

## RESOURCES

### HARM REDUCTION COALITION

[www.harmreduction.org](http://www.harmreduction.org)

### HIV AND SUBSTANCE USE

#### NEW YORK STATE DEPARTMENT OF HEALTH—AIDS INSTITUTE

[hivguidelines.org/Content.aspx?PageID=262](http://hivguidelines.org/Content.aspx?PageID=262)

### CENTERS FOR DISEASE CONTROL & PREVENTION, HEALTH CARE SETTINGS SERVING IDU'S

[www.cdc.gov/ncidod/diseases/hepatitis/recs/idu.htm](http://www.cdc.gov/ncidod/diseases/hepatitis/recs/idu.htm)

### NYC-BASED TREATMENT REFERRALS

1-800-LIFENET

### NEW YORK CITY DEPARTMENT OF HEALTH & MENTAL HYGIENE

[www.nyc.gov/html/doh/html/home/home.shtml](http://www.nyc.gov/html/doh/html/home/home.shtml)

### NEW YORK STATE DEPARTMENT OF HEALTH

[http://nyhealth.gov/diseases/aids/harm\\_reduction/index.htm](http://nyhealth.gov/diseases/aids/harm_reduction/index.htm)

### SAMHSA DRUG & ALCOHOL TREATMENT FINDER

[dasis3.samhsa.gov](http://dasis3.samhsa.gov)

### NEW YORK STATE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES (OASAS), BUREAU OF TREATMENT

[www.oasas.state.ny.us/treatment/index.cfm#](http://www.oasas.state.ny.us/treatment/index.cfm#)

### MANUAL FOR PRIMARY CARE PROVIDERS: EFFECTIVELY CARING FOR ACTIVE SUBSTANCE USERS PREPARED FOR BY THE HIV HEALTH AND HUMAN SERVICES PLANNING COUNCIL OF NEW YORK EDITED BY RUTH FINKELSTEIN, SCD, AND SANDRA E. RAMOS, PHD

[www.nyhiv.com/pdfs/NYAMmanual.pdf](http://www.nyhiv.com/pdfs/NYAMmanual.pdf)

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REFERENCES FOR THIS BULLETIN MAY BE FOUND AT: [www.harmreduction.org/article.php?list=type&type=93](http://www.harmreduction.org/article.php?list=type&type=93)



## HARM REDUCTION COALITION

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## WORKING WITH ACTIVE DRUG USERS

CME  
ACTIVITY  
INSIDE

In New York City, there are approximately 160,000 heroin users<sup>1</sup> and about 106,000 people who inject illicit drugs.<sup>2</sup> Additionally, there are high rates of cocaine, methamphetamine and prescription opioid misuse. Substance users have high morbidity, frequently requiring health care intervention and treatment. Injection drug users are potentially at risk for HIV, HBV, HCV, soft tissue infection and endocarditis. All individuals who misuse opioids, both licit and illicit, are at risk of overdose and in NYC alone there are an estimated 700 opioid related fatalities per year.<sup>3</sup> Thus far, despite the high prevalence of substance misuse and associated sequela, the majority of medical schools do not provide adequate training on substance use nor focus on the intersection between substance misuse and co-morbidity.<sup>4</sup> Consequently, many physicians can feel unprepared to engage in frank discussion about substance use or to provide necessary health care.

The lack of formal training and the minimal attention paid to substance use often contributes to misunderstandings, negative attitudes and stigmatization of drug use and drug users. The stigmatized nature of illicit drug use is in no way limited to the medical profession; negative perceptions of drug users are quite prevalent in the general population and have serious consequences for drug user health and medical services.

### SUBSTANCE USERS AND HEALTH CARE

The literature reports that negative attitudes and beliefs coupled with a lack of knowledge of substance use can impede the development of a good therapeutic relationship and ultimately affect the quality of care that active substance users receive.<sup>5</sup> Substance use disorders are often strong predictors of fragmented health care and often reflect poorly established relationships and compromised communication.<sup>6</sup>

A recent study found that nearly a quarter of cocaine and heroin users reported that they were unable to obtain needed medical care because of their drug

use.<sup>7</sup> Perceived stigma and discrimination contributes to decreased health care utilization.<sup>8</sup> Decreased utilization can then feed into the stereotype that drug users are “non-compliant” or do not “adhere” to a medical regime, providing a rationalization for not treating substance users. In fact, numerous studies have shown that active injection drug users are both willing and capable of reducing risk behavior and engaging in medical screening and service. Data from NYC indicate that syringe exchange participants, (SEP) decreased risk behavior by 80%<sup>9</sup>, and two additional studies of SEP participants reported high rates of adherence to medical protocol: 95% return rate for TB screening<sup>10</sup> and a 83% adherence for HBV immunization.<sup>11</sup>



*“Having posters or brochures in the patient waiting area which promote health even within the context of drug use can be an effective means of indicating the clinician’s interest in discussing drug issues with patients.”*

The goal of this bulletin is to increase knowledge and awareness of substance use and substance users with the hope of facilitating communication with substance using patients. Improved communication generally facilitates more accurate diagnosis, increases likelihood of adherence and may even influence professional satisfaction.

## I. HARM REDUCTION

Harm reduction is an approach to drug use that places the overall well-being of the drug user and society, above the narrow—and frequently elusive—goal of abstinence. Harm reduction is a pragmatic approach directed towards reducing negative, social, and economic consequences associated with drug use. While harm reduction recognizes abstinence as a valuable, and in many cases a desirable outcome, harm reduction perceives drug use along a continuum. A harm reduction model requires the clinician and patient working together to formulate realistic goals that will be attainable while optimizing the patient’s health. For some users, the goal may be abstinence; however, for others,

reducing harm associated with drug use, preventing HIV or overdose, may be the most realistic option. In this bulletin, the concept of harm reduction will be discussed, and two major harm reduction interventions will be described.

### THE TENETS OF HARM REDUCTION

While there is no universally accepted definition of harm reduction, its proponents generally accept these tenets: Psychoactive substance use is ubiquitous in human society, and sanctions against the use of particular drugs are driven more by cultural values than science;<sup>12</sup> Drug users can be engaged in actively protecting their health and that of their communities by accessing services such as syringe exchange and medical care; and Many of the harms related to drug use are not due directly to the drug itself, but rather to other factors that are possible to ameliorate—such as the transmission of blood-borne diseases. Harm reduction is not antithetical to drug treatment. It addresses drug use that may occur before, after, and even during treatment.

### THE BENEFITS OF HARM REDUCTION

As stated above, abstinence is only one means of reducing drug-related harm and not all drug users are ready or able to stop using at a particular point in time. Depending on the circumstance, other goals may take precedence, such as disease prevention, treatment, safety, shelter, food, avoidance of pain (mental or physical), and pursuit of pleasure.

It is important to understand that not all drug and alcohol misuse is reflective of a disorder amenable to treatment. There is a broad continuum of substance use ranging from abstinence, to occasional or experimental (low risk), to regular/ heavy (hazardous/problematic use), to dependence and/or addiction. Regardless of the level or pattern of use, there are benefits to harm reduction interventions. Someone who has consumed a few drinks of alcohol at a party, for example, is advised to have transportation provided by a designated driver. Note the message here is not a categorical prohibition against alcohol consumption, rather we teach people to reduce harm by not drinking and driving.

### NEW YORK AND HARM REDUCTION

In 1992, the New York State Health Commissioner authorized syringe exchange programs in order to reduce the transmission of HIV among injection drug users. As of December 2007, there were seventeen such programs in New York State, thirteen in New York City. In 2001, New York State implemented the Expanded Syringe Access Demonstration Program (ESAP). Under ESAP, licensed pharmacies, health care facilities and health care practitioners who have registered with the State Health Department may sell or furnish without a prescription up to 10 syringes per transaction to persons 18 years of age or older. In 2006, New York State Department of Health, amended Public

Health Law Section 3309, Opioid Overdose Prevention. The amended PH law authorizes programs to prescribe naloxone, an opioid antagonist, to non-medical persons who in turn may administer it to individuals they believe are at risk of dying of an overdose.<sup>13</sup>

### SCREENING

Open discussion about drug use is the starting point of harm reduction. All patients should be asked about past and current alcohol and other drug use during their initial visit. Screening should be repeated periodically to ensure that the clinician has reasonably accurate and up-to-date information for providing patient care. Disclosure of substance-use-related information, however, can be inhibited—or result in negative experiences for the drug user—if one or more of these factors is present:

- There is no foundation of trust between the clinician and the patient;
- The clinician is perceived as judging the patient because of the substance use; or
- The patient believes that the clinician has nothing to offer beyond abstinence-based options which the patient may not be ready to pursue.

By being mindful of these factors, the clinician can help create an environment where a candid discussion of both the benefits and harms of substance use may take place. Having posters or brochures in the patient waiting area which promote health even within the context of drug use can be an effective means of indicating the clinician’s interest and willingness in discussing drug issues.

### EDUCATION

Education is the backbone of harm reduction. When substance users are educated about risks, as well as provided with the tools to facilitate risk reductions,

such as sterile syringes, the majority of users choose to alter their drug-using behaviors, decreasing the rate of HIV transmission.<sup>14</sup>

#### What clinicians should know when working with drug users:

- The actual risks associated with use of specific substances. Exaggerated or unfounded claims regarding the consequences of drug use may compromise trust between the clinician and the drug-using patient, and can jeopardize good patient care.
- Strategies to reduce the harms of these substances. Abstinence is one of many approaches to be considered within a harm reduction framework. Others include moderating usage (frequency of use; amount of substance used; changing route of administration) or taking other measures that lessen the harms of drug use. For the drug-injecting patient, it is essential to provide information regarding options for accessing sterile syringes. This information is also useful for the families and friends of drug users. Additional helpful information include:
  - ◆ The treatment and counseling options that are available, including their potential benefits and limitations.
  - ◆ The importance of seeing things from the patient’s perspective and learning from their experience.
- Education in a clinical setting should be bi-directional. The drug-using patient may have novel harm reduction practices which the clinician may have been previously been unaware of. Providers should be willing to learn from their patients.

#### ADHERENCE

There is often concern that as a rule, drug users are

unable to properly adhere to medications. Research has shown that many active drug users living with HIV or Hepatitis C can successfully adhere to medication regimes<sup>15, 16, 17, 18, 19</sup> however, little has been documented on what distinguishes successfully adherent drug users from others. The patient-provider relationship is one of the several factors thought to contribute to adherence; including open discussions about substance use.<sup>20</sup>

## II. HARM REDUCTION AS AN APPROACH TO OPIOID ADDICTION AND INJECTION DRUG USERS

There are many harm reduction interventions/strategies; two are discussed here: 1) syringe access/exchange and 2) opioid overdose prevention. While this bulletin focuses on opioid use, access to sterile syringes is a key component of harm reduction for all injectors including those who use cocaine, methamphetamine, steroids, and “club drugs.” Also, overdose prevention programs for opioid users are feasible, as well as safe; there is also increasing evidence that they are effective.

### 1. SYRINGE ACCESS

The use of sterile injection equipment is central to the prevention of blood-borne infections among drug injectors. The dramatically declining rate of HIV infection among IDUs in New York City is good evidence of this. In 1990, 54% of IDUs were HIV-positive. In 1992, the first legal syringe exchange program began operations. By 2001, the HIV prevalence among IDUs was reduced to 13%. Similarly with HCV, the prevalence among recent IDUs (<5 years of injection history) dropped from 71% to 38%.<sup>14</sup> A preponderance of evidence finds that increased access to syringes does not increase

drug use among users or encourage injection among non-injectors.<sup>21</sup> Many health-related organizations have recognized the value of sterile syringe access and have called for the elimination of barriers.<sup>22</sup> See Table 1.

#### TABLE 1. PROPER DISPOSAL OF USED SYRINGES AND NEEDLES.

- Hospitals accept used syringes and needles. Syringe exchange programs in New York State can dispose of your used syringes. Call ahead for hours and location.
- Put used syringes in an unbreakable plastic bottle, such as a laundry detergent or bleach bottle, label the container: “Contains Sharps” for disposal in trash—not with recyclable plastics.

#### DISCUSSING INJECTION PRACTICES

In addition to preventing blood-borne diseases, facilitating access to sterile syringes, whether by direct distribution or referral, encourages honest discussion between practitioner and patient.<sup>23</sup> Physicians are in a particularly strong position to discuss safe injection practices. Patients have limited opportunities to discuss injection practices and are likely open to a direct and knowledgeable conversation. It is also possible that the provider may derive a level of satisfaction from offering valued advice.

#### LEGALLY OBTAINING SYRINGES

There are several options for legal access to sterile syringes in New York State: pharmacies, syringe exchange programs, and clinician distribution or syringe prescription.

#### PHARMACY SALES

The New York State Expanded Syringe Access

Program (ESAP) allows pharmacies that register with the state health department to sell up to 10 syringes during any one encounter to persons 18 years of age or older. To date, over 3,000 pharmacies throughout New York State have been authorized to sell syringes under ESAP. Pharmacies are appropriate sites as their staff of trained health care professionals can offer health education to customers. Pharmacy sales are part of a low-threshold intervention in that syringes are available anonymously on a walk-in basis. Syringe access through pharmacies has been evaluated and found to be effective in reducing risky injection behaviors without negatively impacting the communities in which these programs operate.<sup>24, 25, 26</sup>

#### SYRINGE EXCHANGE

New York state has 17 legal SEPs: 13 are in New York City, and there is one in each of the following cities: Buffalo, Ithaca, Mount Vernon, and Rochester. SEPs are staffed by persons who are trained in harm reduction and who have significant expertise in the issues facing injecting drug users. Syringe exchange has been evaluated and has been found to be an effective means of disease prevention.<sup>24</sup> In addition to syringe availability, users may also receive a wide variety of services<sup>27</sup> such as:

- Education about safer injection
- Non-coercive referrals to drug treatment
- Onsite medical care and referrals to outside medical care
- Mental health services
- Public health prevention intervention such as Hepatitis screening and vaccination
- Acupuncture
- Nutrition services
- Access to safe syringe disposal
- Condoms
- Education about safer sex practices
- On-site HIV counseling and testing, or referral to

these services

- Education about overdose and training in reversing overdoses

#### NON-PHARMACY EXPANDED SYRINGE ACCESS PROGRAMS

Under the Expanded Syringe Access Demonstration Program, hospitals, clinics, and health care practitioners who are otherwise authorized to prescribe syringes may furnish up to 10 syringes at an encounter, without a prescription, to persons 18 years of age or older. In addition to doing this in health care settings, ESAP-registered health care practitioners, of which there are more than 30 in New York state, may conduct outreach and furnish syringes in communities—including those not served by SEPs.

#### SYRINGES FURNISHED BY HEALTH CARE PRACTITIONERS

There are two ways in which health care practitioners may furnish syringes in New York State: through ESAP, which requires registration with the New York State Department of Health, and by prescribing them.<sup>28</sup> Prescription of syringes by a clinician has the advantage of offering counseling within the privacy of a medical office.

Information of safer injection can be found at:  
[www.harmreduction.org/downloads/idu\\_manual.pdf](http://www.harmreduction.org/downloads/idu_manual.pdf)

#### Syringe DISPOSAL

Proper syringe disposal is also part of the ESAP initiative. To dispose of used syringes and needles safely, see Table 2.

Information on syringe access and disposal sites can be found at:  
[www.nyc.gov/html/doh/html/hlthtops/hlthtops.shtml#s](http://www.nyc.gov/html/doh/html/hlthtops/hlthtops.shtml#s)

#### TABLE 2. OVERDOSE RESPONDERS CAN BE TRAINED IN ONE SESSION LASTING 10-20 MINUTES. ELEMENTS OF THE TRAINING INCLUDE THE FOLLOWING:

##### I. Understanding the factors that make one more susceptible to a fatal overdose:

- reduced tolerance
- mixing drugs
- using alone

##### II. Recognizing the signs/indications of an overdose

- failure to respond to a sternal rub
- bluish tinge to lips

##### III. Reacting/responding to an overdose by:

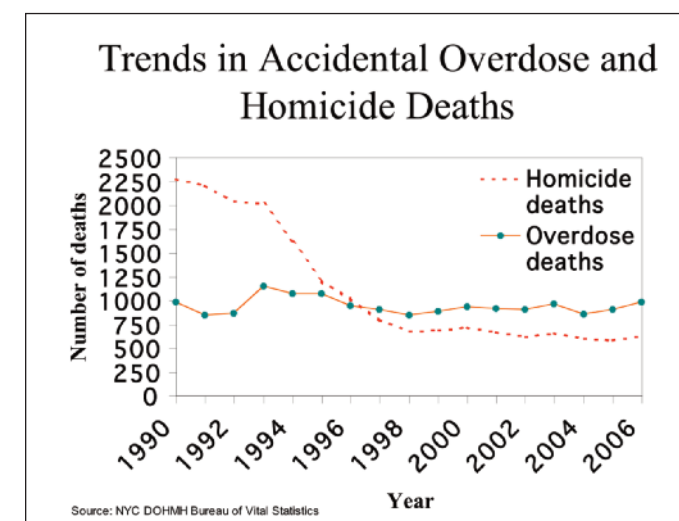
- calling 911
- using mouth-to-mouth resuscitation if breathing has stopped
- administering 1-2 doses of naloxone intramuscularly
- staying with overdoser until EMS arrives

A complete PowerPoint of the training can be found at:  
[www.harmreduction.org/OVERDOSE/ppt/SKOOOP/OverviewOfOverdose.ppt](http://www.harmreduction.org/OVERDOSE/ppt/SKOOOP/OverviewOfOverdose.ppt)

## 2. OVERDOSE PREVENTION

### EPIDEMIOLOGY

Opioid overdose is a major public health problem, in New York City there are an estimated 700 per year or two per day; more overdose fatalities each year than murders or suicides. Drug-related overdose is the fourth leading cause of death among adults under the age of 65. Fatalities are most common among persons with a history of chronic use and after periods of abstinence; therefore, people coming out of drug treatment, detoxification, or incarceration may be particularly vulnerable. The majority of overdose fatalities occur when users combine opioids with depressants such as alcohol, benzodiazepines, tricyclic antidepressants, or stimulants such as cocaine.<sup>29</sup> Persons who have had an overdose in the past are also at increased risk of future overdoses.<sup>30</sup>



Opioid overdose leads to death by respiratory depression, usually taking 1 to 3 hours.<sup>29</sup> Studies report that the vast majority of overdose incidents are witnessed by a bystander, providing an opportunity for overdose prevention training to help reduce mortality rates. Naloxone, an opioid

antagonist used for decades by professional medical emergency responders (emergency medical technicians and paramedics) is a safe and effective agent that reverses the effects of an opioid overdose when administered in a timely manner.<sup>31</sup> In the United States naloxone requires a prescription for dispensing; however, recently a few cities, including NYC, have piloted naloxone distribution in an attempt to prevent fatal overdose.

### NALOXONE INTERVENTION

- It is legal for a non-medical person (someone other than a professional medical emergency responder or a clinician) who has been trained through a program registered with the New York State Department of Health to receive and administer naloxone to a person suspected to be at risk of death from an opioid overdose.
- Entities eligible to implement opioid overdose prevention programs are: health care facilities, health care practitioners, drug treatment programs, not-for-profit community-based organizations, and local health departments.
- Several opioid overdose prevention programs have already been implemented throughout New York State.

### NALOXONE

Naloxone is an opioid antagonist which may be administered by injection (intramuscular, subcutaneous, or intravenous) or intranasally. Intranasal administration is currently considered an off-label use of naloxone. For 30-90 minutes after administration, naloxone displaces opioids from receptors in the brain, reversing their effects, including the respiratory depression which places an individual at risk for death or brain injury. Naloxone rarely has negative effects other than inducing opioid withdrawal symptoms in individuals dependent on

TABLE 3. <sup>37</sup>

## PRINCIPLES FOR MANAGING HEALTH CARE RELATIONSHIPS WITH SUBSTANCE-USING PATIENTS

1. Establish a climate of mutual respect.
2. Maintain a professional approach that reflects the aim of enhancing patients' well-being; avoid creating an atmosphere of blame or judgment.
3. Educate patients about their medical status, proposed treatments, and their side effects.
4. Include patients in decision-making.
5. If possible, establish a multidisciplinary team consisting of primary care physicians, HIV specialists, psychiatrists, social workers, and nurses.
6. Have a single primary care provider coordinate the care delivered by such a team to maximize consistency and continuity.
7. Define and agree on the roles and responsibilities of both the health care team and the patient.
8. Set appropriate limits and respond consistently to behavior that violates those limits.
9. Minimize barriers to participation (penalties for missed visits, etc).
10. Recognize that patients must set their own goals for behavior change; work with patients to achieve commitment to realistic goals for healthier behaviors.
11. Acknowledge that abstinence is not always a realistic goal; emphasize risk reduction measures for patients who continue to use drugs.
12. Acknowledge that sustaining abstinence is difficult, and that success may require several attempts.
13. Be familiar with local resources for the treatment of drug users.

this class of substances.<sup>32</sup> Withdrawal symptoms include agitation, vomiting, and diarrhea. Seizures are also a possibility, but they are rare. The safety profile in the community setting with training and distribution of naloxone appears to be high. Of 319 reported reversals in the field, adverse events included one unsuccessful administration, one seizure and one episode of vomiting.<sup>33</sup>

### MEDICATION ASSISTED TREATMENT

Opioid maintenance with methadone or buprenorphine is not only highly effective in HIV prevention,<sup>34</sup> but it is also highly effective in preventing heroin overdoses. Methadone patients have been shown to have overdose deaths four fold lower than users not in treatment.<sup>35</sup> When France instituted treatment of heroin addiction with buprenorphine and methadone, their overdose rates decreased by 79%.<sup>36</sup>

Information on overdose prevention can be found at:

[www.nyhealth.gov](http://www.nyhealth.gov)

Click on HIV/AIDS

Click on Harm Reduction & Drug Use

Click on Overdose Prevention

[www.nyhealth.gov/diseases/aids/harm\\_reduction/opioidprevention/index.htm](http://www.nyhealth.gov/diseases/aids/harm_reduction/opioidprevention/index.htm)

[www.harmreduction.org/article.php?list=type&ctype=51](http://www.harmreduction.org/article.php?list=type&ctype=51)

### 3. THE ROLE OF THE CLINICIAN

- Implement opioid overdose prevention programs by registering with the New York State Department of Health, or become an affiliated prescriber with another registered program.
- Counsel opioid-using patients as well as family and friends of users regarding risks of overdose risk.
- Counsel patients on where to obtain sterile syringes.
- Prescribe or dispense sterile syringes
- Advise users not to share any injection equipment including water, cookers and cotton
- Advise users to clean skin and hands before injection
- Advise syringe users about safe disposal
- Become familiar with the pharmacology and modes of administration of substances patients may be using
- Become certified to prescribe buprenorphine
- Consider the role that his or her personal experience and attitudes may contribute to hindering the engagement of a drug user

### CONCLUSIONS

An understanding of harm reduction can expand the options a clinician has in caring for drug-using patients. This, in turn, should lead to improved communication between the clinician and patient, and increased health benefits. These interventions may also increase the satisfaction of the clinician caring for drug users as mutually desirable goals are reached.

## PERSONAL PERSPECTIVES

For me Syringe Exchange Programs are a place where the active drug user can go and get new syringes without being judged, even though I have to say, sometimes I was ashamed and I didn't want anyone to see me going in to get my needles, but it helped me from having to buy them a lot more in the streets. When my addiction took over I became homeless. When I was in the street, I remember a program that used to provide needles and they also gave sandwiches and juice. It was them and another agency that came and gave condoms and bleach kits and they would talk to us and treat us with respect. Years later when I decided to get clean I went to this program and they sent me to detox and when I came out, I decided to change my life around. I went to trainings where they trained me to be a peer educator, because I wanted to do something for the people that are out in the streets. The syringe exchange helped me to protect myself from HIV and HCV for many years. Today I am grateful for those who do the work that others think is nasty. Today I live with HIV, yet I work in a Syringe Exchange Program and let active users know that they have a place where they can always get new syringes. I like to give the help that was given to me by an outreach worker/peer educator. Today I am a recovering addict that likes to help others that are not ready to stop, due to the fact that harm reduction will meet you where you are at.

*Diovigilda, 46*

A while back my wife became very sick and ended up in the hospital and started taking medications that contained opioids, (hydrocodone, darvon, oxycodone) and pills for sleeping. She often took over the amount the doctor asked her to take and she also would drink beer with the medications. Often I would find her passed out somewhere in our home. One morning I came home from my overnight job to find my dear wife passed out on the kitchen floor, refrigerator open, water running over the sink to the floor. Good thing a couple of weeks earlier a program had given my peers and I training on Opioid Overdose Prevention. Now was the time to see what I had learned. I was calling her name while checking her pulse and getting no response. So I took my knuckles pressed them down the center of her chest, hard. I held her neck at an angle so I could blow air into her mouth. No response, so I gave her a shot of Narcan from the packet I had received from my training. I called for help. To my surprise, when help came, my wife's eyes were wide open, looking like she had not taken anything. Later, the doctor she was seeing talked to us about this new medication called "Buprenorphine" and she started taking it. That's been over a year ago and you know what, I have not found her passed out ever since.

*Ricky, 54*

For many years, I was an IV drug user. Heroin was my drug of choice. Before my HIV+ diagnosis in 1988, I never revealed my drug use myself. I always noticed the change in a doctor's demeanor, whether it was fear of leaving me alone in his office with his injection equipment and prescription pads, or by the way he talked to me. There was a difference once they found out. They just don't talk to you the same. But you can feel when a person is disrespecting you by his manner (actions, tone of voice, and choice of words). I've had physicians talk down to me as if I were a child or wasn't capable of processing the information. So of course, right away, my defense mechanism was armed and ready. I became very combative and shut down. In 1997 I met a doctor that I am still with today. Over 60% of his patients were addicted to one drug or another, but he gave respect for his patients no matter their situation in life. He held groups on HIV-101 and adherence issue groups. By organizing groups, other doctors soon followed his lead and things improved within the clinic. Upon learning things about my disease and the medications I was taking, I became more interested in my treatment. By understanding my virus and the medications I was taking, staying undetectable became easier.

Understanding that, led me to want to learn more and be able to share that knowledge with others by becoming a Peer Educator. Since then, my life changed for the better and I made the decision to share my education and knowledge of the virus with others. I owe a lot of the decision in part to my health care provider who opened that door for me, in order to pass through and pass it on to others and pull them through with me.

*Donald, 62*

When I was younger and not injecting heroin, but more of a casual user I was living up in Spanish Harlem in the late 1980's. I was there when my girlfriend had just finished fixing up and then she just went limp and white in color. Everyone jumped up and started smacking her, shaking her, screaming at her. One suggested putting ice down her pants and shirt, one started dragging her to the bathtub, someone was yelling for some salt or milk to inject into her. She just got bluer and bluer. When the sound of a siren started to draw close, everyone grabbed their gear and started running down the fire escape. The EMT's did their job like clockwork, probably doing this for the hundredth time. They gave her Narcan, and almost immediately she changed color and her eyes opened. That was the coolest thing I had ever seen. So years later when I dropped into a local needle exchange program and saw they were offering training and a Narcan kit, I signed up. Now that I am doing street outreach, that kit has saved a lot of people. If it wasn't for harm reduction, educating those who are using drugs, I don't think too many drug users would get a second chance.

*Liam, 38*