to the emergency room afterwards, or followed up, had experienced drug use in their own family. And those that were a little harder let's say, had not had that same experience, so you can see the way stigma impacts the way people are treated. So if you recognize that your family member has difficulties with drug use and you see your brother or son or cousin or your son and bring them back to life, you feel more empathy for that person. So that's the impact, that you can undo stigma. It’s unfortunate that people have to experience problematic drug use to get that experience. But that’s what we do when we undo stigma, we end up with a more compassionate and empathetic response.

**Moderator:** And I would almost say, and certainly correct me if I’m wrong. Maybe we don’t need people to have their own direct experience with drugs but maybe if we continue to have conversations like this where we talk about the very real impact of drugs, and the human experience of drug use. That can help promote that compassionate response as well.

**Allen:** Absolutely, I think we talked about harm reduction. To me, it's a little bit like you have a darkroom and you turn on the lights once you turn that light on, you see things a little bit more clearly. Everything we know about drugs, turning on its head. Think about it from the other side, in reverse. Think about ourselves us, being the problem and not the problematic person in front of you. If we begin to think upside down the suddenly the solutions seem more apparent.

**Moderator:** I like your perspective.

**Robert:** That's huge. I often, I guess to piggy back on what Allen is saying. I often have people talk about how do you continue to give syringes to individuals who use drugs and doesn't that perpetuate their drug use. It's an absolute myth. It does not. I can't help but remember quickly as a child, my mother was an intravenous drug user. And as a child, I remember seeing my mother sitting on the couch with a syringe in her arm. I remember then growing up. And like people use drugs, as I got older and older and yeah, I fell into drug use myself and I began to understand what it is to be on that side. And then people who were those harm reductionists, who began to show that concern for me through harm reduction. Helping me understand who I am as a human being. They sort of helped me wrap my head around my own issues with stigma around people who use drugs. It's something that’s going to take a lot of work from within our own communities and outside our own communities.

**Moderator:** I think it is going to take a will work, but I think you're contributing to this conversation is a big part of the work this morning so thank you.

**Allen:** We should be clear that being compassionate and helping people who have issues with their drug use and having a harm reduction approach isn't enabling them to keep using and being self-destructive. It is helping people move away from the self-destructive nature they might be involved in.

**Moderator:** I understand what you’re saying, sure. To break that myth that compassion is enabling. And how can we, if we treat people with compassion, we treat people as humans, we are helping that person live another day to live to a point where maybe if everyone's not treating them in a
discriminatory fashion, they don't inflict that discrimination feeling upon themselves and perpetuate a self-harming behavior. So I think continuing that train of thought, we've talked about the ways that people who use drugs experience discrimination and often experience trauma in their lives. So can you talk to us about trauma informed care. That’s something we hear a lot about in public health and how that feeds into this?

**Allen:** Yea there is a strong correlation in between early childhood trauma and then people moving into problematic drug use. And even if you don’t have that early childhood trauma and you do develop a negative relationship to your drugs, and you get strung out on opioids, there's a former trauma there that you’ve taken on. When someone with problematic drug use shows up within the health care system, you have to assume that person has experienced levels of trauma and we take that into account. And trauma informed care is about building a system around a person that is nurturing and supportive of that person. So you approach it as a collaboration between yourself and that person. You build that trust that level of, that person understands that you want to be there with them, that you’re listening to them. So you create that environment of safety. Because a traumatized person needs that feeling of safety so they can disclose whatever they need to disclose and they won't be judge and it won’t be held against them. That leads them to a position of empowerment. Where they feel that the choices that they are being offered are the choices that they can engage in and accept. And they don’t have to be big choices, either. They can be small choices. The small successes are really important in building bridges to the big change. That’s why it’s important when someone comes in and they have a minor complaint that they want to address and you think they have a major problem with something, they want that minor complaint addressed. You address it and build that relationship with them. So they come back.

**Moderator:** Yes, that absolutely makes sense to me. One of the things we’ve talked about throughout the show is language. I think language can really attribute to stigma or lack thereof. So when we think about language and addressing stigma by and among people who use drugs, can you talk about some of the importance there?

**Allen:** Yeah, undoing stigma is about undoing the way we address someone and the way we think about them. When you think of someone as a junkie or crack head or tweaker, it’s a derogatory term. You've already got a picture of them and their life. You minimize their lives, you minimize their being. So, if we begin to think about people who have substance use disorders, move away from the dichotomous language of clean and dirty, to negative or positive. To throw something in here about drug screening. Drug screening only tells you what someone has in their system. It doesn't tell you what the impact of those drugs or the chemicals they have in their system has been in their lives, yet we make so many decisions based around the THC in someone's system and we punish people for what they have in their system rather than use it as an engagement tool to understand what's going on and when someone feels they're going to be judged and punished, you're not going to get the truth necessarily. The idea of newborns and opioids and the amount of mothers who have delivered babies who have been exposed to opioids, those babies are not addicted. They've been exposed to opioids, but they're not addicted babies. They didn't make that choice. They can't be addicted. We have to think carefully about the language we use and the impact it has on the other end. And you know, very often, what our information we get about people who use drugs comes from media. So we need to hold our media accountable, too. In terms of how they use language because the media is very good at what they want to create. They want to create a division between us all in some ways.

**Moderator:** *laughs* That might be a topic for another show!

**Allen:** Might be. Might be.
Moderator: But I think to your point about shifting language, Robert I wonder if you can share with us an example of how shifting to a person centered language can change a dynamic.

Robert: Yeah, so I think I touched on this a little while ago. Making sure that individuals understand that you are talking to them as a human being, and not as an addict or even not as a person who uses drugs, but someone who has concern for your health, right? For your treatment. For whatever it is that is ailing you. How can I help you? What do you need to get through this day? Are you hungry? Do you have housing? A place to stay? These are questions, this is a language that people who use drugs understand when engaging with them. Talking down to an individual trying to tell them what’s wrong with them and what they need is not going to get very far with an individual who is impacted by these issues. So making sure that we understand how we have this meaningful engagement with people. Take this conversation a long way when it comes to engagement and bringing people in, to what I like to think as this marginalized community. We want to also make sure that also, just to go back again people who use drugs are some of the brightest people on the planet. Right. And they can tell you everything that's wrong with them if you are willing to listen and understand what they're saying. Just because they say I need an opioid painkiller doesn't mean, they're not saying that I want to continue to use drugs. They are essentially telling you that they are hurting in some way and that they need help in treatment someway. Hearing that, rather than hearing that sort of we use drugs. Hearing that you are dealing with an individual who is in pain, it tells that individual that this person is listening to me. And being able to identify that issue means a lot to people. As someone who has been impacted by these issues. I’ve had a lot of people talk to me in a lot of different ways. Some of those way had negative consequences. Other ways, they have helped me to get to where I am today. As an individual who's crossed the Atlantic ocean 18 times in less than two and a half years from a person who was at one point under bridges and under highways, living homeless. And with no hope. And that came from the negative impact from the way individuals perceived me and how they talked to me about who I am as a user. Until I found, until harm reduction found me and brought me from under the bridges, from under those highways and gave me an opportunity to come into what is known as a life without judgment. I'm sitting here today because of that very language.

Moderator: And how glad are we that you are here having this discussion with us, so that's a great story to illustrate everything we've been talking about this morning. Thank you. Allen, let's talk about the Office of Drug User Health and what are they doing to address stigma. Are there programs that are geared towards individual levels, organizational levels, community levels that you'd like to share with your audience?

Allen: Yeah, I mean I think that when we talk about social services, we talk about medical system, we talk about healing. When we challenge stigma, we're talking about healing. That's ultimately what it's about. We're healing people's wounds, we're healing people’s trauma, and we're helping people manage. So the Office of Drug User Health, we operate mostly on an organizational level in terms of what we want to promote. So a lot of training and education, whether it's Naloxone or whether its teaching people how to prescribe Buprenorphine in a way that actually works for people who have opioid use disorder because that's what a critical tool in addressing opioid use. Helping people work through what it is that they offer someone when they come into the organizational health care setting. We can support them around an assessment and working through how they can change that. And encouraging people to hire people who have histories of being in the community and being people who have used drugs. Whether they're current or have a history of drug use and they can bring that knowledge to the table because you know, unless you've sort of have that input you're doing the work from a place of not complete knowledge. So if you address the organizational culture, if you address your organizational approach, you can begin to weed out, or address the individual approach of the nonclinical staff and how they address people, we can talk about working with people around their disclosures and how they talked about their own personal history. But you can also do that by talking about staff and patients as well, the
participants in the programs. And we would also encourage, if you are a program, that you get input. We get input from other patients or other participants in our programs. We should consciously go out and attract people who have a history of drug use to have input into the way services are delivered. To hone the language and destigmatize the environment. Promoting when you do events, if you're not working with people who are affected by what we’re addressing, then they're absent. I mentioned turning on the light in the darkroom. If you do that and you see a situation where the community not actually represented, but you're talking for a community that you're not part of, that's very noticeable once you begin to think in that way. The Office of Drug User Heath, which is a new office in the state health department, it's been around for about three years now, bringing together all of our drug user health programming. You know, that's what we're about. We don't do our work just around interventions, it's about addressing stigma and we want to move the world and move the dial in a positive way.

Moderator: Excellent. So, let me ask you both what is one lesson that you want viewers to take away from today's discussion about stigma, around people who use drugs?

Allen: So one lesson, it's I don't know if it's one lesson. You can undo stigma. First of all, we should not be stigmatizing anyone. We should be thinking about how we can support that person if they're doing something negative, how can we make that into a positive. But stigma is something we can challenge. We can address stigma. We can make the lives of people who use drugs better if we are approach it differently.

Robert: Yeah. Once again, language plays an important role. Embracing individuals through what is known as a true nonjudgmental approach in harm reduction, in my opinion, is going to win the day. Going back to police officers who are in many ways, the front line, or first point of contact. After an overdose or even during an overdose, officers who are those long-term, hard narcotics officers are the individuals who truly understand what it means when it says this war on drugs, these criminalization of individuals, does not work. Individuals like those who are literally going be to be taking, or should be taking the lead in filtering down through the rank and file that we need to be taking a different approach when it comes to people who use drugs. When it comes to these failed policies on the drug use. And making sure that it's understood that we have to start talking differently. Thinking differently. And behaving differently around people and with people who use drugs. These are as I said and will continue to say, human beings. Our jails are overcrowded because of these failed policies. We are 5% of the world, with 25% of the world's people in jail, right here in the United States. I have the privilege of traveling all over the world and when people ask me, “So Robert, where you from?” and I say I'm from the United States. They say, “Oh. I'm sorry, your public health approach, what's happening?” I can say we're working desperately towards moving forward with ending the stigma that we have. And implementing more public health policies that go towards helping individuals who use drugs. And I see the dial slowly moving. I call it the slow tick-tock of politics that keeps us from getting to where we need to be. But I look forward to our public health professionals helping move that dial even further.

Moderator: Absolutely and I think everything that you've contributed this morning will also help to move that dial. I know we have additional resources in our slides handouts that folks can use to find more information. I want to thank you both so much. It’s been a really wonderful dialogue this morning and I think we shared quite a bit of important and perspective shifting information with our viewers. And I also want to thank you very much for joining us today. Please remember to fill out your evaluations online. Your feedback is always helpful to the development of our programs and continuing education credits are available for a limited time. To obtain CNE, CME, or CHES continuing education hours, learners must visit www.phlive.org and complete an evaluation and posttest for today’s offering. This will be available on demand on our website within two weeks of today's show. Our next webcast on December 20th focuses on breast density and cancer risk. Information on Public Health Live and relevant public health topics can also be found on our CPHCE Facebook page and Twitter feed. Don't forget to
like us on Facebook to stay up to date. You can also let us know how you use Public Health Live by taking a brief survey at phlive.org. I’m Rachel Breidster, thanks for joining us on public health live.