Transcript: Prevention's Role in Harm Reduction

Presenters: Kris Gabrielsen and Chuck Klevgaard
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JENNIFER WINSLOW: Welcome, everyone. We're going to just take a minute and let everybody come in and, we'll be beginning shortly. Welcome, everyone, to today's webinar, Understanding Prevention's Role in Harm Reduction, with our presenters Kris Gabrielsen and Chuck Klevgaard.

Today's presentation is sponsored by the Great Lakes PTTC and SAMHSA, the Great Lakes ATTC, MHTTC, and PTTC are funded by SAMHSA under the following cooperative agreements. The opinions expressed in this webinar are the views of the speakers, and do not reflect the official position of the Department of Health and Human Services, and SAMHSA.

The PTTC network uses affirming language to promote the application of evidence based and culturally informed practices. We ask that participants reflect on and apply this to today's dialogue. We have a few housekeeping items. If you are having technical issues, please individually message Kristina Spannbauer or Stephanie Behlman in the chat section, and they will be happy to assist you. The workbook in the chat is for you to download. We will be using it during the training today. We will be using automated transcriptions for today's webinar.

The recording of this training and the workbook will be available on our website. It normally takes seven to 10 days for it to be posted. You'll be sent a link after the presentation to a very short survey. We would really appreciate it if you could fill it out. It takes about three minutes.

Certificates of attendance will be sent out to all who attend the live session in full. A link to your certificate will be sent to your email. If you'd like to know more about what we are doing, or information on upcoming events, please see our social media pages.

Our speakers today are Kris Gabrielsen and Chuck Klevgaard.

Chuck Klevgaard serves as prevention manager for the Great Lakes Prevention Technology Transfer Center. He delivers training and technical assistance to support substance misuse prevention throughout the Midwest. Chuck has supported communities and health agencies as they adopt

evidence based alcohol, opioid, and other substance misuse programs or policies. Chuck earned his BSW from Minnesota State University Moorhead. He is a Certified Senior Prevention Specialist through the Illinois Certification Board.

Kris Gabrielsen is the Co-Director of the Great Lakes PTTC. She has worked in the substance misuse prevention field for over 30 years. She was the Associate Director of the Western Center for the Application of Prevention Technologies, co-authored the first substance abuse prevention specialist training curriculum, and co-authored the textbook, Substance Abuse Prevention, The Intersection of Science and Practice. She has worked with states and communities across the nation to bridge the gap between research and practice, assisting prevention professionals and maximizing their effectiveness.

Welcome, Kris and Chuck. And I'll turn it over to you.

KRIS GABRIELSEN: Thanks so much. Well, welcome everybody. So glad you are here. Chuck and I are very pleased to be able to have this opportunity to talk with you all about substance misuse prevention's role in harm reduction. This has become a very hot topic very quickly. And I know in our discussions with prevention folks across our region, there's a lot of confusion about well, what does prevention do with harm reduction? Is this something we are supposed to be doing, not doing, do it together? What do we do?

So we thought we'd pull this together to help clarify at least at this moment in time, as best the knowledge that we have that can help us move forward on this issue. So we are going to start off with a poll. We would love for you to share with us how much knowledge and experience do you have with the field of harm reduction? Do you have a lot, some, a little, none? This will help us get an idea of who we have on here with us in terms of this webinar.

All right. And we'll give about 10 more seconds. We have most of you participated. All right. Jenn, if you could go ahead and share the results. Great. So looks like we're pretty much in the middle. There's a few of you have a lot, and a few of you have none, but with some and a little, we have a pretty close to a bell curve there. So that's great to know. Thank you.

All right. And I'm going to go ahead and stop sharing that. So with that information, let's take a look at what we are planning, what we have ready to share with you all in terms of the type of training that we have put together. And I'm going to say, at the same time as I go over these learning objectives, in the chat box has been put the participant workbook for this webinar.

We can go ahead and post that again. I know I don't have my chat box up at the moment. But if you all could post that again, if you haven't opened it up yet, please open up that workbook. If you have a printer handy and want to print it out, you're welcome to do that. But that will help you follow along with what we're doing. We also had the PowerPoint slides available for you as well. So please know that that is available for you.

Also, there is a Q&A pod on this webinar. So if you have questions for Chuck or myself, please put those in the Q&A pod. We have quite a few folks here on the webinar. So if you post your questions in the chat, they very likely will get lost. Because there's just quite a bit going on in the chat. So use that Q&A box for questions.

All right. With that information, so what we are hoping you all will walk out of here today with is, you will be able to have a clear definition and understanding of harm reduction.

Secondly, that you will be able to identify the role that harm reduction plays in a comprehensive approach to addressing substance misuse and substance use disorders.

And third, we want you to be able to walk out of here today, or walk out isn't quite right, since we're virtual, but close out of this Zoom webinar today being able to name some prevention strategies that you can implement to help enhance the harm reduction efforts in your community.

So as we're thinking about this, there can be quite a few emotions that arise when we hear the term harm reduction, especially if you're somebody who's been working in the primary prevention field for quite a while. So I'd love for you to post in the chat box what emotion arises for you when you hear the term harm reduction. Go ahead and take a moment to put that in there.

So when somebody says harm reduction, what does that elicit?

Hope, relief, happy, frustration, safety, curiosity. Love these. Better, compassion. Huh? Somebody's like, huh? I like that. It's about time, non-judgmental. So again, all the kinds of emotions. I hope you all are reading through the chat. It just elicits so many emotions in us. Isn't that amazing how two words can elicit these kinds of emotions? That's pretty amazing, isn't it?

So what we would you like you to do is think about what word you have posted in there, and see if that changes over the course of the next hour and 20 minutes or so. And then we're going to check in with you about it again towards the end of the webinar. So thank you for posting in the chat all of you who did.

Chuck, did you have anything to add about that?

CHUCK KLEVGAARD: I think that makes sense. We do want to circle back and kind of get a sense for how we can have this conversation in lots of different places, and to help you to be able to do that. We think it's important to acknowledge how people think about and feel about this issue. Because we come from different places and different points in time, different parts of the country, different segments, different settings. So we appreciate you taking this moment to share your emotion with us, because we think it's a valuable part of the process of building literacy around harm reduction.

KRIS GABRIELSEN: Thanks, Chuck. All right. So we are going to show you a short video here in just a moment. And what we would like you to do as you're listening to this video is, listen for examples of harm reduction you yourself have experienced. All right. So just take me just a moment. I'm not going to play the full video, but I'll play most of it for you.

NARRATOR: Look, you're smart. You're cool. And you don't want to die. So you do things to reduce the harm of the risks you take. That's called harm reduction. It's all around us.

[MUSIC PLAYING]

MAN: Taxi.

NARRATOR: Harm reduction is common sense. It stops people from being injured and dying from things that are preventable. It saves lives. It saves money. It's smart. Here's a fact, last year, 47,000 people died of drug overdoses in the United States. Because you're smart, you know these deaths are preventable. But here's something you may not know, some kinds of prevention don't work.

[MUSIC PLAYING]

MAN: Just say no.

POLICE OFFICER: Who taught you how to do this?

MAN: Any questions?

MAN: It's time to stop the drugs.

NARRATOR: We've tried all these things, and still, the number of people dying of overdoses continues to rise. But remember, you're smart. And because you're smart, you want to stop these preventable deaths. Do you know what is clinically proven to work? Harm reduction. You remember that, right? Harm reduction works for people who use drugs. It knows that people aren't perfect, but they deserve every opportunity to be as safe as possible.

KRIS GABRIELSEN: All right. We will end there. So I would like you to go ahead and take a moment and put it in the chat box what are some of the harm reduction strategies that were shared in the video that you yourself have actually experienced, that you've done? Go ahead and put that. Absolutely, seat belts, sunscreen, D.A.R.E. That was an ineffective. Yeah, vaccines. Great, airbags. Yep, hard hats. Somebody actually used a hard hat, great. Healthy meal choices, absolutely.

So when we talk about harm reduction, we often think of it as this new territory that we've never experienced before, and that can be an initial reaction. When in reality, we do a lot of things in our everyday lives that are actually harm reduction strategies.

So thinking about that, I'm going to go ahead and hand it over to Chuck, who's going to go through and give you more specific definitions in terms of when we're talking about harm reduction with substance misuse, substance use.

CHUCK KLEVGAARD: Cool. You can move the slide for me. Thanks, Kris. One of the things that Kris and I wanted to do as we thought about putting this together for you all is to not just kind of help give you talking points and become literate, but to give you ways to talk with your staff, with your coalition, with other folks in your agency, or in your bureau, being able to give you language to be able to articulate what it is and how it fits. So I think that last sort of quick video helps people understand that it isn't unfamiliar to folks.

It's something that may not have been in the realm of prevention strategies that you implement in your organization, or on your task force, or in your committee. But they are absolutely sort of concepts, ways of thinking about doing the work that we all can get familiar with if we build on stuff that people already know. So really, it's a set of practical strategies aimed at reducing negative consequences.

So you saw in that video that it has to do with the kinds of things that we do to keep people safe, or to keep people from dying in the most extreme case. Most of the folks that I understand and have worked with over many years that work in harm reduction also are really very much sort of advocates for social justice, working on the rights of people, working in the realm as somebody typed in the chat, some of the words that came up, hope and compassion, and respect for humanity and dignity are all some of the things we'll talk about in a few moments a little bit more.

Kris, if you click a few more times, a few sentences that I think makes sense to me in thinking about what we just heard that are good points to make when you talk with your colleagues, is to make the case as they did in the video, that all life activities carry some risk.

There's very few things we can do leaving our house, and in some cases, not leaving our house that don't carry some risks. And so know that our society has been built around providing safety nets, guardrails, or even ways to rescue and support people isn't an unfamiliar or new thing at all. So as we move some of those same things into the world of overdose prevention, or harm reduction more broadly, the sort of ideas of guardrail, safety nets, and rescue antidotes become more familiar territory.

The other point I think is important to cover with folks as you're talking with folks who may be less familiar, one of the goals of harm reduction is, as we've talked about, to reduce danger, consequences, harm, or death, that it isn't necessarily about the complete elimination of that risky behavior. For many folks who benefit from harm reduction, or folks who implement strategies don't necessarily come from the position that we're trying to completely eliminate risk. Often, that's not attainable. And for some folks, it isn't desirable at the time.

So we'll kind of, again, sort of come back at that with some nuance being able to talk about what do we mean by the sort of timeliness of something. I think that change in the world of harm reduction is much more incremental. It isn't about getting somebody to treatment today or moving somebody completely out of danger for all times in the future. It's definitely more incremental, and more about safety in the moment.

So next slide.

So we'll cover a couple of things. And again, in that sort of literacy of understanding the roles, we'll talk about the focus of working with that population of folks that are actively using or actively drinking. We'll kind of broaden that out so that we can clarify what that scope is.

I want to give you a brief history in that my exposure to harm reduction happened in about 2006. And I'll tell you what that was like back in those days, and how different it is now, and why it's so important to kind of acknowledge and understand that history. We'll talk about some of the principles, and give you a chance to get a feel for listening for how those principles become activated in strategies.

And we'll, again, give you an example of some of the range of strategies that are in place so that you get a feel for the types of things that are happening. Again, we're talking about everything from the sort of safety measures, to risk mitigation, to preventing death. So there's a whole bunch of stuff that fits in those different categories.

So moving first into this focus question, so people who are actively using, for lots of us, that feels like unfamiliar territory. If we've done prevention work for 20 or 30 years, have I ever worked directly with folks in a way that are continuing to actively use, and it isn't my goal to get them to stop. That feels really unfamiliar. Giving people that sense of understanding that that is the population that we're focused on now would include folks who might be using alcohol in harmful ways.

And so know that, again, historically, folks who've done this work have worked with folks in lots of different settings. It's sort of early work of harm reduction folks, worked with folks who are actively injecting. So hence, the sort of arrival of syringe exchange programs for example, because of populations that were engaging in behaviors that were harmful, risky, dangerous. So in this case, we're talking about people who are actively using. What we're going to focus on more specifically on behaviors that are in fact, presenting risk, or harm, or danger in that case.

So with that in mind, have the conversation with folks about what does that feel like to work with people who are actively using? Does it feel similar in some ways to working with folks with lived experience? That's at least one familiar sort of place where folks are feeling like for years prevention has

worked with different populations to better understand the ways in which we need to hear perspectives, and understand the ways in which people are impacted by prevention services.

So I think helping develop that common ground, but make the case. We're talking about working directly with folks who are using. And we're talking about, again, sort of using actively with different drugs. We're talking about legal and illicit drugs. We're talking about harmful drinking with alcohol as well. Sort of lots of areas to make sure we cover when you talk about the population that we're focused on. All right. So next slide.

Give you this sort of brief history, remember, my exposure was sort of mid-2000. I can tell you, in those days, we were working in a SAMHSA funded initiative on discretionary initiative back in the days. So those of you who've been in the field long enough to remember what was called SPF SIG. So it was the sort of next iteration of the strategic prevention framework as it was rolled out for the first time back in the late '90s, early 2000. So this was a state incentive grant process, and states were encouraged to look at consequences, to look at the issues where alcohol, or other drug use was presenting very specific kinds of consequences.

So I was working in Massachusetts. Massachusetts chose to prioritize based on the data that drove them there, that overdose in the mid-2000s was the leading cause of death for a specific population in Massachusetts. I can tell you that while we were encouraged to do that, there were still significant barriers to being able to utilize federal funding for things like naloxone. That was not allowed. You weren't allowed to even talk about harm reduction. You could use risk mitigation in some conversations, but it was difficult to be able to even use the language of harm reduction in federal proposals. And you definitely couldn't use federal money to purchase some of the strategies, including antidotes for naloxone reversal.

So in those early years, there were barriers to funding. There were barriers to being able to do research and evaluation. There was certainly a lot of demonization of specific drugs in the mid-2000s and well into the last decade, and lots of stigmatization of the groups that we're using. So we know those were hallmarks of that sort of early years.

In addition, and I would say that continues today, depending on where you live in the country, there was still a lot of political resistance and criminalization of services. Watching Jake Tapper on CNN yesterday cover a big story about supervised injection sites, wouldn't have seen that even five years ago on even a cable news network channel of presenting that in a

positive way as a way of saving lives in a national arena, where again, sort of initiatives were being talked about in that same context.

So I also want to say, decades of activists cooperating with researchers. So to say that there hasn't been evidence based approaches in the field until recently is not true. The earliest work that was being done by activists, and again, sort of some of that starting in urban areas like Baltimore, and San Francisco, and Chicago. Early on, folks were working with researchers to try to determine the effectiveness, to determine the impact of harm reduction.

So if that's in a nutshell the early years, what's happened more recently is escalated really rapidly, the American Medical Association determining that harm reduction organizations provide essential services during the pandemic was a major sort of hallmark of wow, we've come a long way in just a short period of time. A lot of institutional endorsements and federal funding being able to use federal money to not only buy naloxone, but as more recently, to be able to use federal money to buy fentanyl test strips for example. And I apologize if I'm using jargon that's less familiar to people. We'll come back at some of these strategies in a few moments.

But know that, again, this sort of huge announcement about SAMHSA putting out 30 million in a harm reduction grant is major headway in terms of recognizing the fact that harm reduction is important. It's an important aspect of the work that we do, and that it's effective. And that the sort of endorsement of federal organizations, including the Biden administration, recognizing that harm reduction plays a role. Seeing the first ever sort of harm reduction technical assistance center also was an exciting thing to see, having done the work since the mid 2000's to feel like that folks were really on their own to find one another.

Again, sort of as we came to do the work in Massachusetts, we had to find out where folks were doing this work. We called people in Chicago. We called people in Baltimore. We called people in San Francisco and said, can you help us? We don't know how to do this, and found lots of support that way. Whereas now, having an organized TA center is amazing. That's a huge sort of difference in where we stand right now.

Now, all of this said, talking about this history is key. And where you live some of these things are still actively going on. Again, political resistance, demonization of drugs, and stigmatization of groups didn't go away. It was certainly something that prevented us from even doing this work in the 2000's. But it's still depending on, again, where you live, and what organization you're part of, those are still things that you'll want to be able to work against with education and awareness. All right, next slide.

So thinking about principles, you heard folks in the chat sort of typing in words. A lot of the words that I saw up in the chat are actually some of the principles that guide this work. So in addition to the fact that it's based on working with active users and reducing risk, or consequence, or harm, or death, that it's really very much guided by principles.

So starting with the non-judgmental approach, meaning that meeting people where they are is a part of that process. But also coming at it from the standpoint of you may have an opioid use disorder, and I'm

not judging you for the fact that you're using, and that you need this help right now.

So it's nonjudgmental. It's certainly evidence based, feasible, and cost effective. We know, again, some of the real basic costs associated with doing a reversal are in the dollar range, $2 range. Doing test strips might be something that you can do. Again, what price would you put on being able to save a life I think is one of the ways that it's important to frame for people.

And when we look at the fact that I think that prevention in the early days of sort of 2010, 2020, folks were still worried about the fact that so much money that was earmarked for prevention was going into what they thought of as treatment, or harm reduction.

So are the resources scarce? I think that right now, there's a tremendous amount of resources flowing out from the federal government to be able to deal with this sort of dual epidemics that we have going on at the same time.

So I think being able to talk about it as cost effective and evidence-based is really an important point to make. It's acceptance as incremental. So remember that that's what I said a minute ago, that principle of you're not making a referral to treatment. That isn't necessarily the goal of harm reduction. It's to be able to meet somebody where they're at, help them be able to understand how they can be safe, how they can prevent the harm or danger that they might be presenting in the way that they might be using, and also, to be able to meet them if they are ready to be able to move toward getting help, whether that's social services, whether that's housing, whether that's food, or in the case of someone who's ready to go to treatment, to know how to do that, or even how to get Suboxone so that they can feel more comfortable being able to get themselves ready to go to treatment.

So meaningful participation of drug users, former drug users, stakeholders in terms of being able to utilize, and partner, and collaborate directly with the community of folks to be able to change conditions in the community, to be able to work on all kinds of issues.

Remember again, I'm talking about some of the folks who maybe have moved into harm reduction may have come from a place where they at one time were active users, and are now the strongest advocates for affordable housing in the communities that they live in terms of changing conditions in significant meaningful ways by partnering directly with folks with lived experience, and currently active lived experience as well part of getting comfortable with that.

The next set of principles, enhancing quality of life, not abstinence. So again, you hear the goal isn't about abstinence. And being able to talk directly with prevention staff about that is really key. If I've spent my whole career focusing on underage drinking, and abstinence has always been the goal and the messaging, getting comfortable being able to say that's not what this work is about. This work is again, about preventing harm to helping folks have a quality of life, not necessarily the specific type of lifestyle that you recognize or feel like would be valuable for your work.

Recognition of complex social factors has always been part of that, of understanding that again, all kinds of community conditions, determinants, different factors place people at risk to be involved with use, as well sort of everything from the biology to policy, and everything in between impacts the ways that folks get involved with and develop alcohol use or opioid use disorders. So understanding it in that complex arena is valuable.

Now, that's areas where we feel more comfortable as preventionist being able to do this work of recognizing the complexity of what drives use and decision making at lots of levels.

Commitment to defending universal human rights has been part of the history for sure of harm reduction, and in terms of being able to be advocates for everything from criminal justice reform to housing has all been part of that history that I think is important both to acknowledge as being historically significant, as well as acknowledging that that makes our community safer, and more productive, and healthier for everyone who lives in it.

All right. Moving into this last area. I'll give you some examples of some strategies. I've given you a few.

So again, remember earlier, we talked about if the goal was to help somebody who might be actively injecting drugs to use more safely than being able to have the availability and access to sterile syringes is a strategy that fits in that goal. Being able to deal with safe smoking supplies, being able to administer antidotes like naloxone, being able to utilize fentanyl test strips, so people who are actively using know if fentanyl is present in the drugs that they're using, so that they can make decisions, again, to either toss that, or save their life, or use in safer ways.

I would say that with fentanyl test strips, so many folks have utilized those here in the Midwest, and made major headway with regard to people understanding the danger that they've been exposing themselves to, and moving away from even trying to salvage something that tests positive for fentanyl, knowing that it's dangerous and getting rid of it.

So know again, sort of everything from masks and vaccines, to overdose education kits, access to condoms has been part of that history in terms of being able to reduce sexually transmitted infections has been part of a harm reduction work since its early history.

Lots of sex education, motivational interviewing, sort of outreach workers and case managers has been part of the approach, or the vehicle to be able to meet people where they are both sort of in that context of where somebody is philosophically and readiness issues to where they are in the community, being able to provide services going right out to the streets, to the neighborhood, to the corner to the block in that same way.

So strategies and principles, we just gave you eight principles and a range of strategies. We're going to go ahead and play another video. And this time, we're going to ask you listen to the strategies you hear talked about, and listen for the principles that are guiding those actions.

KRIS GABRIELSEN: Just one moment. All right.

HANSEL TOOKES: Harm reduction was started by people who use drugs to save each other's lives.

NARRATOR: Here on 7th Avenue, right under the sun in Miami is Florida's pioneering syringe service program, the IDEA Exchange, where tools like harm reduction, advocacy, and compassion are being used to save lives. At the intersection, stories of research, compassion, and HIV services for people who use drugs. What is harm reduction? At the intersection where

compassion meets community, harm reduction takes on a more active role to avoid negative health outcomes. And it does so by meeting the community where they are at.

CHETWYN ARROW ARCHER: Harm reduction is basically bettering a person's life and the whole community.

BROOKE HEIMANN: Harm reduction to me is being able to go to a place and get clean stuff to use, and not have to rely on like going to a street and buying it, or like hoping you're getting something clean, or whatever it is.

EDWARD SUAREZ: Harm reduction is understanding the world of the other, and immersing yourself in it for long enough to understand from their point of view, meeting them where they're at.

HANSEL TOOKES: Just like we meet people on the street with syringes, I meet my patients by kneeling down. You just have to do what you have to do in order to be on that level, and be on the same wavelength of the people that you're taking care of.

FRANKIE MARTINEZ: Harm reduction to me, is making sure our people here are taken care of.

BROOKE HEIMANN: Harm reduction is basically just having a place to go to, or people to talk to about anything and everything.

EDWARD SUAREZ: Harm reduction is giving more, because that's what they need in the moment.

BROOKE HEIMANN: They offer like Suboxone to help you get off, or whatever it is, like they work with you here. And I just think that's amazing. Because really, we didn't have a place like that.

NARRATOR: Suboxone is a medication used to treat opioid use disorder.

HANSEL TOOKES: There are studies that show people who use SSPs are five times as likely to enter treatment.

NARRATOR: Syringe service programs like IDEA exchange can provide a range of services, including sterile syringes, vaccinations, HIV testing, and help accessing substance use treatment. Nearly 30 years of research shows syringe service programs are safe, effective, and cost saving tools that can prevent HIV and other complications among people who use drugs.

HANSEL TOOKES: Last night that we started 12 people on Suboxone, and those are people who otherwise would not have had access to this lifesaving medication, and now, they're on their road to recovery. Harm reduction is the first step in recovery. Syringe services is the first step.

But now, we have the ability to start people on lifesaving medications for opioid use disorder. We're helping people in their recovery, but wherever they are on that spectrum. We have to respect the autonomy of our patients, and understand that our one way of doing things does not work. We have to adapt, and have a personal approach for everybody that we serve.

EDWARD SUAREZ: Harm reduction is holding someone by the hand and saying, you're going to come with me, because I have the time to commit to you, because you're worth it. And so what do you need? Do you need to go to detox? I'm going to go with you. Did you get them to the door? Did you follow up two days later to make sure they're still in treatment, or did they fall out? It should be hey, I'm in this journey with you. You've now met me. You seem to want to do something to better your life, and I'm going to support you. Let's run that mission.

FRANKIE MARTINEZ: Harm reduction is understanding, and compassion, and strength, and very nuanced.

HANSEL TOOKES: Harm reduction, it's love.

[MUSIC PLAYING]

CHUCK KLEVGAARD: All right. As we're switching back to slides, type in the chat if you heard a principal in action. And I think that's a good way to phrase that as you sort of talk with your, again, with your task force, your coalition, your bureau, your agency, that those principles are not just a piece of paper. That folks who do this work do it because of those principles.

So if you heard some of those things, I appreciate that harm reduction is love. It is about caring. It is about compassion. I love the video where the

gentleman kneels down, so meeting somebody where they're at, actually getting on their level in different ways. You see in a video like that that that is the reality of the principals themselves in action.

In following the chat, I think countering some of what you hear and being prepared to talk about that, one of the sort of misconceptions that folks talk about is the issue of enabling. Am I making it easier for people to use? I can tell you, that the early days of figuring out how to saturate a community with enough naloxone to prevent death was raising a whole lot of concerns in these early days in Massachusetts.

There were folks that were saying that in fact, we're teaching first aid to drug addicts, and using, again, very stigmatized language, and that we were going to make it easier for them to use. And that their greatest fear was that this would increase both the ways in which people use, and the numbers of people that are going to be using, because we've made it easier for them. And you heard in the video that we just watched that that's not true. In fact, the opposite is true.

The more we can help folks, it builds self-efficacy. That when somebody has been involved in reversing an overdose for a friend, a colleague, someone else on the street, it enhances the way that they feel about themselves, their own worth, and their own interest in going to recover. And again, there's a whole lot of data and information to be able to understand that it doesn't enable folks. It doesn't increase use. It doesn't immediately lead to treatment, but that it is one of the most important and major pathways to treatment and recovery that exists today.

So all of that said, sort of have the conversation. Help people to think through and work through the ways that they counter some of this information. So I will turn it back over to Kris.

KRIS GABRIELSEN: We actually have a bunch of questions, Chuck. So I think we are not going to be able to answer them all. I love them all, though, so I wish we could. It makes me think we might set up office hours or something, where folks can log back in and ask more questions, because we definitely won't have time to get to them all.

Several are questions regarding specific harm reduction strategies in terms of how do you do it. Like, what should you include in a safety plan? What should you include in overdose prevention kits? We are not going to be able to get into that on here.

My guess is, I know we could crowdsource this response. If you have great sources for the answering those two, if you want to put those in the chat and lead your fellow participant to that website, I'm sure there's some great websites that have information on that. So what should you include in the safety plan, and what should you include in overdose prevention kits? So if anybody has great resources for those, feel free to put them in the chat.

Chuck, I will ask you this question. What is the difference between harm reduction and protective factors?

CHUCK KLEVGAARD: And protective factors, so I think of protective factors as sort of having across different sort of levels, having things going on in your life that are in fact, reduce the likelihood that you may get involved in using. So if that's the sort of sense of protective factors, it's again, it's operating in different ways, and it's not in the immediate moment where the danger is happening right now.

It's something that's more sort of longer term and present always, meaning, that if you had a loving grandparent who gave you unconditional positive regard, you carry that protective factor with you through life. Whereas, harm reduction is an immediate sort of measure to either reverse an overdose, or to help you make better decisions over what you might be doing in the next hour of your life.

So they're much more sort of-- a couple of hallmarks of differences would be the sort of term and the focus, and the sort of nature of how they operate.

KRIS GABRIELSEN: Great. Thank you. All right. And then another one, we'll just do a couple more. One person commented about the first video, my only confusion with the video is using a seat belt while in a car. Driving a car isn't strictly harmful. And many have to do it to get to work. Or being out in the sun isn't a harmful behavior. People have to do it at times. But with using drugs, it's a harmful behavior, and people don't have to do it.

CHUCK KLEVGAARD: Yeah, I think that was based on the premise that engaging in regular day-to-day life activity presents risk, sort of going out in the sun presents risk. Meaning, if you're tanning all day long, and that you spend a lot of time outdoors, you've exposed yourself to some risk with regard to skin cancer. And using sunscreen can reduce that risk if you are in a situation where A, you might have to be outside. You might work outside. Or

you might just choose that's part of your lifestyle, that you like to tan a certain number of hours every week.

So it's a way of engaging in that life, whether that's something you have to do, or whether it's something you want to do, doesn't matter. It's a way of reducing the risk associated with that. Similarly, sort of wearing a helmet or a seat belt is the same premise, that driving presents some risk, because you can't control what the other driver is doing. You can't control like what's happening in Chicago today. You can't control the weather. It wouldn't be very safe to drive at the moment right now here in the city. So driving presents risk. And in some cases, even if you're a really good driver, it doesn't mean that you can control the road conditions, and the way other people drive, or whether something might fall out of the sky and hit your car.

So there are certainly risks inherent in being able to leave your house and engage in certain behaviors, even though they're neutral in that way. So I think that using that term neutrality implies a moral judgment. So I'd careful about that. So I take that back. I would say, behaviors that we normally think of as safe still may have some risk associated with them, and we still may be engaging in harm reduction.

KRIS GABRIELSEN: Great. Thank you. All right. And I'm going to skip down to Elizabeth's question, because it's going to lead us right into the next section, which I think we need to go ahead and move into, even though I realize there are other questions out there. We just don't have time to answer them all right now Elizabeth says, similar to someone else's question, how does all this intersect with primary prevention efforts aimed at delaying onset of use among youth and young adults? So let's transition into-

And actually, I'm going to stop sharing. I apologize. In order to get over to the video, I need to share in a different way. There we go. All right. So thinking about prevention, we've talked about harm reduction, what it is, who it's focused on, the principles they use, et cetera. I know that this webinar is aimed at folks who work in the prevention field, so this is not going to be new to you at all is my guess for most of you.

So the prevention focus in general, is on people who are not misusing substances. So very different, obviously, than harm reduction, because you're focusing on people who are using substances. So different focus. A definition for those of you who perhaps don't work in prevention field, but here's the one from Substance Abuse and Mental Health Services Administration, or SAMHSA, is, substance misuse prevention efforts work to prevent the use and misuse of drugs and the development of substance use disorders.

So a little more substance to that. So shift from harm reduction to prevention. But where do they meet? Because they do meet. At first glance, you would think, oh, there's no way these two meet. But they actually do. So in short, I like this.

Somebody said this to me the other day. Well, so really in short, prevention is typically focused on—and this is a broad generality. This is not every instance. But in general, prevention is focused on preventing behaviors from happening. So in this case, preventing substance misuse. While harm reduction is focused on preventing the consequences of use.

So if we can think of it that way, for me, that really helps keep it clear in my mind. Yes, prevention typically, is focused on preventing the behavior from happening. Harm reduction is preventing the consequences of the behavior. So hopefully, that will help you all. Chuck is going to walk us through a graphic that also might help us figure out how prevention and harm reduction can complement one another and work together, instead of what may feel like totally separate spheres.

CHUCK KLEVGAARD: Absolutely. Acknowledging a few things I see in the chat, it's great, primary prevention is before diagnosis. I think is a term that we were able to use comfortably in real solid ways for probably 20 years of prevention. I think now the whole notion of dealing with overdose prevention and preventing death made it more difficult to kind of have that be a hard and fast line for prevention folks.

So I like the conversation that's happening there. I think other folks acknowledging that harm reductionists still use regular public safety measures, so absolutely. So you might administer naloxone as an antidote to reverse an overdose, but you're also going to call 9-11. You still want to be able to engage public safety, and to be able to utilize systems in place.

In that same argument, would a harm reductionist call the police because somebody is using an illegal drug? Probably not. I think, again, the goal isn't necessarily to protect them from legal consequences. But we know that, again, sometimes the situation of being able to get someone help may involve accessing the public health infrastructure first, or the rescue and life-saving measure in that way is really more primary more paramount, more important in that context.

So again, because Kris and I wanted to kind of help you frame this for prevention, we want to move this into what's familiar to us. We think about prevention in the next slide in a couple of ways. One of the ways that public health and prevention have sort of intersected has been on the issue of looking at a socioecological approach. So we want to take an example-- and I don't see the slide changing. Perfect. Thank you, Kris.

So to look at the issue of a socio-ecological approach, we want to take a substance and a prevention topic that we're familiar with in just a moment. So this framework first of all, we're going to take a substance on the left, we would then add important context and to look at consequences associated with using that substance. Now, that might be new for folks. But knowing that starting with a problem statement, or looking at data and an assessment is part of what feels familiar.

So adding this piece to say, well let's make sure we also as we talk about this particular issue and this drug, and this sort of prevention goal, that we make sure we include right on the front end of that conversation consequences.

The next story we want to look at is sort of populations. Because remember, that the populations that Kris just talked about, all of these green folks in this population sort of diagram are that audience for prevention. Those are people who are not currently using. Those are people who are not misusing. The folks along the bottom there, those orange folks are actively using.

So in this scenario, to delineate the fact that we're going to focus on both populations. We're not just going to deal with looking at those folks who in fact, sort of fit neatly into the category of they're not actively using, and we want to prevent them from using, prevent them from initiating use, prevent them from engaging in this behavior, that we're going to do both in this scenario. So this particular graphic in this next piece can show us how to do that.

So remember the complexity of what gets folks into this scenario, both with regard to the decisions to actively use, and the settings in which folks use in is all helpful to look at it in a socio-ecological approach.

So on the lowest level there on in the middle of the screen, you see individual influences on whether somebody uses or not. That could be biology. That could be the fact that they inherited and have significant risk factors in their life that are in fact, related to the biology. They may have at a parent with an alcohol use or an opioid use disorder. It may have to do with the knowledge and skills that they have, or the competencies at that level.

So moving out from there is interpersonal, looking at relationships also have influence over whether somebody uses or not. So looking at social and network kinds of influences, thinking about norms at that level setting, situational factors, relationships with parents, with peers, all kinds of interpersonal issues.

So the next level up, thinking about the community and the influences that happen in someone's immediate environment, in the neighborhood that they interact in, are some of the areas that we'll also look at both influences and strategies. And finally, on the outside, the societal issues, everything from stigma to policy are all areas that we have worked in prevention.

So one of the reasons to use this model, or this framework with prevention is that this will help ground folks in areas where they already feel familiar. So prevention strategies live in each of these arenas as well. We're about to show you is that harm reduction also lives and works across many of these same kinds of levels.

So let's take a real example. Well again, we're going to take one, rather than moving into overdose and getting complicated right away, we'll take an area that's still grounded for prevention. A lot of folks have spent part of their career, some focus of the work that they've done in their health department or their coalition on binge drinking. So we know that from statistics most recently, that about 27.7% of 18 to 22-year-olds have reported that they binge drank in the last month.

Now, because we've talked about this in that same way, we're going to help folks make that bridge here, that drinking any amount of alcohol carries risk. And that binge drinking includes specific kinds of risks for acute harm. And again, we know this from our experience that we're at greater risk to black out, and greater risk to overdose, and have alcohol poisoning, or whatever we want to call that. We know that there are significant risks in that level.

Binge drinking also carries risks in other ways. And this is again, areas where harm reduction excels in understanding other kinds of behaviors that come into play when binge drinking is part of the scenario. So everything from unsafe sexual behavior, sexually transmitted infections, unintentional pregnancy, all the way to more deadly consequences, falls, burns, drownings, car crashes.

So if this is what we have in mind, let's put that socio-ecological model back up. Again, there's our populations with that 27% of folks that are in fact, actively using, actively binge drinking in this case, and at risk for the consequences we just talked about. So now, if we put up the socio-economic model, let's look at examples of prevention strategies that feel familiar to people.

So at the individual level, we might be in our coalition implementing social emotional learning, or life skills, or another social skills program. At the interpersonal level, we might have curriculum in place that deals with relationships. We might have parenting programs in place in our community that deal with prevention.

At the community level, we might be dealing with alcohol outlet density, implementing social host laws, or responsible beverage server training programs. And then finally at the societal level, we're benefiting from minimum legal drinking age and advertising that, doing graduated work there.

Alcohol tax might be something that we're engaged in our community, or our state, or even implementing specific kinds of restrictions or marketing that might be happening at that outer level at that ring.

So I want to make an important point right here before we introduce harm reduction. If we just stop there, the majority of what we implement at that level is designed to impact risk and protective factors in those different settings. So making that point really important for prevention is really key. Meaning, that if we just stop there, we know that most of the folks who are actively binge drinking are not impacted by those strategies.

So if you look at every one of those strategies, they're not designed or intended to impact that population that's already actively using. Now, you could try to make the case that some of those strategies being put in place may discourage folks, but they're not actively designed to do that.

So moving into the next area, I make that point. And again, it's sort of coming to grips with the fact that in the way that we currently implement programs with those sort of green prevention strategies, if we stop there, we don't impact reducing harm very directly at all.

Now again, I make this case, and in my early exposure to harm reduction here as folks were sort of bringing me into understanding the importance of a comprehensive approach, is that those folks that are actively using are going

to continue to do so regardless of the fact that you have responsible beverage server training. They're going to continue to use regardless of the fact that you might have a life skills program operating in seventh or eighth grade.

So I think that this all makes the case. And I don't belabor this, but making the point that we're not doing much of anything to help those folks that are already actively engaged in this behavior. So what can we add to that to reduce harm? In this case, a lot of what happens with that outreach program as you saw in that video, is this sort of risk mitigation coaching, going out and meeting folks where they are, and talk to them about how to reduce risk in their lives with regard to the behavior that they're engaged in.

Doing things like motivational interviewing, or peer support at that interpersonal level, lots of evidence there that those kinds of interventions, which feel familiar to us, can actually do more to reduce harm, and prevent risk, and death in that case. Community level programs, increasing the level of screening, things like condom vending machines. And again, as you look at the consequences on the left again, bring your eye back over to the left. What are the things that are happening that relate to that binge drinking behavior? Unintentional pregnancy or sexually transmitted infections is still part of what we want to try to prevent from happening for folks.

And finally, dealing directly with stigma on that level. Lots of strategies that happen within harm reduction directly go at that issue of stigma.

So this whole frame is again, is going to help folks sort of come to grips with what I already know and build on it. One of the things we know importantly about adult learning is that it has to get anchored or grounded in something that we already know.

And so this is a way of being quicker to educate prevention folks, is to anchor it in something they understand, that they know that they already do, and that this is additive, because it's dealing with that population that we normally haven't focused on very much. All right. Moving into this last piece, thinking about the--

KRIS GABRIELSEN: I'm going to interrupt you for just a minute.

CHUCK KLEVGAARD: OK.

KRIS GABRIELSEN: We are getting some great comments in the chat about this graphic. And I just want to point out that Chuck is definitely the architect behind this. And the first time I saw this, I'm like, ah, too much information. But then it was like, OK, we build it out.

I think it does a beautiful job, again, of how are these going to work together. How does harm reduction complement what prevention does? And how do we reach the entire population? We have the green people and the orange people, the column. Again, like Chuck was saying, with our prevention approaches, we're catching in this case, 3/4 of the population, but that still leaves 1/4 out. So how are we going to help that 1/4 of the group?

So for me, and hopefully, it helps folks understand how prevention works hand-in-hand with harm reduction, instead of being in two completely different spheres. All right. So sorry to interrupt you, Chuck.

CHUCK KLEVGAARD: You know, the other comment that I'm seeing in the chat that I'm really loving and appreciating, and didn't say this loudly enough at all, is that in order to do this effectively, you have to be at the table together. I mean, there's no way a preventionist could fill in the bottom part of this graph without folks being in the room together to talk that through. So I think that sort of partnership and collaboration is implied here, but it's absolutely essential to make this work.

So I love that. I appreciate the comments that people found this to be understanding. And we think creating some helpful tools around how to build on what prevention folks already know how to do has been part of what I think would be helpful moving forward for us.

All right. So I think it's helpful to do a couple more things as we tie this up around this overlap or intersection, helping people recap what we just talked about. That for prevention, we're about preventing use. In some cases, we're preventing misuse. We're working with a population that, again, increases the intent not to use has been primarily the goal, that we're promoting early intervention, that we're addressing problems using a public health framework.

So on the other side, we're primarily preventing harm or death in that case. We're bridging services and mitigating risky behavior. That feels different than increasing the intent not to use. We're promoting multiple pathways to recovery. And again, we're meeting people incrementally, and helping them still move toward recovery, but we're not doing it in one meeting. We're doing it over the course of time through a relationship with a compassionate and trusted sort of partner on the harm reduction side.

Providing services based on a specific set of principles. And again, I love that it's principle driven. And I think that it's important to have preventionists understand that. I think we're public health driven on the prevention side. And I think harm reductionists are really driven by that dignity, humanity, meeting people where they are, that compassion, that respect for individuals, all of that stuff reiterated again and again.

So what's in the intersection? Both prevention and harm reduction are about improving the health of the community, doing that in very different ways. We're about increasing the number and proportion of folks who engage in-- not engaging and using at all. The health of the community on the harm reduction side, is being able to have people engage in safer behavior.

Remember what I said earlier too about the issues around improving community conditions for folks to support recovery by supporting housing, by supporting people to have access to care, access to services, dealing with gaps in services, something both prevention and harm reduction folks do.

Promoting awareness of the complexity of behavioral problems, both prevention and harm reduction do that really well. The issue of reducing, preventing, reducing stigma has been on our plates. And prevention has well been on the plates of harm reduction folks for decades.

In fact, sort of the early work around understanding how to deal with the issues around stigma and to address how to make sure that there are compassionate levels of services for folks out there has been the work of harm reduction long before it became a charge for prevention specialists to do that.

Improve the equity and social justice has been, again, sort of something added to our prevention plate in the last decade, but always been part of the job description for harm reduction to deal with equity and social justice. That is at all not new to folks who have worked in their lives as advocates for other folks in terms of the work that they do on a day-to-day basis.

KRIS GABRIELSEN: All right. So let's jump into some more specifics around prevention's role. So let's get to the actual actions of what do we need to be doing in the prevention field to enhance harm reduction efforts to create that comprehensive, that full graphic, that full right hand side of the graphic.

We're going to review five different ideas, activities, strategies that prevention can be doing to help enhance harm reduction efforts. We're going to talk about promoting community readiness for harm reduction, addressing stigma, providing education and resources, coordinating strategy implementation, and then also linking harm reduction to upstream or prevention strategies. So let's take these one by one.

First of all, promote community readiness. Hopefully, I'm guessing most of you, if not all of you prevention practitioners on here are well versed about community readiness, and the importance of community readiness, how to increase community readiness, assess it, et cetera, et cetera. This is going to be really important in terms of harm reduction in terms of increasing the community readiness for harm reduction strategies, both with stakeholders, as well as the general population within your community.

So some specific things that prevention can do is, you can help build the readiness to support harm reduction approaches. You can help correct misperceptions about harm reduction. That will help increase readiness. And you can help build necessary support amongst stakeholders for harm reduction approaches. So some real concrete steps that prevention can take, using our skills, knowledge abilities, experiences to help augment the harm reduction.

Second, we can work more on addressing stigma. Many of you probably already are doing this, but again, acknowledging that some of the work that you're doing already in prevention is already enhancing what harm reduction can do. But perhaps, you aren't doing as much with this as you could. So maybe you add and start doing some more things with stigma reduction. You could work on educating stakeholders and others about the nature of addiction and the recovery process.

And see the second bullet there? You can educate the community, the broader community about substance use disorder related stigma. First of all, promoting the use of non-stigmatizing language is really important, and something that absolutely would be helpful not only for harm reduction, but also for prevention. So again, you can be serving the needs of both areas at the same time. Raising awareness of substance use disorders as a treatable disease, as well as encouraging treating those who suffer from substance use disorders with dignity and respect are some examples.

Many of you who have attended PTTC trainings events are very familiar with this slide, because we show it at the beginning of every event that we do. The reason we do that is to help address issues of stigma.

So something as simple as this, that perhaps every meeting that you start, you have a declaration around using affirming language, and that language matters. Words have power, people first, et cetera. That might be something that you include as a tagline in every document that you send out, some version of this. So some things that you can do incorporating into what you're already doing that can help address stigma.

Third, you can provide education and resources. So this might get again, if you have connected with folks doing harm reduction work within your community, and if they are needing this help, I can't assume it, right? But if they're needing this help, you could help them develop messages around building awareness, and support for harm reduction efforts, again, something that the prevention field has done for many, many years around prevention messages. So applying those knowledge, and skills, and experiences to harm reduction. And these could be things like creating pamphlets, tip cards, instruction sheets, tip sheets, et cetera.

Again, something many of us are very familiar with doing. And some of the topics if you're, like, well, what do we educate on? What are we providing resources for? Here's an example of four topics that you could address, simply examples. There are many, many, many, many more that could be included on that list.

All right. Fourth, coordinate strategy implementation. So what we mean by that is, again, something that is often high on the skills list in terms of prevention is how to do collaborative work, how to create coalitions, how to create task forces that are working across sectors on prevention. Well again, apply that to the harm reduction field.

You can identify existing harm reduction efforts within your community. Perhaps, there already is a task force on overdose prevention, or on harm reduction. And maybe you join that task force if you aren't already there, if you aren't already at the table if they're interested. You could assist harm reduction efforts in creating collaborative opportunities that perhaps, they haven't considered before, but in your work, you've already seen how helpful those collaborative opportunities are.

You could help bring various sectors together. On that third bullet, it says, to coordinate and merge efforts when possible. So very important with our limited time, energy, money that we don't duplicate efforts, so making sure we aren't duplicating efforts within our community. And also, it can be a role that

you play it to help your harm reduction partners work through potential barriers.

What can you do to help them either maybe it's working with the city council, or maybe it's needing to change the state law in order to be able to start implementing some harm reduction strategies. Or it could be that they're wanting to connect with a certain stakeholder in their community, and they haven't been able to get through to that person, because they don't have that personal connection. So again, helping work through barriers can be really important for the prevention folks in order to augment and enhance harm reduction efforts.

And last, but definitely not least is of course, we can help link harm reduction efforts to upstream or prevention efforts. So things like providing prevention services for children and people who use drugs in your community, work on policies that will address both harm reduction and prevention issues. But things like, for example, I was talking to somebody in the Great Lakes region, and I'm forgetting which state right now. It might have been Michigan. But they have teams within their community that respond to overdoses within their community.

And something that they do is, if there are children present when they have responded to this overdose, they connect those children, or they connect through social services with those children to prevention strategies, so trauma informed approaches. There's one program you all might have heard of-- if you haven't, you might explore it-- it's called handle with care. And it's something that law enforcement uses that whenever they respond to any traumatic kind of situation that children are present, they will provide a link to the school and let the school know that this trauma happened.

And there's a notice sent out to the staff and teachers at that school to handle with care that child that next day. And they mobilize trauma responses within their school community to make sure that child is well cared for. And not just for that next day, but over time. So that's one way. Again, it's not the child that overdosed. It was the parents, or the caregivers that overdosed in that case of the example in I believe, Michigan.

And so we're moving into the prevention arena in terms of working with the kids. So great way to connect with harm reduction. Still doing our prevention work. But again, it augments what harm reduction is doing.

All right. I've talked quite a bit, and went pretty quickly, because I know we wanted to get through the rest of this, and we want to have time to answer

some more questions as well. And somebody-- Kristina-- yes, thank you, Kristina. I'm pretty sure that's the correct website address. I looked at it earlier today.

Let me go ahead. We're going to switch gears a little bit. And we have one more video to show you all that I think you might find helpful in terms of-- it says right here-- Finding the Hook, Changing Perceptions of Harm Reduction Strategies and Prevention Conversation. So I'm going to go ahead and start this video for you.

[MUSIC PLAYING]

VALERY SHUMAN: So a lot of the work that I do is in trying to change peoples' minds about harm reduction, to get them to accept it, to adopt it. And people have a lot of misconceptions about harm reduction. They feel like it's enabling drug users. They feel like it's giving up on people, right, like, setting the bar too low.

They feel like if they are sensitive to peoples' pros of using drugs, right, the reasons that they do it, the things that they get out of it, that that's somehow signing on, or agreeing that it's OK to do that. And so a lot of the work that we do is in trying to understand where people are coming from. I think that's one of the most important things when you're engaging with a community, to try and get them to accept harm reduction is to understand what their beliefs are, their misconceptions are, why they believe them, what their fears are, because it's often fear based as well. And to help them understand the ways in which they're already doing it.

That's one of the things that I find is that, people are often practicing harm reduction, but they aren't calling it that. They aren't recognizing it as that. And so we do a lot of discussion around seat belts, right, and speed limits, and really pragmatic public health strategies that we all use that we're all engaged in that are harm reduction, and around eating and nutrition, like, the dietary choices that we make. There's a really great book that I often reference called Eat This Not That. It's like, if you go to a fast food restaurant, this is the healthier choice, totally a harm reduction strategy.

People who are engaged in primary and secondary prevention strategies around substance use often don't recognize that is harm reduction as well. They think of harm reduction as only tertiary prevention, right, when people are already sort of on death's door. But all of that is harm reduction. We're all on the same team. So trying to help people recognize that we are all on the

same team, that they're already engaged in some of these practices can help them to sign on to some of the more overt practices as well.

So another thing that's incredibly important when you're engaging communities around harm reduction is to find what the hook is for that particular community. And it's different in every community. A good example is, if you're speaking to legislators or politicians, they can often leverage information about cost savings to convince people to change the laws and rules.

So for example, there's lots of good evidence of cost saving on syringe exchange programs reducing the incidence of HIV and hepatitis C, which are incredibly expensive for lifetime prevalence. Similarly with housing first, there's great data on how much less expensive it is to house people than to let them remain on the street and use expensive services, like emergency rooms, like jails, like prisons. And so to arm people with that information if that's the hook for them.

But it's different for other people. For some people, it might be their religion, or their spirituality, or their morality that you can tap into that really speaks to harm reduction. For other people, it's about bodily autonomy. So sort of trying to figure out what's important to the people, the audience that you're talking to, and finding what the hook is for them.

[MUSIC PLAYING]

KRIS GABRIELSEN: All right. So we haven't heard much from you all in terms of the examples of how prevention has engaged in harm reduction in your community. Love for you to take a moment and put in the chat box what are some things you're already doing in the prevention field in your community, in ways that you've engaged in harm reduction. What are some examples?

Mobile vaccine clinics, absolutely. That is a great harm reduction strategy and prevention, I should say, in connection to prevention, yes. Our public health department offers free condoms.

So I'm seeing lots of harm reduction strategies in terms of strict harm reduction strategies. I'm wondering how prevention is partnering with-- it's going too fast now. I think I saw one here.

Kathleen says, we're great at training, and community partners for training. So we're getting staff and partners trained to deliver anti-stigma trainings, naloxone trainings. Excellent example of prevention being involved with harm reduction strategies. So meeting one-on-one with a local law enforcement to educate on stigma. And pave the way for more acceptance of harm reduction, Erika says. Great example, prevention working with harm reduction strategies.

So I'm seeing lots of harm reduction strategies being put in there, which is great that those are being implemented in your community. Curious how prevention is working with implementing harm reduction strategies.

So I'm seeing [INAUDIBLE] life skills, guiding good choices, and Wyman TOP for prevention and NARCAN trainings. OK. Adding stigma info to NARCAN training, love it. Working with community partners. Self-care is always good. Absolutely, across the continuum. So somebody says, we coordinate with HIV testing and lock-zone training and distribution. And I lost it.

I've got to figure out how to make it stop. I guess if I hold my cursor down. So now, I've seen some great examples. Someone said, doing presentations on SUD to inform or reduce stigma. Great. Thanks for catching that, Cristina. All right. So great examples in there. Chuck, did you catch something too?

CHUCK KLEVGAARD: I did. Folks looking at issues of prevention, folks engaged with peer recovery coach is a really great idea.

KRIS GABRIELSEN: Love it.

CHUCK KLEVGAARD: Prevention people working with caseworkers in that same way, are outreach workers. I think somebody, again, very quickly coming through the chat, bringing harm reduction into a coalition, or forming a work group, or a subgroup, or a committee within your organization to support harm reduction as part of your normal structure for prevention I saw. So a lot of great ideas.

KRIS GABRIELSEN: Good. All right. Well, let's continue on. I know we're running out of time. I guess we could have used at least two hours on this, huh, Chuck? All right. So a couple more slides here for me, and then I'm going to hand it back over to Chuck. So next steps for you. Here are some ideas from Chuck and me about some next steps you might want to take.

If you feel the need, you might learn some more about specific harm reduction strategies, programs, and populations served, especially to find out within your own community what's going on if you aren't aware of what's going on in your own community. Familiarize yourself with harm reduction organizations serving your community. Identify public health goals you have in common, so between prevention and harm reduction.

We recommend you collaborate, or leverage each other's strengths in terms of prevention and harm reduction, and ask to partner. Because they have many strengths, and skills, and experience, and knowledge that you can definitely use within the prevention field. And plan and implement cross-training on the link between prevention and harm reduction.

Last but not least is, we highly recommend that any strategies you do put in place, that you use both process and outcome data to make the case for continuing, and see what works within your community.

We have some tools for you. We just put up on our website in the product section of our website, we are going to get a permanent page in more of the regular part of our website. But they'll put in the chat box a link to this portal. Stephanie just put that in.

We just uploaded several things for you. A couple of them are the videos that we showed today, a couple of the videos that we showed today. And actually, and then some other products we just created for you.

So we created a fact sheet that you could use in terms of understanding the role of prevention and harm reduction efforts. So if you go to that page, and you click on Download, you will see that you can click on that and download that. It's a PDF document.

We also have a action list for you, or action steps that you can take. So again, that's something if you want to print out and use as a guide, that's up there as well. And the third thing we just added was a PowerPoint slide deck. So this is a subset of these slides that you saw today that are in PowerPoint.

So it's not in a PDF version, but in PowerPoint that you can use to help educate others in your community. There are also some notes in the trainer section at the bottom of the slide, if you aren't in presentation mode, of things that you might want to consider when presenting those slides. All right. So Chuck is going to bring us home.

CHUCK KLEVGAARD: All right. We want to circle back. When we started this webinar about an hour and a half ago, we asked you for some emotions that you had. And there was a whole range of emotions that people had, everything from hope, and sort of confusion, to sort of frustration, to excitement.

So if you've moved along that continuum in some way, tell us about that in the chat. Any shift happened for you today? So in the last hour and a half, we've spent time talking about what it is, why it's so important, how it fits in a comprehensive way, and how we as prevention can begin to do this work, or to help foster, and nurture, and support, and collaborate to get more of this work.

So if you've shifted a little bit in the last hour and a half, tell me about that shift in the chat. More hopeful, learning a lot, safety and hope, motivated. I love the idea that you all can take this slide deck and use it. I can't tell you how many times I've gone to a training as a preventionist and feel like, I want to go back and do that exact training with the people that I work with every day. And I hope that you'll do that. I'm encouraged and excited that so many of you are saying that that's some of what you're going to do next. Learning how it can go hand-in-hand. Reassured that I'm on the right track.

Love it, inspired, expanded, enhanced.

Those are fantastic words. You have been a wonderful audience for Kris and I in terms of being able to kind of think about how can we get folks more both comfortable, more literate, and more engaged on this issue. And you guys have been all three of those.

So last comments, sort of keeping in mind coordinating efforts across prevention, treatment, recovery, and in harm reduction enhances everybody's work, meaning, that it isn't discrete and separate. Meaning, the more that we can see the connections across the continuum, the more effective that the system of care becomes. Prevention practitioners have skills, abilities, and experiences that can help this. We are process people. We are facilitators. We have connections. We can open doors for folks that may not be recognized.

We already have existing relationships with the city, with the law enforcement, with different groups. So we can both facilitate the process, and open doors, and integrate this work together. And that by working together, we can have greater impact.

KRIS GABRIELSEN: All right. A few closing points. I wanted to point out that we do have a Facebook page. And we'd love it if you would follow and like us. You will see that during the session I had it scheduled to put up a Facebook post specifically to this to help continue our discussion. So if you would be willing to go there, they're going to put it in the chat box a link to our Facebook page if you would like to go there.

I have a goal by February 22, 2022 to have 222 likes. We're at like 192. So if anybody wants to help me out, please go in and like our page, and follow it. And then it will go up also into your feed, so you can see it as we post new events, and have different resources you'll be notified about that.

Some upcoming trainings in case that interests you, we have a NIATx Virtual Change Leader Academy that's coming up specifically for prevention specialists. Limited enrollment, so if you're interested, be sure to get in there quickly. We have the fourth part of our health equity series. If you haven't attended the other ones, they're discreet, so you can pop in at any time. But that's coming up on the 24th as well.

Foundations in Prevention Intensive Training Course, this is limited to 30 people. So if you're interested in this, definitely jump on this right away. But if you're newer to the field, this is a great way to get really grounded in the foundations of prevention. What Does NOT Work, we talk a lot about what does work in prevention, but we know lots of research about what doesn't work. And a lot of things that we are doing in the field actually, research has shown does not work. So we want to delve into that. No shame, no guilt, or anything like that though, but let's get grounded in what research shows.

And last but not least, we have Five C's Not D's of Data. And this is strictly on helping present data. So it's not how do you get data, how do you do a needs assessment. It's how do you show it? How do you share it? How do you most effectively share data? Great training. We've had it before. It's not recorded. So you have to carve out time to actually watch it at that time.

To register, Kristina put it up on the chat. There's also the link there. Please, please, please, please, please fill out the gpra form. It will kick you to there usually right when we close it out. Only three questions. It'll take you 30 seconds, 60 seconds at the most. And it greatly helps us know how well the training has landed, as well as we use it for a report back to our funding agencies. And Kendra, you got your question answered. So Chuck, any last thoughts before we log off?

CHUCK KLEVGAARD: No, just the time has flown by to be with you all today. And we have much more to say. So stay engaged with us, and check out the portal. My favorite comment, you too rock. So nobody's told me that I rock for probably 10 years.

KRIS GABRIELSEN: We will have to take that and sit with that for the rest of the day. Thank you. Glad you caught that. I didn't see that. All right. I see folks who still posting in the chat. So we'll keep this live for another minute or so. But thank you all for your great engaging manner through the chat and Q&A. Stay tuned.

We might see if we can open up a community conversation, like office hours kind of thing that to continue answering some of your questions. So keep watch on Facebook as well as email. I saw somebody said they don't do social media. We will definitely put it out in email. So join our email list if you aren't on there. And you can get that from the home page of our website.

Oh, quick thank you. Last but not least, the folks behind the scenes. We've had Stephanie, Kristina, Jenn, and Anne have been supporting us behind the scenes. As you have all seen, they are amazing at getting stuff into the chat, answering questions behind the scene. It makes it so much smoother to have them there.

CHUCK KLEVGAARD: They are really the ones that rock.

KRIS GABRIELSEN: They are the ones that rock. Absolutely. All right. Take care, everyone. Have a great rest of your day.