CLINICAL EDUCATION INITIATIVE
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COVID-19, DRUG USE AND HARM REDUCTION

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COVID-19, Drug Use and Harm Reduction
[video transcript]

(00:08):

Now it's my great pleasure to be able to introduce two speakers for today. Very excited to have both Andrew Reynolds and Christine Rodriguez. Start with Andrew, he's the Hepatitis C Wellness Manager for the San Francisco AIDS foundation and the Principal and Lead Consultant at Reynolds Health Strategies. At San Francisco AIDS foundation, Andrew manages the HCV treatment program at their syringe access site, facilitating treatment for people who use drugs in community based settings. As a consultant, Andrew provides technical assistance, training, and writes health education materials, fact sheets, and articles on all aspects of Hepatitis C awareness, prevention, and treatment. He's the author of the Positively Aware Annual Hepatitis C Drug Guide and sits on the AASLD IDSA HCV Guidance Panel. Christine Rodriguez is a trainer, strategist and advocate with over a decade of experience in drug user health. Most recently, she founded Higher Ground Harm Reduction focused at the intersection of harm reduction and climate change systems disruption. Before this, she developed a harm reduction focused statewide capacity building initiative in Maryland. She led training and technical assistance provision for Hepatitis C testing and linkage to care and cure projects for people who inject drugs at the California Department of Public Health. Using this time in state government to inform her previous work in federal viral hepatitis policy advocacy. Christine earned her Master of Public Health from the University of California, Berkeley and her Bachelor of Arts in American studies from Pomona College. Really pleased to turn it over to both of you, Andrew and Christine.

(02:00):

Alright, next slide, please. We have no disclosures. Next slide. So kind of three simple learning objectives. I mean, you know, I wish we could have picked a more relevant topic than COVID-19. I mean, what else is going on in the world today? But we have been working on a project around supporting people who use drugs and supporting the people who serve the people who use drugs around this COVID-19 outbreak. And so we're really excited to do this presentation for you all. We will have a lot of materials being released probably the next week or two, and we'll make sure to share them with Jeff and the CEI team so that they get out to everybody. But today we're going to kind of do a big, broad overview of COVID-19 and harm reduction. And by the end of the talk, you'll identify three ways that substance use can be impacted by the COVID-19 outbreak. You'll learn at least three COVID-19 prevention strategies for people who use drugs. And then describe three techniques for supporting the health of people who use drugs during the COVID-19 outbreak. Next slide please.

(03:12):

So I'm going to start off by giving just a big, broad sort of lay-person's overview of COVID-19. This is all kind of basic, it's stuff that we know, but I still think it's really important for us to have short, simple messages for our participants for reasons that we'll get into later, but we're really the number one source of info for most of our folks. So being able to explain to people why we're telling folks to stay six feet apart, or why we're wearing masks or why when normally we give you a hug hello, we're not doing

it right now. By talking to people about COVID-19 transmission, we can sort of explain all of that and help them start to do prevention strategies in their lives. So as we know, COVID-19 is transmitted from infected droplets when someone sneezes or coughs and we can breathe those droplets in, so there's one portal of entry. And really it's our mucous membranes that are particularly vulnerable to the COVID-19 way of getting into our body, and that's the eyes, nose, and mouth. Fecal transmission is possible. So when we talk about sort of sexual transmission of Hep C, it's not sort of sexually transmitted by way of fluids like semen, vaginal fluids and the like, but through condomless anal sex, rimming, and other things there could be a risk of transmission that way. So making sure we educate folks around that. Fecal transmission is also really important for our homeless folks who may not have access to a bathroom, and we need to brainstorm with them on ways for them to defecate safely and in a space where there isn't a risk of other people coming into contact with it. Keeping their hands clean and all that type of stuff. And then hand, eyes, nose, mouth transmission is definitely possible with COVID-19 as well as other coronaviruses. And just sort of a quick example is if my hand touched a table where someone coughed or sneezed, and then I rubbed my eye, there is a way for COVID-19 to get into me. And we'll talk about this in relationship to drug preparation in a little bit. Next slide.

(05:36):

So again, the symptoms, we all probably know. The CDC did update this list maybe in the last couple of weeks. And cough and shortness of breath or difficulty breathing are sort of the two kind of classic symptoms. You got that, let's look into seeing if you have COVID-19. But then the CDC lists that you can have two or more of the following. And we've got the list here. I mean, I'll read out a couple of them. Fever, chills, muscle pain, headaches, new loss of taste or smell is particularly interesting. So if any of your folks are reporting that, that might be a good time to either do a COVID-19 screen, or refer them to a place where they can go get tested. Symptoms typically pop up between 2 and 14 days after you've been exposed to the virus. So like if I'm at my site here in San Francisco and one of my guys gets COVID-19, I'm going to disappear for two weeks under self quarantine to make sure that I don't have it. Asymptomatic transmission does seem to happen. So that's another thing that we can't really account for, for symptoms, but when folks have these symptoms, you definitely want to refer them along. Next slide.

(07:07):

And these are other symptoms that we see in the peer reviewed medical literature. I'm kind of surprised a couple of them haven't made the CDC list yet, particularly with the GI symptoms because those seem to be pretty prevalent in a lot of folks with COVID-19. And these ones are interesting for us when we work with people who use drugs, because these mirror some of the things that could happen either when we're on drugs or particularly when we might be withdrawing from drugs. And so it might be a little tricky sometimes to differentiate between a drug withdrawal opioid symptom from a GI COVID symptom. But the GI symptoms that are common with COVID-19 are loss of appetite, nausea, vomiting, diarrhea, and like really painful cramping, abdominal pain. And then there's a whole host of neurological symptoms as well. Some pretty significant muscle weakness, peripheral neuropathy or the tingling or numbness in the hands and feet, dizziness, and seizures. And there've been a lot of reports of strokes in

otherwise very healthy people without any risk factors for it. So that's something for us to keep an eye on as well with our folks. Next slide.

(08:33):

So kind of when we think about COVID lifespan outside of the body and that sort of fomite transmission I talked about earlier, where my hand touches a table then goes to my face. COVID is a pretty tough virus that can live outside of the body for a pretty significant amount of time. We haven't studied it on all surfaces yet. I assume there are people doing this as we speak. But for COVID-19 in particular, they have found infectious levels of the virus on plastic for as long as three days, stainless steel for two days, cardboard for a day, and copper for up to four hours. We haven't looked at COVID-19 on these other surfaces, but we do have some really good research on sort of the lifespan of other coronaviruses. Like the first SARS virus, MERS the Middle East respiratory one is another one. And these are all kind of common products that our folks who are using drugs may come into contact with. Metal, PVC, wood, glass, aluminum if they are smoking fentanyl off of foil. And so recognizing how long COVID can live on these things is another way of sort of providing education for folks, around 'this is why it's super important to wipe these items down before and after use, for example.' Next slide.

(10:01):

We're fortunate in that there's a lot of stuff that kills COVID-19. For our hands, good old soap and water works extremely well. Access to soap and water can be tricky for some of our participants, especially our unhoused ones. So if we can dole out alcohol based hand sanitizer that's a good backup. It has to have at least 60% alcohol in it, and it's really important that we check the labels on that because there are a lot of hand sanitizers out there with either no alcohol in it at all, and that's not going to kill COVID, or a lesser amount. For hands, it must have at least 60%. For hard surfaces and other sort of porous surfaces, we've got a lot of options available to us. Good old fashioned bleach works against COVID-19. You could even dilute it to an extent to make it work. The CDC has some really good recommendations on that. Alcohol based cleaners for surfaces will also kill COVID-19, but it's gotta be 70% alcohol. So sometimes people get these a little mixed up, hands 60%, surfaces 70%. And then there's just a ton of household products from companies like Clorox or Lysol. The EPA's list of approved cleaning cleaning products that kill COVID-19 runs like 15 pages long, it's really quite, quite deep. So a lot of the stuff that we can get at grocery stores and convenience stores like Clorox and Lysol work really well. Next slide.

(11:44):

And so let's think about, if we're thinking about surfaces, what are some high touch drug paraphernalia items that have a risk of having COVID on them? Plastic baggies, bio buckets, pipes and stems for smoking, syringes, cookers, lighters, so on and so forth. Chore Boy or Brillo, again for smoking through pipes. So talking to folks about making sure that hands are washed ideally before and after drug use. But after sometimes we get a little distracted, so if we can at least get people to wash their hands before, that would be a huge harm reduction intervention. And then also encouraging folks to wipe down surfaces where drugs are prepared on, and that type of thing is another great way to minimize the risk of COVID transmission. Next slide.

(12:44):

And then for the people that we serve, I think it's really important to highlight that our folks are vulnerable to COVID-19 infection for both sort of social reasons, lack of access to housing, lack of access to bathrooms, poverty, stigma, discrimination, racism, all those things that seem to highlight much of American healthcare, regardless of COVID-19. And then there's a whole host of other sort of like syndemic factors that can increase risk of COVID-19 disease severity. Many of these are very common in folks who use drugs, so COPD and asthma have been found in higher rates of individuals who use drugs, both those who inject and those who smoke. We see higher rates of cardiovascular diseases amongst people who inject drugs and people who use both crack or powder cocaine. Methamphetamine can constrict the blood vessels, which can then lead to lung damage over time. And we also obviously see higher rates of HIV, hepatitis C, and hepatitis B in people who use drugs. And while we don't really think or it doesn't appear that having any of those conditions increases risk of disease severity, particularly if their HIV is controlled by medications and they have a high CD4 count and undetectable viral load, or folks with hepatitis C or hepatitis B are pre-cirrhotic. But we do know that folks with cirrhosis, that's a risk factor for more serious COVID-19 complications. So for our people who we work with who are cirrhotic, it's really important to really up our game with the COVID prevention work that we do with them when they're in our clinics or spaces, and then helping them to stay safe and healthy when they're home. Next slide.

(14:52):

And I'm gonna turn it over to Christine.

(14:55):

Thanks, Andrew. Good evening, everyone. Next slide. So one of the most salient challenges I think with COVID-19 and substance use that we can all kind of relate to is stress and the collective trauma that we're experiencing right now. And so increased use due to that, triggering relapse is a concern for folks who use substances. Our stimulus checks have been coming out, the $1,200 that folks are getting from the federal government. Both challenges accessing stimulus checks if folks don't typically file their taxes and for those who do, really wanting to pay attention to overdose risk and any spikes that we might see. We know that there tend to be overdose spikes around say the first of the month when checks tend to come out, and so really paying attention to sort of money management, especially if folks are trying to stockpile their drugs to try and have those supplies last a little longer. Increased use to self-soothe or if folks even are housed, due to boredom. There's just not a lot to do every single day when we're sheltered in place, if you have a shelter to be in place. Social isolation and using alone, we know is certainly already a risk for fatal overdose and being very mindful of that. And we want to think about drug setting a lot in these situations. This is the model under which harm reduction sort of conceives of individual risk, resilience by drug type, the mindset of someone, their physical health, their emotional health, and the setting and circumstances under which they're using drugs. So in particular right now, for folks who are experiencing homelessness, who may not have safe private spaces in which to use. Next slide.

(16:55):

Some of the impacts of COVID-19 on drug use, like we've been talking about social distancing can exacerbate that risk for fatal overdose. There have been some recommendations I've heard in Canada, recommending that folks try and stay six feet away if they are using together, but not necessarily using alone. There is a service in the United States, a call line under the name Never Use Alone that folks can call if they are social distancing, if they are using alone, to try and prevent a fatal overdose. We also know that EMS, EMTs, emergency rooms are stretched incredibly, incredibly thin and so wanting to be able to avoid that potential severity of overdose. We're really concerned about drug markets being disrupted, it seems that this is looking different in different localities and not sort of evenly impacted across the country. There might be inadequate access to folk's drugs of choice. There are real concerns about bad cuts when there is inadequate access. So not really being sure exactly what or how much of other substances are being cut into drugs. We've heard that in North Carolina, heroin is essentially non-existent right now and what's being sold is fentanyl. Fentanyl being a white powder that if you're sort of opioid naive, you might just very easily mistake for cocaine, which can present an incredible risk for overdose especially if you're not someone who necessarily typically thinks that you need to have Naloxone around. Really concerned about involuntary withdrawal, not just from opioids which can be very painful, but also alcohol which can be extremely dangerous, as well as benzodiazepines. The withdrawal from those suddenly can be life threatening. And of course increased costs, which can always impact our access. Since folks are sheltered in place, street-based transactions are much more exposed and the risk of encountering law enforcement and arrest increased as well, depending on what the policies of your law enforcement are right now around enforcement of nonviolent offenses, et cetera. Like we keep talking about the stress, the trauma, the isolation, that can be incredibly triggering and cause an increase in use or relapse from abstinence. And lay folks responding to overdose might be hesitant to administer Naloxone or do rescue breathing in the cases that's necessary, and that's incredibly concerning. We've certainly already heard some stories about folks overdosing publicly and law enforcement just not being willing to respond to those overdoses and outreach workers having to sort of take care of folks as these incidents happen, waiting for EMS. Next slide please.

(19:56):

Like Andrew mentioned, some of these symptoms of COVID can mirror either an overdose, a withdrawal, drug use, right? So fever is one that can mirror overamping, which is sort of the term for overdose when you're using stimulants, or regular breathing or shortness of breath if you're using opioids, and gastrointestinal distress particularly when you're withdrawing from opioids is something that's very common. And so being able to tease those out can be, like Andrew said, a little difficult for some folks. Next slide.

(20:34):

So we don't have a ton of data on overdose risk in COVID-19 or overdose fatality. But while it's still theoretical, it's intuitive that it might be a risk, so we want be to be safe rather than sorry. So we know that folks with chronic respiratory diseases are at increased risk of fatal overdose. And so it's intuitive that diminished lung capacity from COVID-19 might increase that risk of opioid overdose. And then

again, social isolation can't be overstated as in terms of risk. Using alone without a safe space, in particular to inject. Lacking access to Naloxone, particularly in areas of the state where there are fewer harm reduction programs or syringe service programs. And a slower response by EMTs, just due to the overwhelm of our systems right now can exacerbate risk of fatality. Next slide, please.

(21:31):

Here's a side by side list for some of these symptoms that mirror signs of overdose. So of course the trouble breathing, shortness of breath, inability to arouse mirroring a lack of responsivity to stimulus. Bluish lips or your face very much mirrors an opioid overdose, especially for folks who are lighter skinned. If you're Brown or Black, your skin is going to look a little more grayish in that case. And vomiting. Next slide.

(22:06):

COVID-19 of course is not a bloodborne virus, however HIV, Hep C, Hep B of course still are. And so we want to make sure that we're still delivering health education and safer injection messaging around those viruses, the same way that we've been doing a great job all of these years. Staying mindful of COVID-19 on hands during drug preparation, like Andrew already mentioned. Don't lick your syringe. That is that's an old standard, an oldie but a goodie. And so we want to keep reminding folks that you really never, ever want to lick your syringe in advance of injection. Can you prepare the drugs yourself, if not, can you learn? The fewer hands that we have on materials, the better. Washing your hands at least before, but before and after use ideally. And keeping a clean surface for drug preparation, whether that is the availability of household cleaners to clean the surface or if you can put something a little cleaner down on top of that surface. Next slide, please.

(23:12):

Another challenge, making sure folks have enough syringes and supplies on hand for things like this. Ideally, you would have supplies for a couple of weeks, the same way you'd have food available for a couple of weeks. And you know, this isn't always possible. Where we have a greater availability of syringe service programs, this might be less of an issue, there might be several programs that folks can hit up to get their supplies. In say outer New York, outside New York city, this might be more of a challenge for folks to to maintain and access adequate supply. Having bleach on hand can be really important for sterilizing syringes, in case you're not able to use a new syringe for every injection. And I would add that having some wound care supplies, would also be really important in these cases, even if you're able to bleach and sterilize your syringes, the points are going to be getting really dull and that can cause some vein damage. Next slide, please.

(24:16):

There are some additional, or maybe some slightly different considerations for folks using stimulants. So here we're talking primarily about powder cocaine, crack, and methamphetamine. Andrew mentioned that we were going to have some materials coming out in the next couple of weeks. This is one that's already available at the link at the bottom of your slide there. Next slide, please.

(24:42):

Some of the recommendations and some of the health education messaging that we want to remind folks and help people access. Food, water, and sleep. We know how incredibly important these are to maintaining a healthy immune system, and so protective against COVID-19 and more severe symptoms, and is a particular challenge for folks who are using stimulants who have suppressed appetite due to the drugs, maybe tend to forget to drink water and could be awake for sometimes days on end. We want to remember that some of these drugs, methamphetamine in particular, can result in an increased libido. So reminding folks around safe sex messaging, safe sex supplies, social distancing can be basically impossible if you're having sex with someone. Right? But what are the options? Can you have your dates online? Can you Skype someone? Can you get creative with your positions? So you're not face to face and exposing yourself quite as directly. Again, wound care. Particularly if folks are awake for a long time, for those days on end, a common hallucination can be crawling bugs under your skin. And so folks tend to be maybe picking at their skin and you want to make sure that we're taking care of those wounds so they don't become infected, again emergency rooms are incredibly stretched. We know that, and this would be of a lower priority, and we don't want folks to be in pain if they don't need to be. Extra injection supplies, as we've already noted. But incredibly important for folks who are injecting stimulants, and cocaine in particular. Folks who are injecting cocaine tend to inject about three times as often as folks injecting other drugs like opioids, and so just need baseline more supplies, especially under these conditions.

(26:41):

Drug checking can be incredibly important. As I mentioned, there's some fentanyl out there that just looks like cocaine. So we've got our fentanyl test strips as a tool that's available to check and see if there is fentanyl present in drugs. Similarly, the same company makes cocaine test strips. So you could use those to see if there's any cocaine in your cocaine, for instance. We were given a great tip by someone at One Voice Recovery out in Salt Lake City around checking your methamphetamine. You can take a small shard and pop that in just a tiny cap full of household bleach and it'll start going spinning around and sort of going crazy like fireworks. If that happens, you know your meth is in fact methamphetamine. And I want to mention also Hep C treatment as harm reduction. I know it's complicated right now with COVID, whether folks are continuing their regimens. Do we start folks on regimens? Are people testing? And Hep C treatment can be really powerful. I always tell this anecdote because of that, I was working with a particular organization when I was at the California State Department of Health, Glide in San Francisco. Phenomenal organization. And they were doing a Hep C testing, linkage to cure demonstration project. They were working with a particular client who was a woman experiencing homelessness, and she had been shooting methamphetamine for a very long time and shooting daily. They were able to test her, she did have hepatitis C. They very happily linked her to cure, she was cured. And she found that when her hepatitis C was cured, the immense fatigue that she felt that she just attributed to sleeping rough every night was in fact, mostly a factor of her Hep C. And so once that Hep C was gone, so was the fatigue. And she on her own chose to stop shooting meth entirely. Right? So this is an incredibly, incredibly powerful intervention that we can offer. Next slide, please.

(28:57):

So a little bit on alcohol and COVID-19, also an increased theoretical risk. Like Andrew mentioned, really wanting to be mindful of cirrhotic patients, folks with compromised immune systems, and heart issues. There are cost and supply issues here, despite the legality of alcohol. It can be hard to afford, especially if you're trying to stockpile and not be in public too often. And alcohol is heavy, right? It's heavy and it's bulky, so hard to carry, hard to store if you don't have a home to store that in. Next slide, please

(29:34):

Managed use or moderation management can be helpful to avoid some really life threatening withdrawal. And it can be hard to do that management and avoid binging so that you are able to maintain your supply for a longer period of time. There are some great resources from an organization called HAMS, like the meat, around harm reduction and alcohol consumption and moderation management planned drinking, planned binge days, these sorts of things to try and track and manage alcohol use with a little more regularity. Next slide, please.

(30:22):

Another word from the World Health Organization, they put a fact sheet out alcohol and COVID-19, what you need to know. In this time there is a lot of misinformation out there, right? And particularly from recent messaging that we've received from the White House, very alarming messaging around trying to perhaps inject disinfectants to prevent or treat COVID which obviously we never, ever, ever want to do. An important message that they included in their fact sheet is that in no way will consuming alcohol protect you from COVID-19 or infection. So wanting to make sure that that messaging is out there, that this isn't the type of alcohol that's going to in any way disinfect your body in some fashion. Next slide, please. Andrew?

(31:16):

Actually I want you to keep talking. That was excellent.

(31:19):

Okay, I will!

(31:20):

I am joking. That was really good, Christine. We are going to share this next section together, so we'll mix it up a little bit. Next slide please. So, you know, I mean, moving into a little bit about harm reduction and sort of COVID-19's impact on our work, it's changed everything for us. I was working our Hep C clinic before coming on for this webinar. And every service that I provided was altered compared to the way that we did it pre-COVID. One person coming into our space at a time, six feet physical distance at all times. So there wasn't the sort of closer, hand holding, hand on the shoulder, the things that we do to kind of soothe people. And so even though we recognize that the physical distancing is a way to keep us all healthy. It still is that space that can kind of like be a barrier between rapport with our participants. As I mentioned, all of our services have changed in dramatic ways and in some ways that

actually prevents our folks from accessing care. None of my folks here at the Harm Reduction Center in San Francisco really have access to telemedicine. So even if there was an option to see a medical provider that way, they don't have a laptop, a tablet, probably not even a cell phone with internet capacity to do that. So the change in services has led to another highlight of health inequity in our society. But again, the safety of staff and continuity of services is the most important thing that we can do. And we do these things to make sure that we're still able to distribute sterile syringes and provide hepatitis C care or methadone and be open and the like. Next slide.

(33:24):

And as I mentioned kind of early on, I think one of the most important things that we are particularly on as frontline syringe service providers, working as health educators, the way that my team and I do here in San Francisco is we are an important conduit of health education. We are absolutely essential in this role. As I mentioned, access to the internet and other forms of health education, we're not doing support groups anymore. We don't have a drop in health education one-on-ones with our folks. And so being in our spaces, even six feet apart from folks, there's things that we can do to keep people up to date as things change, especially around COVID-19 symptoms and services that are available to them in our respective communities. Making sure that we have fact sheets, posters, comics all sorts of like really good culturally relevant materials for our folks is important. You might have to write up some of your own to distribute simple, clear, accessible information to your patients. Just as an example, a fact sheet that Christine and I developed around hand washing, telling everybody you need to wash your hands with soap and water, obviously that's the gold standard way of preventing COVID transmission from hand to face. But, you know, if I'm unhoused, access to running water and soap is really quite limited. So we developed a fact sheet on how to keep your hands clean when you're unhoused, which has a number of options that that folks have. So there might be things that you have to develop on your own to give to folks. Next slide.

(35:16):

It's important to sort of recognize that delivering health education during COVID-19 is very different than delivering it pre COVID-19. Stress impacts memory and cognition. So the messages that we used before COVID-19 and people would get with ease, maybe now it's a little bit harder for them to remember because they got a lot on their mind. And so you might find yourself having to speak a little slower, repeat things more frequently, check in with your folks more frequently to make sure that that they're understanding how you're putting the health education out there. I think it's important for us to clearly identify ourself in our role. I'm not a medical provider, so I can't give you tips on medication and that type of thing, but I am a health educator. I can talk to you about X, Y, and Z. We are six feet apart, that's stressful. There's the risk that somebody is like, 'what you think I'm diseased, I'm going to give you something?' So making sure that we kind of keep a calm presence if we can't hug or even give a fist bump, maintaining eye contact and keep an open body posture while we're talking to people six feet apart is a nice way of being warm and welcoming. Next slide.

(36:41):

And as I mentioned before, I mean this is actually one of the hardest parts for us at the Harm Reduction Center, the things that we can do to soothe people, particularly during very difficult times, we can't do. And so I mean, I try to acknowledge that with folks. I'm like, 'Hey, I can't give you a hug, but I'm going to give you a virtual hug or here's a fist bump from a distance,' like just ways to kind of stay friendly and maintain rapport with folks. A lot of times, all we can do is express empathy. Let people know we recognize how hard it is and how sorry we are, and we're here to work with them and brainstorm with them as best we can, but just know that we're feeling for you during this really challenging time. Again, speaking slowly, using repetition to get points across, I reference it's actually 'chunk check chunk.' I have a typo in there, sorry about that. But 'chunk check chunk' is a sort of classic way of delivering health education. You deliver a chunk of information, you check with the participant to see if they understood that first chunk, and then you add a second chunk to kind of build on it. And you just gotta do that over and over, and that's a way of sort of going slowly and getting feedback from the person. So you can adapt to the way that you're doing your health education. As much as we want to, let's not use euphemisms in an effort to make somebody feel better. Cause you know, as much as we want to say, 'Oh, it's all gonna be fine. Everything's gonna work out.' You know, we don't know. And I think again, expressing empathy in those moments is, is a much more valuable way to interact with them. And then stick to the facts, go with what we know. When I find things in peer reviewed journals, presentations like this where I know folks have looked it over, I'll take those really quite seriously. But you know, if I'm reading an article in even the New York Times that has some stuff on, for example COVID toe which is a thing that I've seen in the popular press lately where there might be some term of dermatological symptoms that could indicate COVID-19 infection. Until I see that in a peer reviewed journal, I'm not gonna use that in my health education. And as Christine mentioned, I'm also not going to say anything that is said at a presidential press conference, unless it's Anthony Fauci saying it. Next slide.

(39:21):

Well, this slide is a little bit out of order, sorry about that. But this goes back to the disinfecting surfaces section. In our homes, at our work locations, making sure that we are consistently and regularly disinfecting the surfaces that hands touch quite a bit are really, really important. I definitely encourage people to disinfect your cell phones. If we saw all the bugs and germs that were living on our cell phones before COVID, we'd freak out and never use them, let alone now. So making sure that we keep these things clean is another way to keep ourselves healthy so that we can continue to provide services to our folks. Next slide.

(40:08):

Here's some examples of drug preparation equipment that if COVID-19 was on and we touched and then we went to our nose, our mouth or our eyes, we could potentially bring COVID into our bodies. Next slide, we'll skip over this one.

(40:30):

And then this last one. So talking to folks about to disinfect what they can, some things like Brillo or cotton filters can't be disinfected. So handling these with clean hands is very important. Ideally we

would use them once, dispose of them safely, and then get new ones each time we use. But if we have to reuse our pipes or stems, cleaning them with a little bleach solution, rubbing alcohol, and that includes alcohol wipes or even just good old fashioned soap and water will work. And it will also most likely disinfect for, particularly bleach, hepatitis C and HIV. And then when we're preparing our drugs on a surface, if we can create a barrier, like a sheet of paper or a newspaper that we prepare our drugs on or clean the countertop with a bleach solution, that's good harm reduction. Next slide.

(41:32):

I think this is Christine's.

(41:34):

Yeah and one thing I'll just add around disinfecting paraphernalia, et cetera, to be mindful of are the plastic baggies that your drugs are going to come in. We can't possibly know how many hands they've passed through to get to point of sale and with so few people out on the street and transactions being very public at some times, we want to make sure that folks aren't if at all possible putting those inside their bodies. In their vaginas or anus, et cetera, to try and avoid law enforcement, that can present a particular risk. But additional measures you want to take, of course, cloth face masks if you're using with others within six feet in particular and to use in the event of overdose that might require rescue breathing. Again, washing your hands, avoiding touching your face, preparing your own drugs, if and whenever possible. And because of the respiratory nature of COVID-19, trying to really avoid sharing smoking and snorting equipment in particular, if that's possible. So you can use strategies like labeling your pipes, using multicolored straws so that everyone has their own color, trying to roll smaller individual joints instead of sharing a pipe, if possible, having individual mouthpieces for your crack pipes or meth pipes if you only have one stem to share among folks, and also considering alternative routes of administration, if that's acceptable. Next slide, please.

(43:13):

Now not everyone's going to want an alternative to injecting, but they do exist. And we want to make sure that people remember that there are other ways to take their drugs, to snort, smoke, or swallow them, or to booty bump drugs if you'd prefer. For folks who are not familiar with that term, it's sometimes in other places called boofing or plugging, this is when you draw up your shot into the syringe like you would to inject, pop the needle off the top, insert the top of the syringe into your anus and depress your drugs into your body that way. Next slide please.

(43:51):

And the other thing we can help folks do is prepare for involuntary withdrawal, which could happen for a variety of reasons. Sellers also are getting exposed to a bunch of folks who might be getting sick and might become sick themselves. Their supply chain might become disrupted for various reasons. Increased police presence makes all illegal activity harder to do, right? So not just the buying and selling of drugs, but I was talking to someone recently who was sharing that they just really can't get around like they used to. If stores are closed, it makes it basically impossible to steal, right? If folks aren't on the

street, then you can't panhandle very successfully. So every sort of facet of trying to survive is being disrupted that way. If folks are on opioids, is methadone or buprenorphine an option? We know that these opioid agonist treatments are the only ones that have been found to be protective against overdose, fatal overdose. And so if folks can access methadone or buprenorphine, that's a much safer alternative. And similarly and also challenging, would a medical provider be willing to prescribe an alternative to methamphetamine? We know that Adderall is very chemically similar. This is a very challenging strategy, but as much as we can try and help folks access a safe supply, the better. Next slide, please.

(45:20):

And finally opioid at home withdrawal kits. If it's going to happen, we can try and help people get through it with as little pain as possible, even though it is not ideal. A safe supply would be ideal, right? But we can make up these kits including Immodium, Tagamet for GI distress, anti-nausea meds, and really critically Gatorade or Pedialyte that have electrolytes and can replenish you that way. Just plain old water to rehydrate as much as possible. Next slide. I think now we can open it up for folks questions or comments.

(46:04):

Thank you so much, Andrew and Christine for that really excellent overview and sharing of your experiences on the frontlines immediately in these beginning months of COVID. We are going to invite anyone who might want to raise their hand to do so, if you want to speak there should be a feature where you can raise your hand and we'll unmute you. We have a very large number of callers on the line, people in the webinars. So also would invite you either using the chat function or the Q&A function to type in questions or comments or also to share what you're seeing and experiencing at this time. Please don't be shy use the chat box. While I'm waiting for questions to come in, I'm gonna just wonder if Andrew or Christine would be willing to share a little bit about the workers in harm reduction agencies, those on the frontline. You focus understandably a lot on clients and people who use drugs at this moment who are accessing harm reduction services, but just wondering what some of the unique challenges you're seeing for those working at your harm reduction agencies at this time?

(47:37):

I can start, Christine. So we actually have one of the things that we're going to be releasing in the next week or two is a guidance for syringe service in harm reduction programs. And there's a significant amount of writing on taking care of staff. And one of the things that we've been doing here at the San Francisco AIDS Foundation, and I know it came up on a couple of other California based syringe service programs, was one way to kind of minimize the impact on our organization is to work in sort of closed distinct pods of like two, three, however number of people you are, but those are the only two to three people that you'll work with. So that way, if one of you should get sick with COVID-19, then you only need to have two people go out on self quarantine for a couple of weeks, as opposed to potentially risk exposing multiple folks throughout the team. It's actually worked really well for us at the Foundation because we've actually had a couple of instances where folks had some COVID-like symptoms, and so

we just said, 'alright, you stay home, you're good to go.' And then we contacted the person within their pod, 'you stay home too,' and then we have a new pod come in and kind of take over. So, I mean, that's one way within the practice. I think anything we can do to make sure that our staff have enough personal protective gear, which is obviously not easy. But when we're ordering supplies for our sites, and we're ordering extra hand sanitizer, bleach cleaners, and the likes so that we can give them out to our staff as well, I think would be a good one. Cause I mean, I have heard examples of places that have had to shut down services because either their staff were too sick to work or their staff had family members who were too sick, so they couldn't come into work. So anything we can do to help protect one another at home, I think is really important.

(50:02):

Thank you. I don't know Christine, if you wanted to say anything.

(50:08):

No, I think that really covers it. I think one of the challenges that is hard and there's not an easy answer to is that some of our frontline folks, our outreach workers, are at risk themselves. And I know people are having to self quarantine and are not able to go out and do the outreach that they want to, that they need to for work sometimes. And that can be really challenging both just like in your soul when you want to be doing this work and practically when you need to make money. I think the pods sort of innovation is one of our best right now.

(50:51):

One other thing that we're trying to sort of encourage, and this is not just Christine and I, like this is part of a larger harm reduction movement, but also referencing what Christine was saying, because times are really tough for our folks in terms of like just making enough money to kind of get by, if there are opportunities for us to pay our participants either by hiring them to do syringe cleanup or pay them for their expertise as consultants for making sure that we can meet people's needs. I think that would be a really important thing for us to do. And as we see new grant opportunities for COVID-19 relief and that type of thing, if we can build in some employment opportunities for our participants, I think that would be not just a nice thing to do now, but a potentially game changer going forward.

(51:58):

Thank you. There is a question from Giselle Diaz, she's asking 'same as sharing a blunt, what about sharing the hookahs nowadays that she's seen out on the streets with the COVID outbreak? Would you recommend that each person needs to use a different hookah instead of sharing?'

(52:18):

Yeah, that's that's a good question. Hookahs are such contraptions. It occurs to me that it might be hard for folks to each have their own individual hookah. That would be great. I would say it would probably be useful to change out the water pretty frequently, but one option that folks might consider is using

disposable hoses instead so that everyone can have their own hose versus just the cap that goes on it. I know I and my sister personally, just like disposable hoses anyway, because they don't get as dirty and hoses are hard to clean and all that sort of thing. So that might be something to consider is buying those disposable hoses in a bulk package.

(53:20):

That's why I love Christine. That was awesome. That was some deep hookah harm reduction knowledge. Fantastic.

(53:30):

Thank you. There's a lot of comments in the box thanking you both for the presentation. But in addition to that, Kenny Vera is asking what you consider the best option for opioid substitution therapy, especially in early treatment.

(53:51):

I open that up to anybody listening who works in OST. Are there any prescribers on the line who would like to speak to that the best option for opiate substitution therapy in early treatment? You can also use the chat box.

(54:14):

Yeah, that's a hard question because it's so individualized. I know that you have to withdraw to start Bup and all sorts of criteria. I would be curious what folks think, but methadone and buprenorphine I think are sort of gold standards at this point.

(54:34):

Yeah. We have had two people in our program successfully start Bup. They went through the suffering and they made it work. And then I do a project with Andy Talal in New York State at 12 methadone clinics. And these aren't folks who have started, these are folks who have been on methadone for the most part. And they've all been able to manage and stay on their treatment really, really well, but again around the starting I don't know. I think it is individualized.

(55:12):

Thank you. It's close to the end of our time, but just want to give one final opportunity for anyone who wanted to ask a question, make a comment, or share some experiences in your work setting. Great. Okay. So with that really want to thank you again, Andrew and Christine for this excellent presentation.

[End]