

## OTP Session 10 Transcript

### **Julie:**

Thank you so much for joining. I know it's like a bit of back to back sessions today. So we really appreciate you taking the time to join our session. We'll just give it, just a moment. Give some folks some time to transition from one session to the other, and then we'll get started. But feel free to introduce yourself. And where you're joining us from in the chat.

Hi, Doctor Katie.

Hello, everyone. So we will get started. Um, hello, everyone. My name is Julie Attys and I am the project manager for the Opioid Treatment Program Training and Technical Assistance Center project. And happy to be supporting the facilitation of this session today.

So, to get started, I'm pleased to introduce a couple of our presenters today. Kyle Harrington and Pedro Alvarez. Kyle, is the harm reduction training and drug checking manager at Tapestry Health, where they lead staff development, community education and drug checking initiatives across western Massachusetts. Kyle has over a decade of experience practicing harm reduction in both formal and informal capacities, and is passionate about building community centered programs that reflect harm reduction as a philosophy of care rooted in dignity, mutuality, and collective survival. They are also an abortion doula and train others to provide compassionate and community based abortion support. Kyle is currently pursuing a master of Public Health and Community Health Education at the University of Massachusetts Amherst, and we also have Pedro Alvarez, who is the director of operations for harm reduction services at Tapestry Health. Pedro holds a bachelor's in sociology from Boston University and is passionate about community education and awareness surrounding the topics of harm reduction and the intersection of health care and innovation. Pedro serves as the Board President for the Consortium, which works to create conditions in which people with lived experience can fully participate in decision making processes related to the needs of themselves and their community. Pedro is a member of the Department of Public Health, Latinx advisory group, the Harm Reduction Advisory Council, the Attorney General's Substance Use Advisory Council, as well as a member of the Brandeis University Drug Checking Advisory Group.

So, the objectives for our session today is to explain how harm reduction is related to person centered care. Name at least one example of harm reduction of a harm

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reduction approach that can be employed in OTPs. And then lastly, name at least one organization with a harm reduction mission that can partner with OTPs. And with that, I'll hand it over to Pedro.

**Pedro:**

Okay. Thank you. Thank you. Julie. All right. So, like Julie mentioned, my name is Pedro Alvarez. I work at Tapestry Health as the Director of Operations for harm reduction services. In that role, I oversee our harm reduction programming here in western Massachusetts. We cover three counties. We have six brick and mortar sites throughout these three counties. We're in Franklin County, Hampshire County, Hampden County. We have brick and mortar sites in Greenfield, Northampton, Holyoke, Chicopee, Springfield and Westfield. But we also venture into seven different communities on a mobile basis where we provide harm reduction services. Um, whether delivery services, tabling events, outreach efforts, where we're allowed to go into these communities and provide these harm reduction services as well.

So today we're going to be talking about, you know, exploring how harm reduction principles can be more effectively integrated into methadone clinics to better support patient centered care. Again, it's a vision. The vision here is a world in which health and wellness is a human right, accessible to all and free from social and structural inequities. The mission is to provide vital, effective and inclusive community health services and resources for optimal well-being and vibrant communities.

Before I go, we're going to pose some questions throughout the slides in the presentation. We're going to run through the slides, Kyle and I will kind of be going back and forth, but also we'll have some time at the end for Q&A. So when we pose these questions throughout the presentation, just way to the end. We're going to have a little conversation after the slides are done. All right.

So tapestry harm reduction I kind of went over this already. But these are some of the services that we offer as far as syringe service access and disposal, overdose education, Naloxone, which is known as Narcan as well, access and education as well, safer use education and supplies, alcohol swabs, cookers, cottons, etc.. Drug checking services. We do have FTIR machines in three of our brick and mortar sites. We currently have these services in our Holyoke, Northampton and Greenfield locations where individuals can bring in, drug trash, drug residue, small samples to get tested. And that way they know what they're actually consuming or what they're purchasing out in communities where they're at.

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We also offer wound care and wound care supplies. We have a wound care nurse that frequents out of our brick and mortar sites. They also jump on the mobile unit that we have, and travel around different communities providing wound care services. We offer safe sex supplies. We offer STI testing, counseling and treatment referrals. Hepatitis C testing and treatment referrals as well. Referrals to detox medication assisted treatment and other programs. Referrals to medical care and community education. Training and technical assistance. Again, we provide this at all of our sites, but we also provide this as an in-service as well. One great thing that we do is work with OTPs in our area where we come in and provide some of these services, whether if it's Narcan education, screening and testing for STIs, or even trying to connect with some of the patients that you guys are seeing at your locations as well.

Okay. Great. So, so just some principles of harm reduction. If you guys aren't familiar with harm reduction, just two like guiding principles on that: one, except for better or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condone them. It understands drug use as a complex, multifaceted phenomenon that encompasses a continuum of behaviors from severe use to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.

Again, it's a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use without requiring abstinence. You know, here at tapestry, we use the term harm reduction for people that are using drugs or illicit substances. The harm reduction is not a new phenomenon. It's been practiced for quite some time. Other forms of harm reduction are, you know, you get in your car and you throw your seatbelt on. People that are smoking cigarettes and want to try to cut down, get into the patch or using the gum. Those are forms of harm reduction. Practicing safe sex. Another form of harm reduction that you guys all might have heard before. But again, here at tapestry, we incorporate it into illicit drug use. So another third principle is it establishes quality of individual and community life and well-being, not necessarily cessation of all drug use as the criteria for successful intervention and policies. Many OTP participants engage in non-prescribed substance use. So if you guys are aware, many of the clients that you see or some of the clients that you see might continue some of their use as well, even though they might be on methadone, they might be using other substances. So again, it's an opportunity for us to engage with them as well and provide some education and provide some harm reduction services, for those individuals as well.

Success includes more than abstinence. Um, it's, stabilizing their use, reducing their use and engagement in safer use practices. Again, that's what we try to embody here.

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We're not ones to make decisions for anybody else. I think the individuals have the right to make their own decisions on that. What we try to do is empower them to make safer practices through this education as well. I think Kyle is going to take over now.

**Kyle:**

Yeah. Thanks, Pedro. Yeah. So, here at tapestry and in the wider harm reduction community, you think about drug use as a spectrum. I think many of us have been taught more traditional frameworks of thinking about drug use as a binary of either abstinence or, quote unquote, substance use disorder or addiction or dependence. And harm reduction asks us to get a little bit more, honest and complicated about what drug use really can look like. And so we think about it along a spectrum of abstinence, experimentation, occasional use, social, recreational use, heavier use, maybe dependence and then more chaotic use. And this is not a prescriptive or diagnostic tool by any means. But rather it's meant to offer language, understanding, a framework for people to explore and express their relationship with drugs. Um, one thing to note, too, is that people move fluidly between different points on the spectrum at different moments of their life, different times in their experience with their health and their bodies, as well as substance type. Sometimes folks have a more chaotic relationship with one drug and are able to manage a less chaotic relationship with a different drug. I think often about caffeine as a good example of this. A lot of times, folks will stop using drugs like coke or heroin or drugs that might be more stigmatized, but continue to use caffeine, which is also a drug. Right. So we we all have different relationships with different substances. And this framework allows us to, to get a bit more honest about that. And then the last thing that I'll note is that there's risks that exist along every point in the spectrum, including, at the experimentation, um, point as well. And so with those risks, also, harm reduction is the opportunity to reduce harm, to maximize health and pleasure. And so we'll post two scenarios, for you all to start to sit with and think about as we continue through the slides. And then, as Pedro mentioned, we can circle back to them at the end of the, the session. The scenario is someone who smokes methamphetamine daily and has stable housing and employment. Some of the questions that we might think about are, where you would place this person on the spectrum of drug use. How different factors, like the unregulated, unpredictable drug supply or over amping risk may influence your your placement of them. And how might this person define their own location on the spectrum?

And then our second scenario is someone who used to inject fentanyl or dope daily and has recently transitioned to smoking instead of injecting. Same questions. Right? Where would you place this person on the spectrum? How do different factors, uh, influence

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your placement thinking about both the drug itself as well as the route of administration. And then how might this person define their location on the spectrum?

Um, and so the the fourth principle of harm reduction that we will introduce is right, is that harm reduction calls for non-judgmental, non-coercive provision of services and resources to people who use drugs in the communities in which they live in order to assist them in reducing, um, harm that they might experience from using drugs. Which really I think aligns with person center services, particularly in the non-judgmental and non-coercive provision of services. We know from research that people are more inclined to engage with services when, um, when there isn't a sense of coercion or a sense of force and that those services are more likely to positively impact the person's health if it comes from within their own desire, motivation and readiness to do so. And harm reduction really follows that, that same line of thinking.

**Pedro:**

So the cycle of stigma. Stigma again, it's negative beliefs about and attitudes toward people who use drugs. And, you know, even us here at tapestry, we're guilty of that as well. Even individuals that walk in, you know, we're human. We judge. But it's understanding the individual. And trying to understand where they're coming from, providing empathy as well when they walk in through our doors. Stigmatizing culture. It's people who use drugs, and the people around them believe that they are not deserving of being treated with dignity and respect. Um, and that creates barriers to support. People who use drugs avoid seeking resources and support out of fear of judgment and other consequences. Again, it creates a cycle of that, and then it kind of repeats itself. That stigma, the stigmatizing culture and the barriers to support that we see day in and day out in some of the places where we either work or we collaborate with as well. I believe this is a video, a quick little video. Let's see if we can get it to play.

**Video:**

It's hard. It's hard to think of like exactly what, like, you know, people have said. We don't want you or your kind, um, bringing down the neighborhood. And I don't come to a doctor's office or to a hospital. I'm not walking into a courthouse. I'm coming there for help. Not because I'm in trouble. My mental health was just not, uh, not controllable and such that, like, even like my own father just, like, wanted to separate himself for me. You know what I mean? And leave me to languish. So many times I said, well, I could just go self-medicate, but I'm here to try and get a proper medical treatment and pain and treatment for my pain properly. And instead I could walk out the door. But then I put

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myself at risk because I'm using, uh, what's supposed to be heroin isn't heroin anymore. It's fentanyl and this stuff's killing people on the street now. And when you leave somebody so vulnerable and so frustrated, instantly, those addictions come back because they're the only ones that comfort you. It's hard for me to say this. I feel like bawling because it's just ridiculous. This. I, I can't take that kind of treatment. I'm a human being, and I think I deserve a little bit of respect.

I'm not homeless anymore. I'm not on drugs. And it's been like a solid year of, almost solid year anyways, of being really stable. There's all sorts of changes that have occurred because of, uh, living here.

**Pedro:**

Alright, like I said, the video is very brief. But it just highlights the stigma that goes along with individuals that are using substances, um, trying to seek out services and trying to seek out assistance with their use. And some of the reasons why they don't seek out certain services or seek out treatment because of some of the treatment that they've gotten and the stigmatizing attitude around that as well. And, like I said, this creates a cycle of stigma in OTP engagement. Um, you kind of highlighted, the video highlighted, what individuals experience. But there's also a quote: "What I consider my recovery is that I would never let anybody put me down". So again, we hear things like this at our at OTP programs as well, where individuals are coming in, especially trying to connect them to services.

Whether they had a bad experience. We have individuals that come here seeking out medical treatment because they've been to EDs, they've been to hospitals, um, because of their use. They were mistreated because they're chronically homeless. They're, um, treated a certain way. Looked at a certain way. And that's an uncomfortable feeling for individuals. And again, it creates the cycle of stigma where they're treated this way, they feel that way, and they don't seek out these services as well.

We have other factors with that as well, as far as external stigma, um, provider attitudes, policies and internalized stigma, which is the shame and the isolation that leads to disengagement and worsened health outcomes. Studies show strict OTP policies, abstinence only rules, increase dropout rates and reduce MOUD retention. And harm reduction strategies like syringe access and naloxone distribution increase engagement in OTP settings.

I love the Wonder Woman image here. Kind of holding syringes. It's just the revolution is coming. And the poster states that revolution is coming, but it's just empowering

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individuals as well. And I think that's the message behind that as well. And harm reduction is a movement for social, for social justice built on a belief in and respect for the rights of people who use drugs. And there's been a big movement around that as well. Not only locally, but, nationally as well. There's drug users unions. And again, it's that empowerment piece, you know, empowering people to make these safer practices and making these decisions on their own as well. Kyle, you want to.

**Kyle:**

Yeah. Sure. Good. I think one of the things, um, that I am grateful for in terms of harm reduction, is that it provides community and, the, the framework allows for people to stay in community even when they're using drugs. And that, we know that isolation is not where, where we heal or we, uh, get better, get well, stay well. And harm reduction really provides that community. Um, and in addition to the movement, it also provides a really practical set of strategies, um, aimed to reduce the negative health, legal and social consequences that result from, uh, experiences of using drugs, of having sex, of being, uh, in the sex trade. Even self injuries of harm. I'm noticing that more, uh, providers who work with people around disordered eating are talking about harm reduction as well. So this framework is really applicable to, to a variety of contexts.

But it particularly emerges out of this space of working, uh, with folks, um, who use drugs and, or are maybe in the sex trade. And provides practical strategies that folks can use to reduce the, the everyday harm of those practices. Um, and there's a few ways that we might be able to think about applying harm reduction in OTP settings and that I've seen, applied in OTP settings successfully.

Person-centered care, uh, supporting goal setting led by participants, and not dictated by providers. Really digging into that motivational interviewing space. And practice of, um, drawing out insight and goals from, uh, the person. Um, and motivating from that space. Making harm reduction supplies accessible and visible. I'm always, uh, much more comfortable in a space when I walk in and see naloxone visibly present. That makes me know that a provider at least cares enough, um, to, to be visible in their practice of harm reduction and to, to make it known that, um, they believe that people deserve to survive overdoses. Right? Syringe access, fentanyl test strips as well, having these supplies available to patients, participants of OTPs, can be really, uh, meaningful and symbolic.

Having flexible MAT models. Low barrier as possible. Integrating microdosing regimens. These things, uh, we know from research increase engagement. If we can wade into the

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waters, uh, the waters seem less scary. It doesn't have to be a cannonball dive into abstinence or into MAT, but maybe, it's more of a wading in.

And then not being punitive. And providing non-punitive poly-substance use counseling. Instead of discharging folks when, uh, when they use in a non-prescribed way. And can we actually weave people more into the fold of care, uh, rather than isolating people. Um, and think more about poly-substance use as increased risk and, and so when people are more, more at risk, more vulnerable. We don't want to isolate people, but rather we want to sit with them for a bit longer and think a bit more about, uh, providing that drug education and providing, uh, safer use counseling, connecting folks with resources. Hey, have you heard about your local syringe access program? What other resources might be useful to you? How are we practicing reducing our harm if we're going to be using in this way?

**Pedro:**

So, OTPs and syringe access, there's different ways we can collaborate. I think, harm reduction in full OTP settings can work in various ways. It bridges. It can be the bridge between community and clinic. You know, harm reduction serves as a bridge by providing wraparound services that address, uh, social determinants of health, whether it's housing, legal support or, uh, food insecurities, and what not. It also supports retention in care. Um, programs have successfully retained patients who might otherwise be lost to follow up. We offer wraparound services. Including basic needs like food and shelter and integral to recovery stability. It's about connecting people to the resources as well, and literally meeting people where they're at with that as well.

And then empowerment through peer support, you know, can provide non-judgmental, real-world guidance to patients fostering long term engagement. And this is what we see when we, you know, with that collaboration with local syringe programs, we provide, uh, prevents HIV, hepatitis C and other infections. Alternatives to injection equipment. We offer smoking supplies, sniffing supplies, conversations around that as well.

And minimizing the harm that comes along with that as well through this education. And repairs trust with health care. Like I said, we're a bridge to a lot of that for individuals, you know? And just building that relationship with individuals, a lot of the work that goes into the harm reduction programming is that relationship building with individuals and building that trust level with folks. And it's easy to make these referrals and these soft handoffs to individuals as well. Evidence around that is 58% reduction in HIV risk for people who, who inject drugs using syringe service programs. Our greatest impact

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when combined with medication assisted treatment, up to a 50% HIV risk reduction when MAT is provided as well.

Okay. Overdose education and Naloxone distribution. This is one of the key things that we do here as well. Community naloxone distribution - I don't know why it did that. Okay. Turning it off. - community Naloxone distribution reduces mortality in groups at high overdose risk. OTPs can expand Naloxone access beyond patients to social networks experiencing increased risk. There's onsite distribution through harm reduction, community health, education, standing orders, co-prescribing.

So again, part of the the collaboration that we have with small OTPs in our area is coming in providing naloxone education, whether if it's on a one on one basis, or we set up a table and when people are coming in for dosage, we're trying to connect with them there or, you know, most, most of the time they're holding groups and they're asking us to come in and present on Naloxone education. Give, give everybody a training, but also leave Narcan, naloxone behind as well. So there's opportunities for that.

**Kyle:**

Yeah. And then these are just some, additional harm reduction strategies that, uh, are sort of standard in terms of thinking about, uh, what's possible for folks to be weaving into their practice or their rituals of use. If they're continuing to use whether they're, uh, also a patient of an OTP or not.

Avoiding using alone. Taking turns when using. We know that, uh, using alone is one of the greatest predictors of someone experiencing a fatal overdose. And so again, this piece around harm reduction, bringing, bringing folks into community and, uh, and preventing that isolation, quite literally saves lives. And so, teaching folks that you're working with, to, uh, or checking in with them about, uh, if they're using alone, um, if they're familiar with never use alone hotlines like safe spot, which is one of the resources here in Massachusetts, uh, that folks can call when they're using alone and have a peer support them. These are things that, uh, prevent people from, uh, experiencing, uh, real harm. Right. And so if we're able to offer those things. Um, routine STI testing. Sometimes people will come into our syringe access programs for STI testing, um, and will leave with supplies that they didn't know that they could access. Or, uh, just another provider that they trust.

Right. And so being that trusted touchpoint, uh, with health care, can be, uh, really meaningful and can do some of their reparative work, uh, around the, the stigmatizing harm that's been caused within the healthcare space. Having naloxone easily available, knowing how to use it, having it being visible and out, being out and loud and proud

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about carrying it. Drug checking when possible, having things like fentanyl test strips available, or referring folks to drug checking services like the ones we offer at Tapestry. The substance use law that passed in Massachusetts in December of last year, uh, has made drug checking, uh, legal. And so folks are able to have fentanyl test strips on them or access drug checking services with protections.

And so these things are meant to, at a statewide level, increase access to, uh, not only drug checking services, but harm reduction as well and be another touch point.

Teaching folks to start with a lower dose and use slowly. And the unregulated drug supply is so unpredictable. And so, if people are able to start low and use slowly, they might have a better gauge of how potent the substance that they're going to use is. Um, and doing some education with people around, uh, that poly substance use piece.

Right. If, someone is a patient at an OTP, uh, clinic and is taking MAT as prescribed and also using other sedatives on top of that, uh, or using stimulants on top of that, um, what does that mix look like? What is the effect and the person's body? What potential risks and harms can come from that? So starting with a lower dose, um, might support the person in that way. Always having new sterile supplies available. And that is both an individual and community level safety, uh, intervention. We reduce HIV rates, we reduce, um, wound rates when we use new supplies every time. Keeping an eye out for skin issues and wounds. Knowing that your local syringe access program might have a wound care, uh, specialist like we do, and referring folks there. One of the things with wounds is that, um, they're very personal for folks, and can be a very intimate thing to share. And so being a provider, uh, who is safe to show wounds to is, uh such an honor. And also, again, another touchpoint with healthcare that a lot of people don't have. So knowing your local wound care providers, knowing how to refer folks and how to be that safe person, um, is, can be really profound. And then practicing safer sex, sharing safer sex supplies, having a bowl of condoms out in your office and available, again, signals or, um, sends the message to folks in that space that you are a safe person to have those conversations with, to access those supplies through. Um, and that alone is, is harm reduction itself.

**Pedro:**

Thank you. Kyle. So this map here highlights, um, syringe access programs throughout Massachusetts. So the red are brick and mortar sites. The blue little mobile, um, those are mobile units, again, here in Massachusetts. For a syringe service program to operate in a community, they need local approval from the local board of health. So that's what you see here.

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Individuals, you know, so getting access from a local approval. Again, talking to the Board of Health, um, having conversations there. Most communities might not have a brick and mortar site. Some communities are super small that don't need a brick and mortar site. Providing a mobile unit would suffice to be in there in that community, um, and provide services that way.

And here, like I said, in western Massachusetts, we're located in three counties all the way up from, um, Franklin County down to Hampden County, um, covering Greenfield, Northampton, Holyoke, Chicopee and Springfield. In the Berkshires, you have Berkshire Health, um, out in Pittsfield, in North Adams, that provides services out that way. I had some numbers and can't really find one.

I apologize for that. But right now there's about 60, um, syringe service programs, and I believe there's about 56 OTPs in Massachusetts. That just kind of explains some of the work and the opportunities for collaboration, statewide. So again, I encourage any of you that don't have a connection or, um, started any collaboration with a syringe service program in your area, please reach out. Again, you can look up different locations at the mass.gov website. This is where I pulled this map. But definitely reach out, try to connect, try to get in some services, some in-service or trying to connect your, your folks that you're seeing to a syringe service program. Even if they're not using, just to have conversations on harm reduction testing, and obtaining naloxone as well.

All right. So that was our presentation. Again, you have our website here. Our email addresses. Um, if any questions or concerns you want to reach out afterwards, if we haven't, if you're in the area and you haven't connected with one of us yet, please feel free to reach out. We're pretty good at getting back to people right away. And, you know, sending staff over to provide either in-service or even having a conversation of how we can collaborate moving forward. Thank you.

**Julie:**

Great. Thank you so much, Kyle and Pedro. We will transition to our Q&A. Feel free to unmute yourself. Raise your hand, put questions in the chat. We have about 20 minutes for Q&A, so yeah, feel free to ask questions or if you had any thoughts about some of the questions that were posed in the presentation.

**Unknown:**

Oh, so the last time I was at a harm reduction presentation or a drug testing presentation, I was informed that although xylazine test strips exist they are not really,

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like up to snuff and so they can have, I can't remember if it was false positives or false negatives and so they're not really being distributed now or encouraged because they're not accurate. Is it. Is that still the case?

**Kyle:**

That's a great question. Yeah. So the xylazine test strips have have certainly gotten more accurate, uh, over the past year or so. There's been a couple of validation studies that we've been involved in and that other communities have been involved in. So I would say that they are more accurate right now. But we're not quite at the point of, uh, feeling comfortable enough to distribute them. Although other, uh, harm reduction organizations across the country are in some ways. We do use xylazine test strips alongside our, uh, spectrometers when we do drug checking, uh, on site. And so, that is one way that we're able to, to use them, in, in concert with another technology. But they're not, I don't quite feel comfortable distributing them because of the false positive rate being so high will lose people's trust in the, uh, reliability of them.

**Unknown:**

Another question. Maybe for the larger group here. And Pedro and Kyle, you're welcome to, um, share your thoughts as well. But I'm just curious if, um, clinics or treatment settings could speak to how we're navigating, um, what feels like an increase in alcohol use in combination with opiate use? And, um, I think it's just, it's hard for a lot of our program staff to kind of, how we support you know, harm reduction practices around alcohol use and methadone maintenance and, you know, some still pretty well-established protocols of, you know, point of contact breathalyzers and dose denials and, unfortunately, not a lot of treatment options in combination with, you know, methadone maintenance and alcohol use. So I'm just kind of curious if others are seeing that and how you all are kind of, if you're changing protocols or practices in your clinics to, you know, try to reach that population because we're finding it a real struggle. Like how, how to treat folks that are struggling with both.

**Unknown:**

I don't want to hog, oh go ahead, go ahead.

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**Unknown:**

No, I was going to call on you.

**Unknown:**

Oh, okay. I was like, I, I, I mean, I, I think that's a great question. I don't mean to hog everything. I guess what I was going to say is I've been in my OTP for like just over four years, and I, I don't know if there's an increase. I mean, I, I know that in general, there's an increase in alcohol use disorder since the pandemic. That much is clear. Um, so so I wouldn't be surprised if there was an increase. But I, I do think the broader question of how OTPs deal with people who have co-existing use disorders. It's something that as like, I'm a PCP Board an Addiction Medicine and, you know, alcohol is everywhere. And I think we just don't ask the question. And yes, we do discover it if somebody happens to know, happens if somebody is forthcoming at intake and says that they have had a having an alcohol use disorder or they came from detox for alcohol or whatever, but I do think there are like, I know our clinic has our spectrum has recently changed some of the protocols for like positive breathalyzers like you can, now there's like a different range. You can have a positive breathalyzer but not be denied a dose. And I know that on an individual basis, we try to make a lot of, like at Framingham, like we try to make a lot of, um, harm reduction approaches to it. Right? Because if we're going to somehow cut people off from a person's methadone because they're using alcohol, I don't feel like that really helps either.

But I do think that broadly, um, like, I'm always sort of like talking to our staff and saying, well, when somebody, you know, when the nurses counsel somebody about a positive breathalyzer, we need to say more than don't mix alcohol and, and methadone. Like you should, you know, have a real conversation if they have any interest in a medication for alcohol use. So I feel like it's very, we're very methadone focused when, when really we do have tools and there are usually physicians available to. Yeah, it should be a bigger discussion, than just, you know, the, the connection between not mixing the two.

**Julie:**

Anyone have anything to add?

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**Kyle:**

Thought I'm having just around poly-substance use in general is, getting curious about, like what the person is, is getting out of mixing those two things. And what feeling or sensation or, thought experience they're seeking. And if there's a way to support them, um, alternatively. I think one of the really beautiful things about, um, OTP work and maybe methadone specifically is that it's safe supply. And so, um, folks are able to go to the clinic and know what drug they're accessing at what dose. With the support of a clinician. And when we use drugs that are part of the unregulated drug supply, uh, we don't have that privilege. And so if folks are mixing substances that are both regulated and unregulated, um, and maybe have similar or different effects, getting curious with them about, um, about that, like what they're seeking, what they're getting out of it, um, and thinking about ways to support them in safe supply. Can we weave safe supply into, into the mix? And leave out the unregulated, unpredictable substances?

**Julie:**

I also see that, Natasha put in the chat that it is a time to educate the patient and also asking, what they need. Which is great. Any other questions?

**Pedro:**

I got one for the group. And I'm just curious because, again, I know there's, uh, a wide spectrum here of individuals from across the state. And I'm very familiar with some of the OTPs, um, in this area. But how have any of you guys seen harm reduction impact, like, patient outcomes in your practice? Like, do you guys practice it? Do you guys, um, are you guys connected to harm reduction services? Has it impacted your practice in any way?

**Unknown:**

I, I would like to answer that. I, I've actually had, I've met both of you in person. Kyle, you've come and provided some, um, information to our pregnant and, um, pregnant and parenting population. You come in, um, occasionally to do some, some, education to our OTP clinic in Springfield. And, Pedro, I know you. I've been down at your site, and you know anything I need from you- Fentanyl strips, anything, you've always been there to assist. So I know for us, you guys have been really key. And, like, also, you provide, um, there's a whole other part of tapestry that I didn't even know was available. So we've also tapped into that, the health and reproductive part of, um, of tapestry. So

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we've been utilizing them and, um, yeah, I feel like if, if tapestry isn't at the clinic, then, you know, there's we've got to look at that. Because we, there's so much that you guys provide. You guys also provide a monthly, um, unit that parks in our, um, that parks in the parking lot that provides wound care to our patients who will come over and see you. So you guys are everywhere, and I really appreciate that. And the work that, and the collaboration that we've been able to do together. I actually just sent an email the other day, so I'm waiting for a response because I need, um, it's that time again. So, um...

**Pedro:**

Definitely. And I think I, I yeah, I think I, you sent it to me. So I do owe you an email. Yeah. I appreciate the kind words and just some explanation of how's it working out in your location as well. So thank you for that.

**Christy:**

So I don't currently work in an OTP. I actually work for a health plan, but I used to do, um, well, I'm, I'm a certified CARN, and, and did in-home injury addiction treatment services. And one of the things that we really did that was, is, is break down the idea of what harm reduction is, right? Because I think a lot of people thought, okay, harm reduction is needle exchange. Harm reduction is, you know, safe spaces. And we would break that down to like a really, really, really micro level and to the point where even though it was a bit controversial at the time, we said harm reduction is teaching the, the member that has four DUIs how to use Instacart to have her alcohol delivered instead of her driving to the store to get more and, right? So we would really get creative about what is it that's driving the individual? Because then everything else that came with the legal fees, and every, right? Like that's, and so how do we really individualize harm reduction care to make sure that it was patient-centered, that it was something that they were also willing to do. And sometimes that's not talking about you know, it's really getting creative around what does harm reduction mean. And breaking out the cycle of what we think harm reduction means.

**Pedro:**

Definitely. Thank you for that. That was a great, great example that you provided.

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**Christy:**

Yeah. And I, that, I love that example because a year later, after being in our program for a year, she was sober. Right. So she took these harm reduction, these baby steps of like one thing at a time. Let me stop one thing at a time. And sometimes our harm reduction is, can you stay sober until 10 a.m. and with me at 10 a.m.? All right. Next week we're going to stay sober until 11 a.m., right? So it was these really minor baby steps. We're not telling them to stop using. We're just saying, can you use a little less or a little safer or whatever it was that, that, that was going to work for that individual and it really had to be individualized.

**Pedro:**

Thank you for that. Yeah, there's definitely some misconceptions with harm reduction. And I think you all, all on this call now practice harm reduction in your own way. You know. And that's great that you brought up that example as well. So thank you, Christy.

**Christy:**

You're Welcome.

**Kyle:**

Your example, Christy, made me think about Dan Big, who was one of the founders of the National Harm Reduction Coalition, used to say the phrase "any positive change". And so harm reduction being any, any positive change we can weave into our lives, whether it's about drug use or not. And so I, uh, think the, the example of Instacart is a really beautiful one, or the incremental, you know, one hour at a time. Is another, you know, the small wins. Can we celebrate them? And, the experience of having those being celebrated by a provider, I think too, really increases someone's sense of self and, um, value and, and all of those things as well.

**Christy:**

Trust, right? That's really how we build trust in the provider is by us, we're not telling, right, like me, the provider, I'm not saying you must stop. Right? I'm saying like what, what are you willing to do today? And then and then they felt heard. And it's like, if it's nothing, it's like, okay, let's check in tomorrow. Right? And, and nothing is okay. And,

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and that's the trust building that trust for when they are ready to make a slightly different change. Let's talk about that.

**Pedro:**

Definitely. Thank you. I've seen Natasha, you came off mute a couple times. I don't know if you want to ask a question.

**Natasha:**

Yeah. I just didn't want to interrupt anybody.

**Pedro:**

I've seen, I've seen you come off me. I was like, you ready to make your move?

**Natasha:**

I'm Natasha. I work over at the High Point, for OTP, I'm their medical assistant and for harm reduction, I, I also just ask the patients what they need. Okay, what can I, what can I do to help you just slow down a little bit with your use? Okay. So, also a little backstory of me. I'm ten years sober, um, from using heroin. So I have a special connection I consider myself to have with the patients. Um, but it's more of just asking them what their needs are. No one ever really asked me when I was going through my process of healing. And it is a healing process. So if I can just go and ask them, like what, like what is causing you to want to use at seven, 8:00 at night? Well, I feel sick and horrible. Well, how do we make an appointment with the provider so you can discuss that? And some of them don't even know that's a, that's an option, because they just consider it like, oh, I'm just coming in to get my dose and leaving and there's nothing else. But there's more involved. And I plaster condoms everywhere, and lube, and everything and anything they need.

There's Narcan all throughout the building. There's a couple patients here that I think are the sweetest, because they will come and grab a bunch of Narcan from me just to go bring to the encampments. And, I mean, I wish I knew where they were myself, because I'd go there with cases upon cases just to go and help them or, you know, just sometimes I even have patients, they'll just be like, hey, do you have any extra gloves? I need a couple of gloves. I'm like, I don't even want to know what you need it for, but,

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yeah. If it's going to be some type of harm reduction, come see me. Um, but it's just also a matter of just asking them what they need, and a lot of time they will be like, wow, no one's ever asked me that.

Or, oh, Tasha, I used last night, and I don't know why. I'm like, how were you feeling in that moment that you did that? That's what you need to figure out. That'll help you. And a couple of them have been like, wow, thank you. No one's ever asked me that question. It makes you think. It's all about trying to make them think a little bit.

**Pedro:**

Yeah, definitely. Thank you. And you know, thank you for sharing. And congratulations on your ten years.

**Natasha:**

Oh thank you.

**Pedro:**

That's phenomenal. And it's you know, it's simple as that. Like asking someone like, what do you need? You know, that goes a long way. Just kind of taking that into consideration at that moment. What is it that they need? You know, that just goes a long way there and building that trust and that relationship with individuals. So thank you.

**Natasha:**

Or even just seeing if they're a little bit down at a moment and I'm just like, is there anything I, anything you need? Yeah. You know, what is it they need today?

**Pedro:**

Yeah. For some people, that's probably the only time they're getting that, is coming to see you.

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**Natasha:**

Yeah. So I try to make sure I'm a smile every day for them and a hello because not everyone has that.

**Julie:**

And it looks like, the, someone is singing your praises in the chat as well. You're working on emergency kits, which is amazing.

**Natasha:**

Yes, yes I am. Oh, so it's these little kits that I'm making. You know how you have take-home groups or overdose prevention groups or HepC groups and stuff like that for you to be able to go through the program. So I'm creating little kits for them and it's all stuff that's from Mass Clearinghouse, you know, so it's all available to everybody. But it's like a little overdose prevention kit where, um, Michelle has the kit. I wish she was on here so she can show it to everyone. But even them just getting a CPR mask, for them to have that barrier for when they are trying to help someone in overdose.

**Pedro:**

There you go. I think she's showing it now.

**Natasha:**

Oh. She is. Where are you, Michelle? I need to see it. Yes. Now, you know, we have condoms in them for the Hep C, and, you know, just learning about those things. So, yeah, so many different things that I'm trying to do a little extra for the patients.

**Pedro:**

Thank you for that. Pretty sure they appreciate that too.

**Julie:**

Thank you. We have time for one more question or comment or a question for the group or a question for Kyle and Pedro before we transition. Any more questions?

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I can, um, if you want to show the kit a little bit better, I can, un-spotlight Pedro and Kyle. So that way, Michelle, you can show.

**Michelle:**

There was two of them, but I ran out of the, of the other one. So I have the one on, like, which one's this one, Natasha? Get on.

**Natasha:**

I'm getting on. Where are you? That one is for the Hep C and HIV prevention, just gives them a little bit of education, but also condoms. You know, and not just the male condoms but like, for the female condoms as well. And, I mean, if you guys have a minute, I can just show you guys real quick what I threw together for the, um, overdose prevention.

**Julie:**

Yeah.

**Natasha:**

It'll take me just a second, I apologize. So, also, it'll have Narcan in there in the little bag. Right. So it's these little bags right here. And I put in the mask. That helps everyone for that. I also put in, everyone needs to know this information. I hand these out like crazy. And then the safe spot for safe use. So you have a spotter. And then Narcan goes in.

**Pedro:**

Nice.

**Natasha:**

And it also has, you know, the instructions for Narcan. And I put together these little, the fentanyl test strips. But I also put the education on the back of them and it's just stapled together. And that's actually all throughout the whole clinic. And I give a little care

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packet, I call them care packets. It's so funny. These little care packets, out to all the clinicians for OTP. So all of the harm reduction stuff I have available in my office and throughout the clinic is in each office as well. So it's just like a revolving eye site for them to constantly see that that stuff is available for them, for their safety.

**Julie:**

It's amazing. Thank you so much for doing that. Natasha.

**Natasha:**

Thank you.

**Julie:**

We are at the end of our session.

**Pedro**

Kyle, thank you so much. For your presentation today. I've learned, um, new things today, and I'm sure we've all left with some real life examples of how we can be implementing harm reduction in our settings. And, so really appreciate, um, your time, everyone. So we do have to transition to the next session and the last session of the day. Um, Shaivi is going to put some information in the chat and I'll also share my screen with the details for the next session. So we are going to make our way back to the main zoom room, that same link that you use to join that opening session for today, um, we're going to be having a session on expanding access to telehealth and innovative strategies for patient-centered care. We'll have an amazing panel, um, for you all. Some people from Spectrum will be speaking about the work that they're doing around this. And, so hopefully you are able to join. So I'll stop sharing. And again, thank you all for joining. So hopefully we'll see you all in the next session. Thank you all for having us.

**Kyle:**

Thanks everyone.

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**Pedro:**

Have a good day.