2 year program review:

2016-2018

Prepared by: Brandie Wilson
Edited by: Jessica Smith

HACHR
1522 3rd Street
Eureka, Ca. 95502
hachr707@gmail.com
707-407-6013

Report Overview

This review will cover the past two years of Harm Reduction and syringe exchange services provided by the Humboldt Area Center for Harm Reduction (HACHR) to Humboldt County, and more specifically, Eureka, Ca. We will review the breadth of our services, pa rtnerships, exchange policies, overdose prevention and correlating data for the calendar years 2016 and 2017. In an effort to lend voice to the data, evidence and research surrounding harm reduction work, this report will also include relevant supplemental articles and research. We will also provide a brief outline of developing programs and projects.

Report Goals:

1. Meet State of California defined, Health and Safety Code regulations for Syringe Exchange Programs (SEP) in code 121349[3] which states; SEPs authorized in California cities with no Health Department shall submit a bi - annual report to their authorizing body. This report covers the calendar years 2016 and 2017.
2. HACHR utilizes a number of in -house programs and approaches designed to address the negative effects of illicit substance use. Through this report we hope to illustrate the ways in which our work is often nonlinear, focusing on multiple programs and goals at a time, making HACHR a robust organization and a leader in many areas of Harm Reduction. .
3. Further the knowledge and understanding held by leadership and community regarding the breadth, challenges and accomplishments of our program.
4. Discuss the limi tations and successes of our program and its consumers.

History & Purpose:

The main focus of our work since the inception of HACHR in 2014 has been addressing the absurdly disproportionate numbers of Hepatitis C Virus (HCV) and

Drug related deaths in Humb oldt County. As you may know, these issues are very closely tied to a historical lack of access to services for people who inject drugs (PWID). In our methodology and approach we utilize The Principles of Harm Reduction as described by The Harm Reduction Coalition, who are some of the foremost experts on Harm Reduction. In the interest of clarity, we use the definition of Harm Reduction as, " Harm reduction is a set of practic al strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs" (Harm Reduction Coalition). Our organ ization holds this definition of Harm Reduction to be true and we do so proudly. We continue to push for humane policies as well as look for ways to reduce the harms of drugs, which cannot be done without addressing policy.

Harm Reduction is not a new m ovement, in fact it has been around Forty plus years. It began in the 80's at the dawn of the HIV epidemic when healthcare providers and PWID would fill strolers full of syringes and go to areas where people frequented. This was an effort to prevent the s pread of HIV. At this time, syringe exchange was illegal and we were in full swing of Nancy Reagan's Drug War. This meant that accessing syringe services was neither a real nor viable option and so the issues became compounded. We are now watching HCV rav ish our community and this too can be prevented with the proper implementation of Harm Reduction. We hope by the end of this report you have a clear picture of our work, its importance and the care we take in developing and running our programs.

In 2014 we began the process of compiling best practices, drug related data, and the different types of programs we wanted to see housed in our organization. We then engaged with graduate students and consultants that led to building the framework of our 501c3. Du ring this time we worked on our founding paperwork and tax status as well as registered with the State of California and IRS as a charitable organization. In 2015 we were given notice by the State of California thatour status as a 501c3 was approved and has been effective since the time of application in 2014.

In 2015 we began community clean up and development of our founding programs: Overdose Prevention, Syri nge Exchange and Health Education. Our community clean up efforts predate any other outreach efforts or programs we have. In the interest of data driven best practices and meeting our consumer base where they are at, we first needed to gauge how deep the issue was that we were beginning to address. During these clean ups we would also take a wagon full of healthcare and hygiene kits and provide information and referrals to linkage to care for people who desired those items and support. To further our effo rts to build a program based on evidence, research and data, we enlisted the help of Humboldt State University through a community partners relationship. Even though we are an organization of academics, healthcare professionals, treatment providers, and Ha rm Reduction experts we know that it is important to garner help form outside entities to ensure policies are created without uninformed bias.

Since beginning our partnership with HSU we have engaged and utilized the efforts and skills of students within the Bachelors and Masters programs in both Sociology/Criminology and Social Work Program. Our organization, consumers and community have benefited greatly from this partnership. Our relationship with HSU has grown exponentially over the past three years . We started with one intern per semester and we now are hosting at least 2 interns and 5 volunteers each semester. This semester's current partnership with HACHR and HSU is the most robust one yet. We have a group of about 50 students working in four diff erent groups that are creating and implementing different projects at HACHR.

In every area of our operations we exceed what is required, asked of, or told to us. We seek out more than one answer, more than one source and more than one perspective. Our dec isions are always based on a culmination of facts. Matters of public health should not be decided by belief or misinformation.

Data Collection, Referral & Encounter Overview

HACHR refferal data since authorization in 2016.

2016 Referrals	2017 Referrals	2018 1st Q Referrals
142	189	61

We are a young program, and with our development over the past few years has also come a deeper development of data collection. We originally started by collecting only State required data. At that time we did not have a strongly developed way to track the referrals and case management services that we provided; our initial data collection was very basic. By providing services and referrals over the last two years we have learned what works and what doesn't for our program. Not only have we developed, revised and improved instruments used to collect data but we have also developed and deepened our methods of collecting and gathering that data.

Traditional paper referrals can generate a huge number of tick marks under the referral column, but this method often lacks in follow-up and therefore success. Tic marks are not our goal, but consumer success is, and we have found great success in our warm hand off model. This model essentially provides case management on site--making phone calls and appointments for consumers, providing in-house services from Nurse Jennifer from HepCare Stream, and providing rides to a variety of appointments. This eliminates the major cracks in the system where we see people fall through. For example, if someone is in crisis and is suffering from major infections they may not display the most calm or rational behavior. Therefore, handing someone in crisis a piece of paper with a name and phone number on it, and requiring them to call on their own, may not be successful. Instead, we work to schedule appointments while consumers are present, or have Nurse Jennifer assist them on site. Because we were not counting immediate case management or linkage to care as a referral, as we were providing much more intensive support services, our number of referrals may appear low. In reality, we have provided more care and services to consumers than we would have using a traditional referral system.

Our goal is n ot simply tic marks on paper to show effectiveness. We want to show lowered abscess rates, lower ER visits, decreased sepsis, increased entry into treatment, and a reduction in physical and mental health issues related to substance use. Our goal is to impr ove and refine all of our services and procedures, including the way we record our data, so that we may show as accurately as possible the breadth and success of our work. As we grow and strengthen our procedures and generate more capacity for staffing we are expanding support services and seeking out more referral options that we may be able to provide.

It has become increasingly clear that there is great misunderstanding and misconception around the specifics of HACHR referrals --how they are given and what constitutes effective support. All too often we see our data taken and manipulated with no sense o f understanding about collection, requirements, or implementation. We hope that this small discussion of our referral and warm hand off methods lends a more clear understanding about the work we do to support our consumers. Supporting our consumers is one of the most critical work we do and we asked them to submit confidential comments regarding our services and you can view a few of them here. Additionall y, we distribute a yearly consumer survey and utlize the Soclology Department at HSU for its design, implementation and analysis. We are currently in the process of distributing this years survey and you can find the results of our last survey here.

HACHR Encounter Data:

2016 Encounter	2017 Encounters	2018 1stQ Encounters
885 (duplicated)	2674 (duplicated)	885 (duplicated)

In 2016 we saw 885 people. While some of these may have been duplicate encounters, meaning we may have seen the same person more than once in a month, all of the encounters are counted. In 2016 we were predominantly operating in the PalCo marsh, which meant the r est of the PWID community was not accessing our services. We also did not operate for a full year of exchange services.

In 2017 we settled into our brick and mortar location and saw a vast increase in the scope of our consumer base. Clearly our services did not create a vast increase in people who use drugs, but our organization became more accessible to a wider variety of people who use drugs throughout the community; we began to serve people who were housed, unhoused, employed, unemployed and so on. By increasing our accessibility we also increased the amount of people we saw, especially compared to 2017. The growing number of people using our services is a clear indicator of the need for our services in this community.

1st Quarter 2018 continues to illu minate that we have not yet reached all of the folks who may need our services. In the first quarter of 2018 we saw almost 900 folks, and daily we see one to two new people coming in for services.

Physical Health Programs:

We have been very successful at building sustainable programs that directly address a number of overarching public health concerns. Some of the work we do includes reducing the barriers to accessing medical treatment, addressing risks associated with poverty, overdose, and lack of educat ion and information. Under our umbrella of Harm Reduction work lives many different programs designed to engage, connect and support people who use drugs in meaningful ways that promote positive growth. We have built the following health related programs within our organization: syringe exchange, naloxone distribution and education, safer sex supplies and education, and in -house linkage to care (mental and physical). We are currently working on an in -house Medicated Assisted Treatment Program, and HCV in h ouse treatment.

Overdose Prevention and Education:

In this section we will discuss Eureka and Humboldt county drug related deaths, as well as local and national approaches to addressing this health crisis --the third and most deadly wave of opiate use we a s a Nation have endured. Humboldt County has endured a drug death rate steadily above the national average for quite a number of years. Our rates have historically averaged around 3 -4 times the state

and National averages (CDPH). As shown in the followin g chart from the Humboldt County Coroner's Office, drug related deaths are not a new phenomena in Humboldt County. However, through dedication, community wide efforts and collaboration we are beginning to address the issue with a multitude of evidence based, humane approaches.

Table 1: Drug poisoning deaths and mortality rate per 100,000, all manners, 2005-2017

Drug Poisoning Mortality Rate, 2005-2017				Humboldt County drug poisoning deaths by manner with median age at death (manner determined by Humboldt County Coroner's office)				
YEAR	US	California	Humboldt County	Median age at death (years)	Total annual drug poisoning deaths	Suicide drug poisoning deaths	Unintentional drug poisoning deaths	Undetermined or other manner
2005	10.1	9.0	27.0	50.0	37	5	32	0
2006	11.5	9.6	30.0	46.0	39	4	34	1
2007	11.9	10.5	31.9	45.0	41	3	37	1
2008	11.9	10.4	35.0	44.0	45	5	39	1
2009	11.9	10.7	29.4	50.0	39	4	33	2
2010	12.3	10.6	30.9	48.0	41	6	32	3
2011	13.2	10.7	34.2	49.0	48	5	36	7
2012	13.1	10.3	31.9	51.0	46	7	36	3
2013	13.8	11.1	24.4	51.5	38	6	27	5
2014	14.7	11.1	28.2	52.0	41	9	31	1
2015	16.3	11.3	25.9	52.0	40	4	36	0
2016	19.8	11.2	30.6	51.0	46	7	36	3
2017 (Prelim.)			32.4	44.0	45	0	39	6
			Totals	50.0	546	65	448	33

While we watch the rest of the country experience alarming spikes in opiate related deaths, we as a community have been enduring those alarming numbers for well over two decades. The many layered and systematic reasons for Humbol dt's drug use data is a conversation for another report.

I urge you to reach out to any number of groups that are on the front lines of this issue. Some local groups could include Food for People, Open Door, RxSafe, Public Health, Human Rights Commission , and California Center for Rural Policy. This issue is one that has been systemic in our community for a number of years and I encourage all of you to engage in discussions about it. This issue is not one that will be solved by short sighted reactionary responses such as shutting down a needle exchange, punitive punishments or utilizing only a single model of treatment. Rather, this issue requires an all hands on deck approach, including a variety of collaborations and support. Our organization has been fortunate to have the opportunity to collaborate with National, State and Local groups doing this work. We stay on the cutting edge of overdose prevention approaches and techniques,

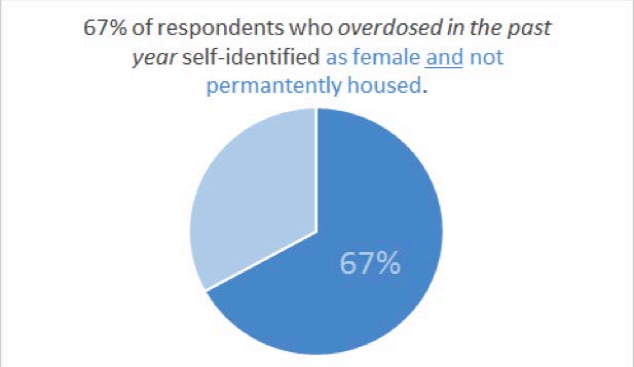
and as long as our community is experiencing disproportionate rates of dr ug related deaths we urge everyone to become educated on this matter.

2016 Overdose Prevention & Education:

On January 16, 2016 Dr. Jasen Christensen signed a Standing Order for our organization. He did so again October of 2017. A Standing Order allows our organization to provide naloxone distribution and education to the community and is described in California Civil Code section 1714.22 link this. The modality of a standing order is similar to that of a flu shot standing order. 2016 was the first year of our overdose prevention & education program. In that year Humboldt County collectively increased Naloxone distribution by 900%, with our organization as the leading group behind those numbers. We successfully distributed 1,008 (two -dose) Naloxone Kits along with education and prevention tools. We primarily utilize a peer distribution model and we had a total of 112 *Self reported reversals.*A self reported reversal is when either the person who administered the Naloxone or the person receiving the Naloxone comes in to get a refill. They notify us of successful reversals and we then have a conversation about th e event. During this conversation we discuss any number of relevant factors the person is willing to share such as where the overdose took place, if 911 was called, how many doses of Naloxone were needed, if they would like support services, and if they t est their substances.

It is important for all community members to carry Naloxone during periods of health crisis such as the one we are currently experiencing. We should also encourage all law enforcement and service providers to carry Naloxone. Curren tly, there are a few Law Enforcement Agencies that do carry naloxone, including the Arcata Police (2016), while the Humboldt County Sheriff's Office is in progress. We hope to see some progress or attempts at carrying Naloxone by Eureka Police Department. No one wants to be at this point in society, but this is where we are, and we must respond appropriately. At this point, the United States has lost more people to overdose in 2016 than we lost soldie rs in all of the Vietnam War(Drug Policy Alliance).

It is of vital importance for us to understand who is at greatest risk of overdose so we can properly arm those around them. Our Co unty and City health data shows Tribal Communities and housed, mid -life people taking prescription opiates are the populations most affected by opiate overdose. This means arming friends and loved ones with Naloxone is the best response and this is directl y inline with the approach laid out by the CDC. A 2016 survey of HACHR consumers illustrates what is happening to people who are using opiates and poly -substances. The survey showed that 67% of respondents had overdosed in the past year and self identified as women and unhoused. Clearly, overdoses and substance use knows no class, gender, race or housing status, so we were determined to work even harder in 2017.



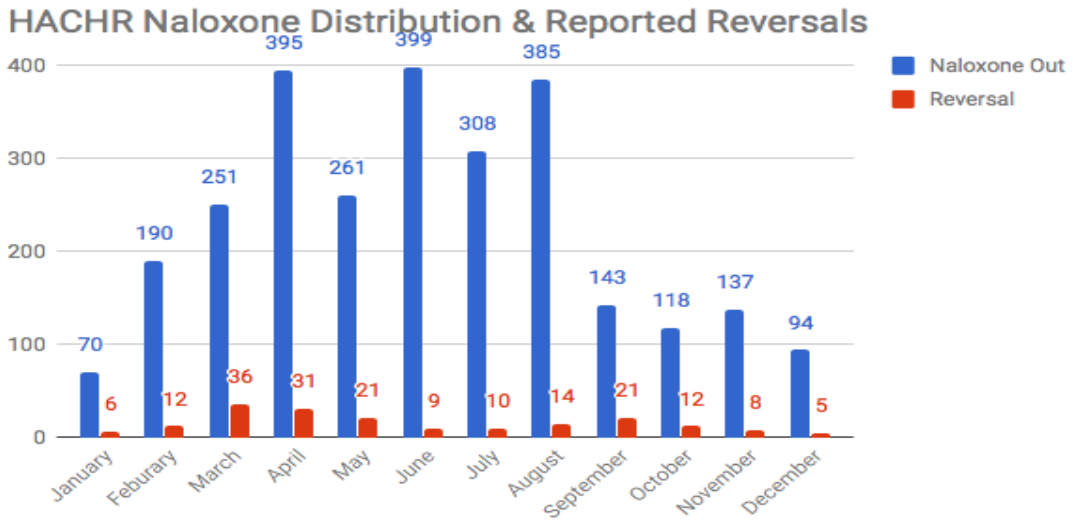
There are no statistical graphs for Naloxone Distribution for 2016 due to a theft of our com puter which meant the loss of our data base and graphs. Our 2016 Naloxone Data was recovered from our year -end reports sent to funders and community partners, then double checked with calculations of the hard data from our daily data sheets.

During 2016 w e had the privilege of providing Overdose Prevention training for people from CrossRoads, Serenity Inn, Area 1 Agency on Aging, Council Members, and parents and community members, just to name a few. The RxSafe Dashboard is a wonderful, local resource we can use to dig deeper into overdose prevention information. This resource allows you to look at local and state level data, and the work being done to address the opiate crisis.

2017 Overdose Prevention and Education:

In 2017 we continued our Overdose Prevention and Education program with the hopes of doubling our Naloxone distribution as well as amping up our education and linkage to care. During 2017 our Overdose Prevention program grew to be much more than just Naloxone and basic education. We began education around overamping and stimulant death, fentanyl education and testing, and continued to provide and refine our Overdose Prevention Curriculum.

We successfully accomplished our Naloxone distributi on goal of doubling our efforts in 2016, and we distributed 2,751 doses of naloxone with 185 Self reported reversals.



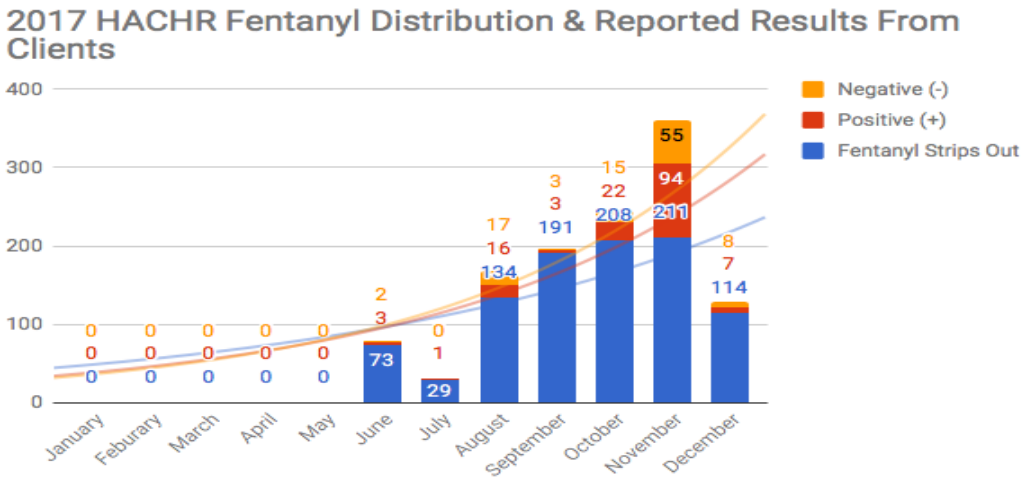
We had the honor of providing Overdose Prevention and Education trainings to groups like The Family Resource Center in Rio Del, A few bars that wish to stay unnamed, and Transition Age Youth (TAY), just to name a few. HACHR's Overdose Prevention program continues to grow and strengthen as we broaden our scope of work and focus on all drug related deaths instead of just focusing our work and conversations on Opiates.

Fentanyl

The appearance of Fentanyl in the State and Nation has greatly increased the prevalence and frequency of overdose deaths. Due to Fentanyl being incredibly strong, it takes a miniscule amount to send someone into an overdose event. Due to Fentanyl compounding the overdose death issue, Harm Reduction programs started utilizing drug test strips from BTX to detect the presence of Fentanyl in substances. Our organization began using these Harm Reduction tools in June of 2017. There has been some conversation as to the efficacy of these tests. However, two different studies have shown these test to be an effective method for testing for Fentanyl and Fentanyl analogues. BTX acknowledges these test as an effective way to test substances on the street, even though their intended purpose is for urine screens.

One of the largest potential issues with these tests is the high level of sensitivity. BTX are testing for nanograms of substances as opposed to micro-grams or grams which is what inevitably will end up in the solution. It is possible for false positives to be thrown if there is too much of any substance in the test solution. Our organization and the Humboldt County Drug Task (HCDT) Force have been working together to try and find the true efficacy of these tests. At this time we are one of the only organizations that has gone to this length to find out if these tests truly operate the way they are meant to. HCDT has generously taken a few samples of potentially positive substances and run them through the lab. The substances tested negative from the lab. However, lab tests do not test for all Fentanyl analogues and the BTX tests do. What this means for us as a program, as well as a community, is that we must continue education, prevention and treatment in order to achieve the best outcomes and reduce the loss of life.

Having conversations often lead to healthier decisions and better outcomes, and these tests provide us the opportunity to engage in dialogue. We have found, like many other programs, that if a substance does come back with a positive test from a BTX test, people take appropriate steps to prevent a potential overdose. The rhetoric that people don't care and wont test is not accurate. The following graph shows how highly utilized our testing program is.



As indicated in the graph, we distributed 960 test kits in a seven month time frame with 146 cases of fentanyl positive substances. The high number of positives in relation to the number of tests out and reports back is what led us to begin to question ho w much we should rely on these test to be completely accurate. Once we had a large number of positives show up we had to seek out answers as to why. We continue to engage with the makers of the tests, researchers, and State and National leaders to try and make sure our information is true and credible. One approach we have taken is to deepen our instructions and conversation when giving out the tests. We make sure to go over the instructions for use, and inform people to use the smallest amount possible wh en testing.

In every area of our operations we exceed what is required, asked of or told to us. We seek out more than one answer, more than one source, and more than one perspective. Our decisions are always based on a culmination of facts. Matters of pub lic health should not be decided by belief, misinformation or uninformed masses.

Overamping

Humboldt County has had a steady death toll due to Overamping and prolonged stimulant use for many years. This past year as we watched Opiate specific deaths lower we saw Amphetamine related deaths skyrocket. A recent report from the Humboldt County Coroner's Office indicates that our stimulant related deaths rose by ten from 2016 -2017. We urge the readers of this document to spend some time

with the mortality report if you have not yet had the chance. It will help illuminate many of the issues that we are up against and why this issue is so hard to address. The Coroner's report shows that it is historical and systematic issues that are seriously impacting the community. If this was a new and recent phenomena caused by one or two events, the persistent Take Back Eureka voices would make sense. However, this is not new. This is an ongoing systemic issue in Humboldt and must be addressed in a multitude of ways. One thing we must always remember is that Amphetamines have historically been very prevalent in predominantly white, rural communities and we fit exactly that description.

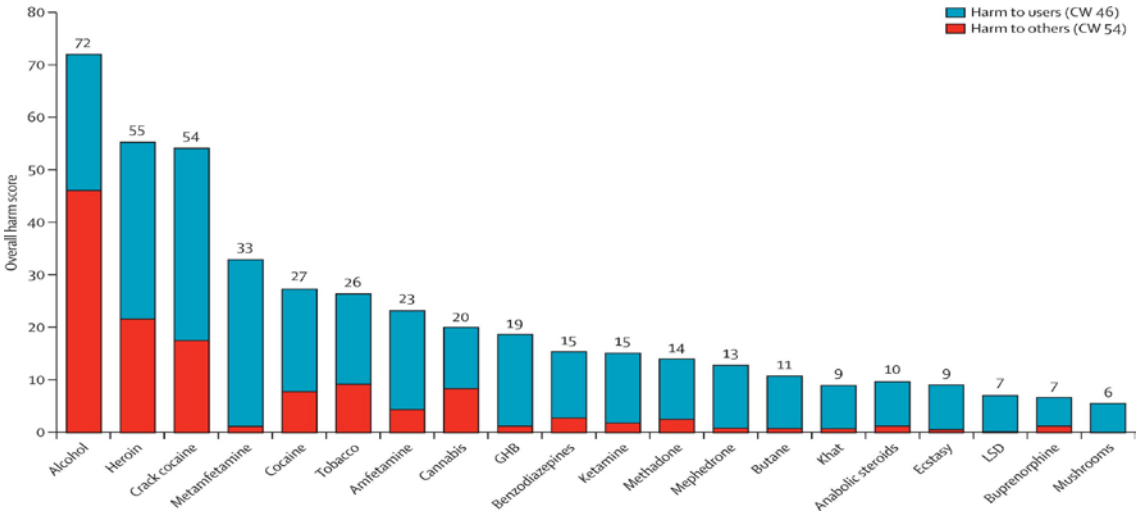
Some of the ways our organization is working to combat the issues related to overamping are very basic since there is no overdose antidote for stimulants. We are seeing our opiate overdose mortality rates drop. However, the mortality rates associated with stimulants in this community is alarming.

DRUG RELATED DEATHS January - March 14 2018

Date	Age	Sex	Manner	Drug(s)
1/4/2018	58	F	ACC OD	Overdose due to Methamphetamine Toxicity
1/6/2018	33	M	ACC OD	COMBINED DRUG AND ETHANOL TOXICITY: ETHANOL, FENTANYL, MORPHINE, AND D-METHAMPHETAMINE
1/13/2018	53	F	ACC OD	NORTRIPTYLINE TOXICITY
1/21/2018	41	M	ACC OD	Opiate Intoxication: Morphine; Codeine; 6MAM Present
2/26/2018	68	F	ACC OD	Combined Drugs; Opiates & Oxycodone-Hospital Screening
3/1/2018	52	M	ACC	Methamphetamine
3/9/2018	56	F	ACC Drowning	Methamphetamine; toxic level
3/14/2018	51	F	Pending	Methamphetamine Use

As clearly shown in the chart provided by the Humboldt County Coroner's Office, in the 1st quarter of 2018 half of the substance related deaths were a result of Methamphetamine. This information does not include deaths associated with alcohol use as it is not an illicit substance, yet it has been proven to cause the most

personal and social harm. A study published by Lancet in November of 2010 shows Alcohol to be the substance that causes the most harm to self and others.



Methamphetamine causes more harm to self than anyone else, by far. It is for these reasons that we provide ways for people to keep safe from s ome of the implicit harms associated with Methamphetamines.

One of the major issues related to Methamphetamines and overamping is overheating. In the warmer months this is something we must pay close attention to and find creative ways to teach people how to stay safe. It may seem too simple to be effective, but we provide a shade tent, cool water and quiet space during drop in hours for people who may be in danger. Lowering people's elevated body temperature during these times is critical to preventing da ngerous overheating. Another important action to take if someone is having issues related to overamping is providing a quiet, low -light space where they can disengage, cool off and lower their heart rate. We know that people who use Stimulants are at extre mely elevated risk of stroke and heart attack and we try to educate people about how to prevent these deadly events.

Over the past two years we have found that real information about substances, and especially stimulants, is greatly lacking. We repeatedly hear people try to stop heroin by using stimulants because they are under the impression they cannot die. Even though this is anecdotal, it lends a small view into the mountain of misinformation that we are trying to battle through. We have a number of

educational materials that we have produced and our most recent one is a handout about how to stay safe in an overamping situation. Our approach of meeting basic needs with water, shade, quiet, and some food are simple and effective. The barrier however, is we are currently open for drop in services ten hours a week. This means people in crisis may not always have the ability to stop in, nor are all overamp ing situations happening to people experiencing homelessness. Stimulant use is very common with people experiencing homelessness due to a need to stay awake and alert to prevent bodily injury and rape.

Syringe Exchange. Yes, it is an exchange.

For Much of 2015 we engaged in community clean ups in different areas and parks in Eureka. One of the more common areas that we began to frequent was the PalCo Marsh. We began doing outreach and clean up in the PalCo Marsh and Coopers Gulch, well before we began ex change services.

(https://www.northcoastjournal.com/humboldt/can -humboldt -county -solve-addiction/Content?oid=3299177).

Pre-authorization time was spent gauging the need and range of services that were going to be required of our program. During this time, before ever providing syringe exchange, we would clean up sharps that were in the marsh. One of the driving factors that led us to bette r understand the need for syringe services was a serious scene we witnessed one day when doing outreach. We happened upon a camp of 5 people who all ranged in ages from young to mid twenties. All of these young folks were sharing the same syringe and using water that had puddled up in their tent.

We contract with an outside agency for weighing and disposing of our biohazard. Each week, Eco-Medical out of Fortuna does a third party weigh out of our waste and then disposes of it according to OSHA and all gov ernmental regulations. They have submitted our weight manifest and a report of inspection fidining for our organization.

In March of 2016 HACHR was authorized to provide syringe services in Eureka. At that time we implemented the recommended best practice by the California Department of Public Health. An issue brief from CDPH states; “The California Department of Publ ic Health, Office of AIDS advises syringe exchange programs (SEPs) to adopt needs-based distribution policies with the goal of ensuring that program participants have a new, sterile syringe and other injection equipment for each injection. Restrictive syri nge access policies such as variations on one -for -one exchange or the imposition of limits on the number of syringes participants may acquire per transaction are not supported by public health evidence and may impose harm upon SEP participants. This recomm endation follows the U.S. Public Health Service guidance that advises people who inject drugs to use a new, sterile needle and syringe for each injection.”

We implemented the policies outlined by CDPH for syringe exchange programs in California. This was to ensure that not only were we doing each necessary piece as outlined by the state but that we also were operating in credible ways that protect staff, volunteers and the community. Some of these policies include needlestick protocol, collection and disposal, and a syringe dispensing plan. In all of these cases we implement CDPH policies and procedures almost word for word. The policies that our organizat ion operates under provide thorough and detailed actions, boundaries and required services. Similarly, just as with most areas of our operations, we exceed what is asked of us.

In March we began providing one day of exchange in the PalCo marsh and one day at St. Vincent De Paul free meal. We continued to provide exchange and outreach services in the Marsh until eviction day, when we pitched in and helped people move out. After May 2nd we began going to the sleeping sites and providing exchange. This was to minimize the issues around people no longer having a stationary place to collect their sharps waste and to remain connected to our consumer base.

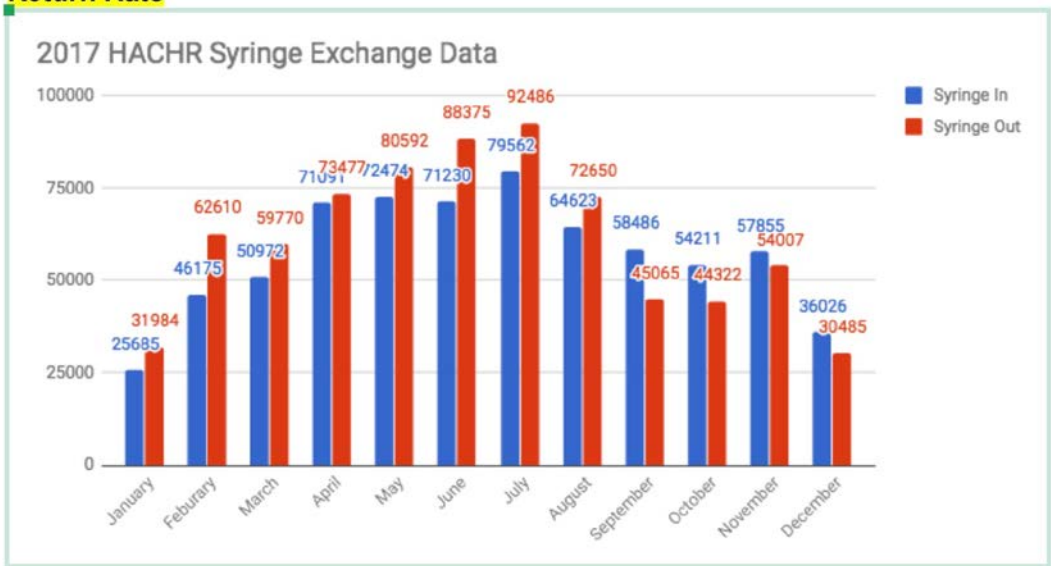
In August of 2016 we were able to secure a location in Eureka, near the County Courthouse at 924 5th Street. Securing this location allowed us the ability to begin our drop in services. However, this location posed a huge barrier to substantially

improvin g return rates. It is a well documented fact that fear of Law Enforcement is a barrier to improving return rates and we saw this to be the case at our 945 5th Street location. Due to our community's grossly high prevalence of HCV and transmission rates, we continued to maintain our needs based policy. In 2016 we distributed 240,189 syringes and 193,867 were returned. This equaled an 80.70% return rate. This is o n average a very normal return rate and in many places is considered a good return rate. This is not the case in this community.

2017 exchange

In 2017 our services and location experienced a lot of growth and change. In 2017 we had settled into our 924 space and had begun to implement many programs in our new space and growing program. Our inception of exchange services in 2016 barely began to give a glimpse into the true need for Harm Reduction services in our community. Yes, our exchange numbers are l arge, and to people uninformed of how SEPs work they may not understand the sheer need or what the numbers even really mean.

2017: (688390 syringes collected / 735823 syringes distributed) = 93.5% Return Rate



The need in our community is huge and so it may seem as though paternal, reactionary rules are warranted. However, they are not useful , warranted or best

practices, nor are they shown to increase return rates (Kral 2014). The real danger associated with syringes is when people who need them don't have access to them. As we watch our HCV rates continue to skyrocket we are seeing other related issues develop. We have been warning what puni tive, restrictive measures would create, and now we are here.

In 2017 Herman Spetzler and Open Door Community Health Centers allowed us use of the old Mobile Medical building at 1522 3rd Street for our program. This building has had a very long history wit h people who use drugs. A number of decades ago this building provided low rent rooms that housed many people who were experiencing issues with substance use. At one point the building was condemned and had to be rebuilt after a fire. Our building then b ecame the Mobile Medical Office and served some of our most disenfranchised community members, as it still does. After Mobile Medical, the building became Open Door's Suboxone clinic until the program outgrew the building. It then served as an administrat ive offices for Open Door until it sat vacant and then was given to us.

During the transition time in August and September our exchange was closed for much of it with very sparse hours. This greatly impacted our organization and the community in many wa ys. During our transition period a clean up was done by PacOut Green Team. They went into locations where camps had been the night before and pulled out Containers and syringes, both old and new, took them over by the skate park and took pictures of them. These photos were shared widely across social media. Because the community did not understand that people keep their syringes in their camps because they have no other place to go nor anywhere to take their syringes, these shared photos caused a great hyst eria campaign to begin. The target of this campaign has been our program, and ours alone. This was supported by a number of council members as it was shared over and over again, and we soon became the organization held fully responsible for any and all syringes within this community. This was made clear by the recent ordinance that has been passed, as it does not apply to any other entity but ours and is not built on fact or best practices.

Since August, we have been forced to go to a progressive needs bas ed which is basically a 1:1 for much of our consumer base, even in the face of a growing cluster of new HIV cases; 4 new cases in the last 6 months. This is what we have been warning the community about. This is the issue that our community can not afford in multiple ways --not health, not loss of life and not the potential to spread. We cannot afford these consequences, and yet here we are. A *progressive* needs based approach is essentially a 1:1; if someone brings back their syringes then they may get more if, overtime, they consistently show they are able to bring them back. This does not promote “new supplies for every shot” as laid out by the CDPH, AMA, and WHO. HIV has no cure, but we know how to help prevent it. Hopefully in the future this community wi ll put the effort in to help reduce the spread of infectious disease. Syrine litter is not a quantifiable danger to the spread of disease. There has only been 1 case of HIV potentially spread through syringe litter (which is suspect since the person stuck was also an IV drug user), and 3 cases of HCV worldwide (none of them were in the USA nor were they children).

Life Skills and Connection:

HACHR aims to support our consumers as whole, complex people who may find interest in participating in a variety of p rograms. All of our programs and projects are not only geared to improve the mental and physical health of our consumers but to also increase involvement, build new skill sets and strengthen existing skills. Many people in our organization started as consu mers and through slow, sustained progress are now employed, housed and engaged in different types of treatment. Some of our programs include art group, peer leadership, peer educators, and Old Town Clean up. Connection, or lack thereof, can be the decidin g factor in someone's personal success or failure, and is especially true when addressing issues of substance use. We have created programs that have been proven to work and that have extensive input about their design and efficacy by HACHR volunteers and peers. It is this involvement, at the design level, that promotes inclusion and a highly utilized program.

Art Group:

Art group is a collaboration between Leslie Castellano of Synapsis and HACHR, is held every Tuesday during drop -in hours, and is led by a lead Peer. The program is overseen by Leslie, who obtained funding for the art supplies as well as hourly pay so that a peer can lead this group. Art group is going well and has been engaging people on different levels in a supportive environment. This g roup is not only encouraging to our consumer base but also provides skills and leadership development for our Peer leaders.

Peer Leaders:

Our Peer Leadership program has been in place since our beginning and has proven to be very successful. Skill bui lding and development are major components of this program, and through doing so we have watched people build new lives. One of the core principles of Harm Reduction is “nothing about us without us” and we absolutely hold that at the core of our programs. People who currently or previously used drugs are involved in every step of development and implementation of our programs. This fosters inclusion and increased access to community which has been proven to promote healthier options and choices.

We have a few types of Peer Leaders: Kitchen Coordinator, Outreach Coordinator, and Health Educators. Kitchen Coordinator is in charge of making sure the kitchen runs smoothly during drop in hours, creates shopping lists, helps create the menu, does dishes, and as sists with shopping. We have just hired a new Kitchen Coordinator as our previous one just left the position. He has moved on to become part -time paid staff which left us an opportunity to now support another Peer in the kitch role. The Kitchen Coordinator position can be a challenging job, as this person is also responsible for keeping an eye on the space, so this position really develops interpersonal skills, attention to procedures, and enforcement of boundaries. Even though this is a challenging positio n it is a great building block for communication and leadership. Kitchen Coordinator is really in the thick of it all and has to show integrity in their work and word. This position requires people to begin to build healthy boundaries and communicate them well. Those skill are developed over

time but this role really helps show why boundaries are important and how to tactfully ask people to respect them.

The Outreach Coordinator is a Peer who has grown leaps and bounds over the past two years and has prov en to be an amazing leader. This woman, just like all HACHR peers, started out as a consumer. Through her own courage and with support, she began to create slow, sustained progress in her life. HACHR's Outreach Coordinator is responsible for scheduling hel pers, scheduling stops, maintaining and managing supplies, staying current on related health information, training student helpers and general oversight of the program's development.

Health Educators:

Peer Health Educators are not a paid position but the y are a critical force in preventing the spread of disease in our community. Our peer educators have the most current information on local trends of STD's, HCV/HIV, Overdose Prevention, communicable disease, soft tissue, and treatment. Peer Health Educato rs are a pivotal piece of getting a handle on our local drug use rates and related data. It is through these peer's networks that we can provide real and accurate information on substances, their use and health care issues. We work to maintain a very high level of engagement with state and national organizations that closely monitor trends, research, and treatment and we provide this same information directly to our peer educators. We also work to include them in conferences. In October The National Harm Re duction Conference will be held in New Orleans and we will be sending two staff and two peer educators to attend.

Developing Programs:

While we have been providing services for two years, we are in no way done building our programs. The original vision of HACHR is almost in place and is missing HCV testing to treatment and suboxone. The Suboxone component may be a little ways off, but tes ting to treatment is not, and we are working on a new self - care program. Our programs and their implementation design are built on evidence so they take time and large collaborations to develop and create sustainability.

Testing to Treatment:

HCV testing and treatment is a founding vision of HACHR, and we are at the final stages of completion thanks to a lot of work and large collaboration between HACHR and Open Door. Some of the capacity building around HCV testing to treatment, not only in our communit y but with HACHR, came from Jennifer Slepin, R.N. of HepCareStream. CDPH, AIDs United, Project inform and numerous other advocacy and health organizations call for the prioritizing of testing and treatment of people who use drugs intravenously and especial ly homeless women under 30. We have also been asked to join the select group of folks working on HCV in their communities through *Getting to Zero*. *Getting to Zero*is a state policy planning group formed to create the strategy for getting to zero for HCV i n California. We have been asked to participate in the *Getting to Zero*for HIV in California as well.

Herbal Self Care Clinic:

This is a special project created and implemented by a community member who is very interested and concerned with the lives and health of people who use drugs. This will be a bi -monthly workshop for HACHR consumers about herbs and self care. This is also serving as a class to help people understand what actions they may want to take to stay safe from overamping or herbs they may wa nt to use in future detox plans. This person is a sexual health educator and an herbalist; she is doing this class as a way to support the folks many deem disposable.

Program Limitations:

Being that we are a young program, for the past few years we have been steadily growing and building our program, our support base, and collaborations. Starting and building a program comes with its own set of unique challenges. Couple those with the chal lenges of Harm Reduction work in a rural area and it proves to be a large and meaningful workload. The two areas where our program was really lacking was funding for staffing and access to Doctors and Medical Staff that

weren't already overburdened. Minima l access to medical care is something we as a community struggle with daily. However, for people who use drugs this greatly increases, and until recently this was especially true for issues relating to HCV.

Staffing Capacity:

It has only been a little mor e than a year that we have had the capacity to have paid staff. Within the past 15 months our capacity for staffing has grown exponentially. We now have three hourly positions and three peer stipend positions. The hourly positions include Executive Directo r (ED), SEP Coordinator and Old Town Clean Up, and our Peer Positions were discussed in a previous section of this report. With the increase in staffing we have been able to increase the amount of students and volunteers we can manage which allows us to ru n more programs and stay current with all of our resources. Staffing also allows us the ability to host many more educational trainings and events in the community as well as participate in groups such as RxSafe Humboldt, Syrine Management, California Hep atitis Alliance, and the HSU community advisory board, just to name a few.

As our program becomes more robust and we continue to overcome the obstacles set in front of us, our funding support base grows as does our ability to increase staffing. In this com ing year we are hoping to increase the pay of our current staff but to also add at least one more staff member.

Limited Doctors in Area:

Minimal access to medical care is something we as a community struggle with daily. However, for people who use drugs this greatly increases, and until recently this was especially true for issues relating to HCV. As we as a community work together to improve access to medical care we will likely see a decrease in some of the health issues related to substance use. Albe it anecdotal, we have seen a reduction in soft tissue infections in our consumer base as we continue to give appropriate education and supplies. The Nurse from HepCareStream has really built amazing

capacity with doctors and medical staff locally around HC V and she is making good progress with how we treat people who use drug in medical settings as well. She has been a valuable resource for our community and program. Before she leaves town she is working to ensure that a Nurse from Open Door will be prese nt to help continue her work with our consumer base.

Conclusion:

In this report we have discussed our operations, Internal/Local/State policies, challenges, data collection, partners and successes. We have illustrated with confirmatory data that we have a reputable return rate and program, growing and continuously devel oping support services as well as appropriate services and education for PWID and our community as a whole. We hope that through reading this report and the supplemental information provided that it will lend to furthering the understanding of the operatio ns and policies that drive our program as well as reduce the spread of deadly misinformation. The consequences of spreading misinformation is deadly and it is only though honest and open communication that we as a community can develop and implement evide nce based practices that are grounded in science and evidence.