Robert Bossarte: Welcome to OOMPH. OOMPH is an informal discussion with injury control researchers to help our listeners think about these topics in a brand new way. Today, I am joined by a panel of very learned and esteemed co-hosts, colleagues. I'll let them introduce themselves, starting with Sara who our broad listenership has heard from before. Go ahead, Sara. Dazzle them.

Sara Warfield: Hello, I'm Sara and I'm a third-year PhD student in the school of Public Health, department of epidemiology.

Robert Bossarte: That's dazzling.

Dan Shook: My name is Dan Shook. I'm the director of the WVU greater Morgantown Safe Communities initiative, and I just want to apologize ahead of time for my voice and these kind of weird noises I'll be making because I have a contagious upper-respiratory disease.

Sara Warfield: Great.

Robert Bossarte: Good to know it's contagious. The rest of us will be going down soon.

Sara Warfield: [crosstalk 00:00:43] close to me.

Robert Bossarte: Yeah, thank you. And today's seed of discomfort, Robin Pollini.

Robin Pollini: Hello. Thanks for sitting next to me, Dan. I'm Robin Pollini. I am an associate professor and also the associate director of the Injury Control Research Center, sponsor of OOMPH.

Robert Bossarte: Sponsor of OOMPH. And we dragged Robin here today, somewhat unwillingly.

Robin Pollini: You did. Thank you for inviting me to sit in the seat of this despair and discomfort.

Robert Bossarte: Thank you for agreeing to sit in the seat of despair/discomfort. And we're going to talk to you today about your research and work with the community, which West Virginia is thrilled to have you. And we're going to open it up to whatever you want to talk about.

Robin Pollini: Oh my goodness.

Robert Bossarte: Isn't that generous of us?

Robin Pollini: Yes, and unexpected.

Robert Bossarte: [crosstalk 00:01:26] because we're usually so scripted and so formal.

Robin Pollini: Yes, I expected questions.

Robert Bossarte: Yeah.

Robin Pollini: Do you have any questions you'd like to ask me?

Robert Bossarte: I do, thank you. Should we start with questions from the audience?

Robin Pollini: I'd love that.

Robert Bossarte: Sure. How about me? Sounds good.

Robin Pollini: Why don't you go first?

Robert Bossarte: I'll start with the question. So, what do you do?

Robin Pollini: Wow. Okay, so ...

Robert Bossarte: I know, but they don't. I'm sorry for pretending like I don't. Go ahead.

Robin Pollini: So I often say I do drugs. So I research drugs.

Robert Bossarte: Interesting.

Robin Pollini: Primarily injection drug use and all of the adverse health effects that come with injection drug use. My focus is primarily harm reduction, so looking at how we prevent overdose, HIV, hepatitis C, abscesses, and all of those things among people who inject drugs. And so I do research on that as well as a lot of community work. And I've done it many, many different places, but I'm now happy to be in West Virginia.

Robert Bossarte: Is there a particular focus or ... let me back up. What brought you to West Virginia? Why West Virginia?

Robin Pollini: Great question.

Robert Bossarte: Apparently Sara was going to ask that question.

Sara Warfield: I was.

Robin Pollini: Thanks Sara. I had the same question.

Robert Bossarte: Hey Sara, do you have a question for Robin?

Sara Warfield: No, it's okay. No worries [crosstalk 00:02:30]. You're doing a great job.

Robert Bossarte: Thank you.

Robin Pollini: So the question is for those who didn't catch it the first time, what brought me to West Virginia? So I am a rural person by birth. I'm from New Hampshire, and I grew up in a town of 3,500 people, and so when we started seeing more drug use in rural areas, I was very interested in that and also felt that it's something to contribute because I'm a person who understands rural culture, how things happen in rural communities. So I started doing work in more rural areas, first in central California, and then was meeting with people in West Virginia, trying to figure out if there were ways that I could help here because I was living in Maryland. Kind of kept talking to them. Things didn't pan out, but then when I saw the advertisement for this job that I'm in right now, I applied for it and got it. So thanks for hiring me.

Robert Bossarte: We're lucky. Now Sara, I have another question I'd like to ask, but it may be a question that you want to ask, so I thought I'd check with you first.

Sara Warfield: Go ahead. Take it for me.

Robert Bossarte: Am I good? Alright. So, are you sure?

Sara Warfield: No, go ahead.

Robert Bossarte: Alright. So, why drug abuse? Or why drug use as a topic of research, and why harm reduction in particular? I mean ...

Sara Warfield: I was going to ask that, but yeah.

Robert Bossarte: I think you're going to do that for every questions.

Sara Warfield: Harm reduction, specifically. Yeah.

Robin Pollini: That's a good question, I guess.

Robert Bossarte: Thank you. High five. Thanks.

Robin Pollini: So I definitely wasn't one of those people who knew what I wanted to do right out of the gate, so I took 10 years between my undergrad and grad school. And I was working in a variety of health ... actually, so, my undergrad degree is in international politics, and I was an American-Soviet studies major. In my senior year, the Berlin Wall came down. There was no Soviet Union anymore. So I always tell students to have a plan B.

Robert Bossarte: Oh yeah, that's a curricular.

Robin Pollini: Yeah, exactly. Maybe you're studying HIV and the cure comes up tomorrow. You want to have a background plan.

Robert Bossarte: I studied 14th century French poetry.

Robin Pollini: Did you really?

Robert Bossarte: No. But it's really obscure.

Robin Pollini: Anyway. But I got interested in health and started doing a variety of health-related jobs. And the last one I had before I went back to grad school, I was doing infectious diseases and I wanted to kind of keep up on what was going on with HIV. So I took this night class at Harvard and ... name dropping. Took this night class at Harvard. And I wrote my term paper on needle exchange programs, and was really interested in the research around needle exchange, and there were some really cool studies where they bar coded syringes, and sent them out into the community, and then they came back. And I just thought that was the neatest thing ever.

Robin Pollini: But clearly, all the data show that these are very effective programs in reducing HIV. And so it seemed like a no-brainer to me. So at that time, there was actually a full federal ban on using federal funds to fund needle exchange. So you couldn't use any federal funds for anything really into needle exchange. And the president at the time, Bill Clinton, was deciding whether they should repeal that ban. And every indication was that it would be repealed because of all this great science. And so, at the very last minute, which was the day before I turned in my term paper, he decided not to repeal it.

Robert Bossarte: Based on what? Obviously not evidence.

Robin Pollini: Well, the story is that he was ready to repeal it and then on a plane trip, the drugs are, at the time, Barry McCaffrey sat next to him and convinced him not to.

Sara Warfield: Hmm.

Robin Pollini: And that was it. So everybody in Washington thought he was going to repeal it, and I became very angry. I said, well wait a minute. We know that these programs work. Why wouldn't you do this? So mostly I'm fueled by righteous indignation about the fact that there are many areas which we know what we can do to make health better, but we don't do it for a variety of reasons. But then I went to John Hopkins. I was going to study something else, and I very, sort of, fortuitously ended up going to an HIV class, and then walking up the sidewalk with this woman who, harm reduction, needle exchange was her specialty.

Robin Pollini: I started chatting to her about all these studies, and she said, do you want a job? So this walk down a sidewalk basically changed my life. Maybe saved my life, but it definitely changed my life. Yeah, and I've been doing it ever since.

Robert Bossarte: And, tying it back to your original point about wanting to do something in rural areas, is there something unique about harm reduction programs in rural areas?

Either the impact, I mean there's ... I'm betting there are unique ways that they are implemented.

Robin Pollini: Yeah.

Robert Bossarte: And unique barriers.

Robin Pollini: Yeah, so generally, harm reduction programs were always instituted in urban areas, and their implementation in rural areas is a relatively new phenomenon, in part because we now have a lot more drug use, and particularly things like heroin use and injection drug use in rural areas, although there has been some, you know, always over time. So we're seeing these programs more in rural areas, but they do come with particular challenges. One is a challenge of confidentiality. So people who are going to these programs, you know, everybody in town knows each other.

Robert Bossarte: Right.

Robin Pollini: So you want to be able to go somewhere where people aren't going to see you going in. That's why a lot of rural programs are mobile, so they drive around to different areas instead of being in one set location where people can see you going in and out. Definitely a lot of rural areas tend to be more politically conservative, and needle exchanges don't do as well in politically conservative areas. Transportation issues are a really big deal, which is another reason why mobile units are good for rural areas.

Robin Pollini: So there's a variety of things. I think one of the benefits I have as a rural person, I'm not from West Virginia, and definitely the culture between New England and West Virginia is different, but I can go in and sort of operate in a small town because those people are very much like the people that I grew up with.

Robert Bossarte: Right.

Robin Pollini: And so it's building a lot of trusting relationships, both as a researcher and with the needle exchange and the people that they provide services to.

Robert Bossarte: Dan, what do you got?

Dan Shook: I have a whole bunch of different things, but you know, the one thing that you brought up, I know there are different parts to harm reduction but you mention needle exchange, which seems to be a controversial issue right here in the state of West Virginia. Why is a needle exchange program good? Why do we need one?

Robin Pollini: Yeah, so there's 30 years of science behind needle exchange programs that show that they're effective in doing a number of things. One is reducing the incidence of HIV, and it does that through reducing syringe sharing. So if there

aren't enough syringes in the community, and you and I are using drugs, we might share a syringe because we don't each have our own, right? And so it'll help to reduce the incidence of HIV. It reduces needle sharing and sharing of other injection equipment, which reduces hepatitis C. It reduces syringe reuse, which results in abscesses and really serious systemic infections, like endocarditis, which is an infection of the lining of the heart and the valves. Very difficult to treat.

Robin Pollini: And they also do things like ... needle exchanges do things like provide referrals to treatment. So there was one study that people quote all the time, that people who are engaged in syringe exchange programs are five times more likely to enter treatment than people who don't. Obviously you need to have treatment slots available for people to go to, which is another problem we have in West Virginia and a lot of rural areas. A lot of needle exchanges distribute naloxone, which is used to reverse opioid overdoses. So just a wide variety of things that these programs do.

Robin Pollini: And so we know that they're effective. And so, you know, in a place where you have a lot of injection drug use, they're really, really critical programs. The other thing I'd say is that these programs are very respectful of people who use drugs, and they meet them where they are, make them ... help them to make healthier decisions. And so these are programs unlike, maybe, a physician's office or an emergency room where people feel really welcome. And those programs are tailored to them, and so they feel comfortable going to them.

Robin Pollini: I think sometimes people forget that drug use is, by definition, illegal. And so you're asking someone who's engaging in illegal behavior to present themselves in an institutional setting to get services, and that can be a really difficult decision for people to make.

Robert Bossarte: So let's have fun and put the controversial things on the top. [crosstalk 00:10:10]

Robin Pollini: Fantastic. Lets do it.

Robert Bossarte: So, those are all the reasons to support harm reduction programs and syringe exchange programs, but where's the opposition coming from? I've heard some of it. I know we've had some of it in this state recently.

Robin Pollini: Mm-hmm (affirmative), we have.

Robert Bossarte: I know some of it's out in my backyard, that these are people who are doing illegal activities, and these are people who have other failures, however we want to individualize this in any discriminatory way, and we don't want them there. Where's the opposition coming from?

Dan Shook: Yeah, I've been in meetings too where law enforcement, their heads explode when they hear that people are passing out needles to these addicts. And it sounds like they're not getting the information.

Robin Pollini: Well, I mean, law enforcement has a different role, right? So as public people, we're concerned with keeping people healthy. And law enforcement, they're charged with keeping people safe, but also enforcing the law. And so when you have drug use being illegal, that already kind of puts public health and law enforcement at odds, although I'll say, there's many communities where they work together really effectively just to keep people safe and healthy. So the major opposition to needle exchange programs tends to be that people think that we're handing Rob a pen because ...

Robert Bossarte: Rob needs a pen.

Robin Pollini: Yeah, Rob needs a pen. People think that it enables drug use. So they say, well, you're giving people syringes and so now they're going to inject drugs, and if you didn't give them syringes, they wouldn't inject drugs. And we know that that is patently false. So people are going to inject drugs whether you have syringe exchange programs or not, which is evidenced in West Virginia by the fact that we had an injection drug use problem before we had syringe exchanges, right? So, it doesn't enable drug use, and we know that from research. People don't inject more. New people don't start injecting because we have syringes.

Robin Pollini: What it does do is it enables people to inject more safely who are going to inject anyway. So when people talk about enabling, I like to say, yes, it does. It enables people to inject more safely if they're going to inject. So I would say that that's the major opposition. Other things are that people will say that there's more syringes out in the community. Studies show that that's generally not the case where needle exchange operates because you can bring syringes back.

Robert Bossarte: And why is that bad?

Robin Pollini: Why is it bad to have ...

Robert Bossarte: More syringes in the community?

Robin Pollini: Oh, I mean discarded syringes. I mean, you want more syringes in the community because your goal is to have a new sterile syringe for every time a person injects.

Robert Bossarte: But we don't want them in our parks and malls.

Robin Pollini: Absolutely. Nobody does. And that includes people who inject drugs. A lot of them are parents. They don't like to take their kid to the park and see syringes around.

Robert Bossarte: You know, you said something profound I had to reflect on for a moment. It sort of reminds me of the sex ed classes.

Robin Pollini: Thank you.

Robert Bossarte: You're welcome. Yeah, the sex ed classes and distributing condoms, right?

Robin Pollini: Yes.

Robert Bossarte: We get kids condoms, they're going to have sex. They got [inaudible 00:12:49] sex, chances are it's going to reduce itself, right?

Robin Pollini: Yeah.

Robert Bossarte: So syringe service programs don't work if people aren't injecting drugs. There has to be a demand first.

Robin Pollini: Yes, exactly. And in general, those ... it's a little different here because we house syringe exchange programs for the most part in health departments. But in general, when nonprofits set up syringe exchange programs or even other entities, we set them up where the drug use is because we don't want people to have to travel far to get the services. So in general, what you see is the services are co-located in a place that's convenient for the people that need to get to it.

Robert Bossarte: So you're telling me that the availability of syringes is not a motivating factor to start drug use.

Robin Pollini: That is correct.

Robert Bossarte: Oh [inaudible 00:13:31].

Robin Pollini: Scientifically proven.

Robert Bossarte: It's good. We cleared that up. I feel like we've done a public health good right. I wanted a pen because you made a comment about ... as public health, we're interested in keeping people healthy. And I think, and I'll want your opinion on, it seems that the support for harm reduction programs and support for injection drug using populations does this in two ways, right? We keep the individual safe by making sure that we reduce the risk for infectious disease and other adverse outcomes. But by working on our environment in our community approach to manage, to working with this population, we also work on addressing some of the underlying factors that may have contributed to the likelihood of drug use in the first place.

Robert Bossarte: And if our long term goal is to promote resilience and safety and health and acceptance, then the harm reduction programs are, in many ways, an extension of that effort as well, or can be.

Robin Pollini: Yeah, they are. And I think one of the things that has gotten sort of lost in the recent conversation in West Virginia is that these programs do two things. One is a sort of issue of keeping the individual person who's in front of you safe, right? Keeping them safe from disease. But if you keep enough of those people safe, you're protecting your community from disease. It's like vaccination, right? If you vaccinate all the people in your medical practice, those people are going to be safe. But if you're the only one doing that, the disease is still going to come into the community. You have to have a certain number of people covered.

Robin Pollini: And so syringe exchange is the same thing. Providing syringes to 15, 20, 100 people is going to keep those people safe, but it's not going to keep your community from transmission of disease. So our goal is to get as many people involved in those programs as possible. But, you also create sort of more resilience in a community when you lift up the people that are most marginalized.

Robert Bossarte: That's right.

Robin Pollini: And so what these programs do is say, we're glad you're here. We acknowledge what is it you're doing. Why don't you tell us how we can help you to stay as safe and healthy as possible until maybe you decide to do something else. And so those relationships are really profound, and I think people who don't do harm reduction aren't aware of that. And I know Sara volunteers at a syringe exchange here in Morgantown, so she can speak to that as well. It's a very profound human experience that takes place in these settings.

Sara Warfield: Yeah, and when you hear about that stigma that's associated with these individuals, it's really sad to hear about some of the experiences that people have had. And this issue is often highly politicized right now. And people who inject drugs are often very stigmatized, and I know you've researched on this as well, so given your experience, what do you think can be done to change the stigma on these individuals that we can make [crosstalk 00:16:18]?

Robin Pollini: Yeah, so stigma comes up a lot. There's a lot of campaigns going on around stigma, and stigma and drugs. I just wrote a paper, I think we were talking about this the other day, where we looked at a study I did in California, in central California which is really rural, among people who inject drugs. And we interviewed them about a variety of things related to accessing syringes and those kind of things. We didn't ask about stigma. It's actually a very difficult thing to ... what is stigma, right? Like how do you talk about it?

Robin Pollini: But people brought this up in the majority of our interviews, that when they went into a pharmacy to try to buy syringes, they were turned her away or made to feel bad because there were a drug user. When they would go to the emergency room, they were put at the back of the line because the people and the emergency room didn't want to deal with them. They are treated everyday, all day, by people on the street, by their family members. Not that, you know ...

definitely sometimes, you know, we're all difficult to deal with at one point or another.

Robert Bossarte: Not me.

Robin Pollini: Except for Rob and Dan, obviously. But you know, they experience this everyday, all day. And it's a really big factor in their health and their ability to obtain services. So I've thought a lot about this because my theory is, from the research that I've done, is that a lot of times when we look at drug users, people that don't interact with them very often, they see a stereotype. And so Dan used the A word, addict. I never use that word because it suggests that this person is only their drug use.

Robin Pollini: There are people who use drugs, they do use drugs, but they also have all of these other characteristics and experiences and whatever. And so my theory is, is that if we could move from seeing them as a drug user or the A word, addict, to an individual like Sara, who is a student but also does this, and this, and this, that that changes how people look at them and treat them. And so I'm really interested in thinking about ways that we can sort of add that humanity. And when people look at people who use drugs.

Dan Shook: Can I ask you, and are you allowed to speak about the project you're working on now? Which actually for me, you've taught me a lot to understand that this is a disorder. This is a disease, and these are people. They're not some distant and, you know, some organism sitting out them, but people with feelings. Are you allowed to ... do you feel comfortable talking about the project?

Robin Pollini: Yeah, the photo voice project?

Dan Shook: Yes. I mean, that's pretty cool.

Robin Pollini: So I'll mention this. We're actually, I think going to do ... maybe it'll air before this, but we're going to do a podcast on the photo voice project that I'm working on ...

Dan Shook: Cool.

Robin Pollini: With Health Right in downtown Morgantown. One of the ways that I think that you can sort of try to humanize people ... I hate to use that word because they're human already, but really humanize people who use drugs is to allow them to tell their stories and present themselves as multifaceted people. And so I have realized a dream that I've had for a really long time, which is doing a photo voice project with people who inject drugs here in Morgantown. Photo voice is when you give cameras to people from marginalized or vulnerable populations and let them use those cameras to tell stories about their lives because often, they don't have a voice or a foundation to sort of tell that.

Robin Pollini: And so we got a grant from Mon County Coalition and ICRC is matching those, and we have a documentary photographer from Los Angeles who's been beaming in, but she's actually in town now, and a group of about ... between eight and twelve people who participate in the needle exchange who have been taking photos and learning about photography and using that to tell about their own lives. Then we're going to have an exhibition, and we're going to be able to travel with it, so take it to different meetings.

Dan Shook: Cool.

Robin Pollini: And we'll talk about that in another podcast, but what's really striking is that we go to those sessions. They're about an hour and a half. And we don't talk drugs at all. We talk about art and beauty and ways of seeing and community. And it's just a really powerful experience, and I can tell that the participants are enjoying it, but probably not as much as I am. So more on that in another podcast.

Dan Shook: Go ahead.

Robert Bossarte: No, go ahead.

Dan Shook: I only had two more things before I hack up something.

Robert Bossarte: Which we all look forward.

Robin Pollini: Thanks for that visual.

Dan Shook: I feel it's coming.

Robin Pollini: The seed of disgust.

Dan Shook: One is personal, but I'll ask that one second. But the first one is, when I was down in Charleston with Rob not too long ago, I overhead some conversation, or maybe it was in a meeting where we were at. And I woke up and heard this part, but I heard some comment about the opioid deaths in West Virginia are going down. And I know we lead the nation in this, and I'm thinking, okay. Is that true? And if it is true, why would they be going down? Do you have any data suggesting that?

Robin Pollini: So we have consistently had ... West Virginia has consistently had the highest overdose mortality rate in the United States. Right now, it's 52 per 100,000. We've been number one since ...

Sara Warfield: 2009.

Robin Pollini: 2009, okay. So almost a decade. I have heard rumblings that that number might go down this year, but I have not seen the annual data. So I really think it's too early to say.

Dan Shook: And we shouldn't assume that oh, we're doing a good job because it's going down, correct? Or ...

Robin Pollini: Well, there's a variety of things that can impact it, right? One is a lot of the increasing death has been fueled by fentanyl, which is a very potent opioid, much more powerful than heroin, that's been cut into the heroin supply in West Virginia. And some places in the country, it's just straight fentanyl. You can't even buy heroin anymore. That has pushed up the number of deaths significantly. If it goes down, it could be because we're getting more people into treatment. It could be because we're getting more in naloxone out, which is the drug that reverses opioid overdoses, and so people are overdosing but they are getting reversed.

Robin Pollini: It could be that people are just learning a lot of ways to use safer. So you know, testing your drugs, there's all kinds of things you can do to inject more safely. So it's really hard to say. You have to control for a variety of things, but I think that we need to wait for next year's numbers and see.

Dan Shook: Okay, my last question before I hack up something, this is personal. I tend to be ... the emotional side of me tends to overpower the intellectual side. I want to know, how do you emotionally deal with a population of people that we tend to disregard, that we don't work with everyday, that we're not very close to? I mean, it's got to be emotional for you as well, right?

Robin Pollini: So yeah, I've had this conversation a lot recently which is, I'm a researcher. Right? I do community work, but I'm a researcher. And I am not a frontline harm reduction worker. So there are people that go out, and they're working with people who inject drugs all day, everyday, right? Or some of the social workers I work with. Those people are frankly traumatized right now because they have seen so many people die. And they have seen so much suffering. So I'm at a very privileged place, I think, that I have the opportunity to engage with folks who use drugs. I really enjoy that. That's my favorite part of the day.

Robin Pollini: But I also have the opportunity to step away. And so, is it hard? Sure. I mean, you ... people kind of self-select for this work. So, you know, you go to the needle exchange and you befriend someone, and then they don't show up anymore. And you say, well I hope I got into treatment, but maybe they also are not with us anymore, you know. You never know. Or you'll see people maybe on your staff who used to use drugs and they were in recovery, and then they relapse. You just see a lot of human suffering. A lot of human suffering.

Robin Pollini: And I also have to be careful of that with my staff. I have staff right now that are doing qualitative interviews with folks about overdose, and I was just reading one. I was like, wow, this is really intense. You have to be mindful of the fact that your staff need a lot of emotional and mental health support. So it is challenging, but I do think that people self-select for this work and are just really committed. Righteous indignation is the initial thing, but then it's just, if you don't do the work, who will do it? Right?

Dan Shook: Yeah.

Robin Pollini: So you have kind of an obligation. But I just ... I really love what I do. And I would rather spend time out in the community with people who use drugs than here with you.

Dan Shook: [crosstalk 00:24:42].

Robert Bossarte: We get that.

Dan Shook: Yeah.

Robin Pollini: I do get that sense.

Dan Shook: Well, thank you Robin because you know ...

Robert Bossarte: We all feel the same way.

Robin Pollini: Yeah, really? About Dan? Yeah.

Dan Shook: I cause some people to start using drugs. You know, I think we tend to forget, I know I do, about the people that work with these individuals that need our help. And the family members. I always forget about the family members of these people.

Robin Pollini: So I have a Massachusetts project where we're also ... that was one of the ... I was just reading an interview from a family member whose son overdosed five times, and she's talking about responding with naloxone and you know, like I said, I'm in a very privileged place. I don't live that reality every day. But I'm just learning about, through this study that I'm doing in Massachusetts, about how families are affected. I really think that it's something that we don't think about. And it's really important for West Virginia because for every person we have who uses drugs or injects drugs, they have a family. They have a mom and a dad, and a lot of times, kids ...

Robert Bossarte: Kids.

Robin Pollini: And brothers and sisters. So I'd love to see more research on how we can support families better.

Dan Shook: I think you've even [inaudible 00:25:44]. I'm misquoting you. We've talked before about how this is a community issue or thing that we need to work with instead of just battling it by ourselves or with a small group.

Robert Bossarte: Well, that comes from Robin. Yeah, it's not just about any particular segment of the population, but it affects the entire population. I know in my particular field of work, in suicide prevention research, we talk about every death from suicide

impacts at least six people directly. And you, you have to consider not just the individual that you've lost, but the impact that that person's death has had upon the family and the community because ... and I guess that's where I was going with my comment with you earlier. We tend to ... you know, you'll correct me if I'm wrong, but it's a moral judgment, right, that we tend to ... it's the same with persons with mental illness you have with suicide.

Robin Pollini: Absolutely.

Robert Bossarte: It's a moral failure of their part. They chose to use drugs. They're, of course, they're a problem. But it's not. It's our community and these people arrive at this place and ...

Robin Pollini: We can chose to treat people differently who have mental illness or addiction issues.

Robert Bossarte: Yes we can.

Robin Pollini: That's our choice as community members, right?

Robert Bossarte: And we can choose to see this as our problem, not their problem. Because the reality is, as you've said and as Dan was highlighting, it's a problem of families and of communities and the impact is felt by everyone, not just the individual who's injecting drugs.

Robin Pollini: Yeah, I mean ...

Dan Shook: It's about us, isn't it?

Robin Pollini: Yes, it's about us. I will say that in West Virginia and a variety of states, we do have a real deficit in services. And so it's very frustrating to me to watch that we somehow expect people to get better without having access to drug treatment or naloxone. Like, this person has overdosed and then they didn't go to treatment. Except, there isn't any.

Robert Bossarte: At the same time, we're even, implicitly perhaps, telling them they're bad.

Robin Pollini: Yes. This is your failure.

Robert Bossarte: That's right.

Robin Pollini: It's your failure that you use drugs, and then it's your failure that you didn't stop, instead of providing all the tools for people to have a fighting chance at doing that. And even when we provide treatment, is it evidence-based treatment? Is it treatment that we know works? So we sort of set them up to fail in a number of ways, I think. And that's very frustrating to me.

Robert Bossarte: So here's a giant questions. How do you go about fixing that? Where do we go from here? Where would you put your emphasis, or where are you putting your emphasis to try to help changes [crosstalk 00:27:49]?

Robin Pollini: Yeah, I have no idea.

Robert Bossarte: That's what I would say.

Robin Pollini: I mean, it's sort of this continuum, right? You and I have talked about it. So, you want to keep new people from coming into the drug-using population. So there's a primary prevention part. I don't do any of that, so I can't really speak to that. There's the part about keeping people who use drugs healthy, right, until they might decide to do something else. And then there's a part about getting them out of that if they want to stop using. So for me, I think we need a lot more harm reduction, right? Keep people healthy while they're using. But we really need more treatment. We really, really need more treatment in West Virginia and all across the country because there really are people waiting and wanting treatment who were telling them they're bad for using drugs, and they can't get into a program to get out of it, right? And I just think that's cruel. It's cruel.

Robert Bossarte: But those things are all related, right? The primary prevention, the providing assistance to people who are injecting drugs now, to getting people into treatment. There are certainly lessons to be learned from those who are currently injecting drugs about what may have prevented them from starting in the first place, a lot of which I imagine goes back to community and circumstance and settings.

Robin Pollini: Yeah, I don't think ... one of the reasons I stay away from primary prevention is it's really complicated.

Robert Bossarte: Yes.

Robin Pollini: Like the things that contribute to someone using drugs are really, really complicated and a lot of them are, you know, it's multilevel. I kind of stay clear of that because it's too complicated for me.

Robert Bossarte: Yeah, but what's interesting is that I don't think you find that complexity in the common narrative at least.

Robin Pollini: No, right.

Robert Bossarte: I mean, I think there's a tendency to point to West Virginia and say, okay, this is because we have a lot of unemployed people, a lot of people on physical labor who [crosstalk 00:29:19].

Robin Pollini: It's more complicated than that.

Robert Bossarte: Right.

Robin Pollini: Yeah, exactly.

Robert Bossarte: So even understanding there's a complexity to that that's not recognized right now and trying to find some way to address that complexity, which may ... almost certainly requires community-level change, I think is important.

Robin Pollini: Yeah. I mean, I think that when you look ... so I was trained in Baltimore, Maryland which has had a drug problem for a really long time. I worked in Tijuana, I worked in California. I don't think the reasons are all that different, right? If you talk to a person who uses drugs in downtown Baltimore and you talk to a person who uses drugs in southern West Virginia, there are a lot of things about lack of opportunity, lack of hope for the future, poor socioeconomic ... lack of resources. All of those things factor in. So I've always kind of wanted to do a study where you talk to people, urban and rural. And I bet you wouldn't find all that many differences.

Robert Bossarte: I think that's a fun study.

Robin Pollini: Yeah, absolutely.

Robert Bossarte: We should do that. Or you should do that.

Robin Pollini: Let's pick a city we want to travel to and yeah.

Robert Bossarte: Why not Baltimore? I love the charmed city.

Robin Pollini: Sure. Me too. Baltimore's fantastic, and it was a great place to study drugs. I did my dissertation on overdose back when nobody cared about overdose and I went out to move my car one day, because I don't like paying for parking, and there was a guy overdosed right in the street. And I thought, wow, I guess this is a good place to study overdose because I just literally walked right into one.

Robert Bossarte: Literally stumbled across your research work, yeah.

Robin Pollini: I literally stumbled across him in the street.

Robert Bossarte: Was he okay?

Robin Pollini: Yeah, so interestingly, he was in the middle of the street, lying there, and his girlfriend was trying to feed him pizza, trying to get him to wake up.

Robert Bossarte: It's like naloxone.

Robin Pollini: And so I went over ... yeah. I went over and the ambulance had already gone and left. So he had refused transport, which happens all the time. And so, he

and a medical student ... I and a medical student sort of helped walk him, drag him to the emergency room which was just down the street.

Robert Bossarte: Please tell me they had administered naloxone before they drove off.

Robin Pollini: I don't know. But this was 2000 and ... I mean, naloxone was just ... it's been around a long time.

Robert Bossarte: It's been around a long time.

Robin Pollini: But Baltimore was just starting its program, and they were one of the earliest. And I think Chicago is one of the longest-standing programs, but Baltimore was sort of one of the earliest adopters of a city-wide program. Yeah.

Dan Shook: Sara?

Robert Bossarte: Yeah, Sara, what do you have? You've got that look.

Sara Warfield: Yes. No, you guys asked a bunch of the questions that I was going to ask.

Robin Pollini: Well, Sara, you do some of this work, too, right?

Robert Bossarte: Yes, you do, Sara.

Robin Pollini: See how I turned it around?

Sara Warfield: I wouldn't say I do [crosstalk 00:31:49].

Robert Bossarte: That was nice.

Sara Warfield: I would say that I'm researching and I'm interested, so I'm not there yet.

Robin Pollini: What are the things that you've learned from volunteering at the needle exchange?

Sara Warfield: I would say, you get a personal level and understanding of what's going on. And to hear some of the narratives really do speak to some of the issues that are there, like treatment. I mean, I'll never forget hearing or having a woman come in and she said, I want to get treatment. I want to get help. She actually wasn't there to get syringes, and couldn't get her in. And seeing her months later, and months later, and get worse is extremely sad because if you don't meet that person the time they're wanting to change and the time they're wanting to get into treatment, you've missed a huge opportunity.

Robin Pollini: Yeah. Readiness for treatment is fleeting. It comes and goes, and so the trick is to have treatment on demand, so when that person is ready, we're like, great. Let us take you there right now. That's not what happens.

Sara Warfield: It's not what happens at all. And another thing is the adverse childhood experiences and some of the things you hear about. I mean, there's so much to what's going on and what these people have been through. Everyone makes mistakes. I know growing up, I've made a lot of mistakes. I was ...

Robin Pollini: Tell us about those.

Robert Bossarte: Yeah, why don't we start there?

Sara Warfield: My parents somehow made it through my teenage years. But I think that's why I really love the saying, love people first and ask questions second. It's to just be human and to think about other people and be altruistic and not ...

Robin Pollini: I feel like this is all really important, but we're about to approach a kumbaya moment where we all join hands and ...

Robert Bossarte: I know. [crosstalk 00:33:28] a group hug in this thing.

Robin Pollini: Is there? You won't be able to see that on the podcast, but [crosstalk 00:33:32].

Robert Bossarte: You'll sense the energy though.

Robin Pollini: Yeah.

Dan Shook: Just frustrates me about a lot of things is how do you fix it? I mean, I know what you guys do is not part of the cycle. You talked about, I think, primary prevention and if ... you know, I've had the Maslow's hierarchy of needs, you know ...

Robin Pollini: Well now you're just showing off.

Dan Shook: Well I am because I just have that up on my screen right now and I can read it and because I'm a PE major and I can at least read the screen in my head.

Robin Pollini: [crosstalk 00:33:55].

Robert Bossarte: What screen?

Dan Shook: So we identify all of these needs, which is kind of cool, but what are we doing on the reservations in South Dakota? What are we doing in souther West Virginia to help people with their basic needs of food and shelter and jobs? I mean, what ...

Robin Pollini: The most normal, yeah ...

Robert Bossarte: [crosstalk 00:34:17].

Dan Shook: The safety, yeah. I mean that's so frustrating to me.

Robin Pollini: Safety in all realms, really. Security.

Robert Bossarte: Security.

Dan Shook: Yeah, so what do you do? Do you just build a business in this area? Or, I think it goes way beyond that but, that's the part that's tough to go to sleep with, knowing okay, you're helping to deal with this part of this cycle, but how do we fix it at the other end?

Robin Pollini: You know it's also very ... and again, this is not my area of expertise, but I'll just say I have, in talking to people who are in my studies or inject drugs, I'm always struck by the fact that sometimes it's just one bad decision, right? Or one event that happens to them that sets them on the road. You know, we were all at that place at one point, and for some reason, something happened with this person. Sometimes you can't even really ... you know, they're like other people in every way, but there's one thing that happened that set them on this road, and then just things keep snowballing and snowballing and snowballing ...

Dan Shook: And sometimes is that really ...

Robin Pollini: And nobody says I want to be an injection drug addict.

Robert Bossarte: Wait, it's so funny. We accept that with other [inaudible 00:35:20] outcomes, right? So lots of people get injured in car accidents, but they say, I just didn't put on my seatbelt because I was just going down to the corner for something. And it's just that one, small decision that feels inconsequential at the time that turns out to be a big deal.

Robin Pollini: Yeah.

Robert Bossarte: I would just like to say, though, I think part of the answer, I hope, is breaking down some of these barriers between us versus them and acceptance of the idea that this is a community's problem and it's not rooted in the individuals. Certainly they're individual decisions and things that lead to consequences that you can't foresee. But the acceptance and the coming together to find a solution and stopping the marginalization process so it's not someone on the outside that's trying to look in, that's not within in the control of any one person. It's in control of the community.

Robin Pollini: Yeah. And I think that's one of the important things about ... we're sort of talking around about what's happening in West Virginia now in some communities, it's like, people who don't use drugs are being pitted against people who do, when actually we're all members of that community.

Robert Bossarte: That's right.

Dan Shook: You know, we'll let, again ... this was like, my almost last thing I was going to ask you about but you know, you talked about the one mistake. Aren't there ... and this is probably for another discussion sometime, but are policies and laws set up at times that are unforgiving of the one mistake that, you know, in the scope of mistakes is not that horrible?

Robin Pollini: Yes.

Dan Shook: Thanks. Another podcast.

Robert Bossarte: That's another podcast. So, I think we've learned a lot, and I think at this point, I'm going to go around the table and ask people for their last questions. It's my favorite part because I will predict the response I usually get from people. No. Right, ready? Sara?

Robin Pollini: Sara's really excited about this part of the agenda.

Robert Bossarte: Do you have a question?

Dan Shook: Would you mind reading ...

Robert Bossarte: We can hear you.

Robin Pollini: That's a really professional operation. I'm so glad you invited me to talk.

Robin Pollini: I think you asked me, why did I come to West Virginia University? One of the reasons is that when I came and did the interview, two of the students, one of them being Sara, wrote me emails afterwards.

Sara Warfield: I sure did.

Robin Pollini: And said please come. And that actually had a big impression on me.

Robert Bossarte: Thank you Sara.

Dan Shook: Nice job.

Robin Pollini: It made me ... I knew that if I came here, I'd be really welcomed and appreciated, so students can be very powerful in the recruitment process. Take note.

Robert Bossarte: We've known this from our conversations together, but you're such a better person than I am.

Robin Pollini: I know.

Robert Bossarte: It's amazing, isn't it?

Robin Pollini: Sara knew that too.

Robert Bossarte: Sara does. She knows that.

Robin Pollini: That's why she emailed me.

Robert Bossarte: Well, we'll come back to Sara with something. Dan, first of all, I'd like to say, you've let our listeners down. There's been no ...

Robin Pollini: Hacking.

Robert Bossarte: Phlegm ball that we've been able to tell.

Dan Shook: It's right here. I can't wait til we're done. I'm going to go get rid of it.

Robert Bossarte: Oh, okay. Do you have a question that might hurry that along?

Dan Shook: No, I'm pretty good. Thank you.

Robert Bossarte: Great. So, it's your chance to tell us whatever you want. Your closing thought on what you want us all to take away from this.

Robin Pollini: So I have this T-shirt that I wear when I go out and do outreach. It says, be nice to drug users and it has a big smiley face on it. And that is what I'd say, is try a little compassion and understand. I think we'd all be a little better off. I feel like I should be saying sciencey things during this podcast, but all of this stuff is really important too.

Robert Bossarte: No, we're not really a sciencey podcast.

Robin Pollini: But I do do science.

Robert Bossarte: Yeah, you'd probably think there was science sprinkled about in all of your comments.

Robin Pollini: Yeah. Thanks for making this easy on me.

Robert Bossarte: So thank you to our listeners and our guest, Dr. Robin Pollini. If you're interested in learning more about harm reduction, visit www.harmreduction.org. The Harm Reduction Coalition is committed to drug user rights and social inclusion through programming related to policy, training, overdose prevention, and advocacy.

Sara Warfield: Alright. Thank you again for tuning in to hear our conversation with Dr. Robin Pollini. If you have any questions or comments for Dr. Pollini or any of the co-hosts, make sure you share them with us on Twitter, Facebook using hashtag ask WVUICRC. We hope that this conversation helped you think about harm

reduction and the drug abuse crisis in a new way. Be sure you subscribe to our podcast on iTunes. Goodbye from your friends at OOMPH. We make injury control cool.

Robert Bossarte: Woohoo!