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CONNECTING CARE PODCAST // EPISODE #17 // TRANSCRIPTS

Caring for People Living in Open Drug Scene Encampments: Challenges and Opportunities

Dr. Alex Walley:

A collision of drug criminalization, inadequate and discriminatory housing policies, and inadequate mental health and substance use care services has fostered open drug scene encampments in communities around the world. Open drug scene encampments concentrate social, medical, and public health challenges that include HIV transmission and opioid overdose. Policy-makers, public health, and medical providers need to understand open drug scene encampments in order to provide compassionate and effective care.

Dr. Jessie Gaeta:

I think we have to be thinking way upstream in terms of the reasons that these spaces form. In the US and in Boston, the context for encampments, we have to remember and constantly surface, and that is systemic and intertwined issues that are very deep in our society and come back to systemic racism, poverty, the overdose crisis, the failed and racist war on drugs, even drug prohibition as a policy, insufficient mental health and addiction services, and, of course, unmet housing need. These are the real core reasons that we have encampments and open drug scenes.

Dr. Alex Walley:

You're listening to Connecting Care. I'm Alex Walley, an HIV primary care doctor and addiction medicine specialist in Boston, Massachusetts. This month, Jess, Sim, and I talked with Dr. Jessie Gaeta, a national expert who has been a primary care and addiction medicine physician at the Boston Healthcare for the Homeless Program since 2002. Our conversation covered a lot of ground, touching on some of the factors that contribute to the establishment and growth of encampments, how best to talk and ask about housing status, and helpful and harmful approaches to open drug scene encampments and the people who live there.

Dr. Alex Walley:

This is our 17th Connecting Care podcast focused on improving the health and wellness of people who use opioids and who are at risk for HIV. Topics we've covered in the past episodes include care in the time of COVID, HIV pre and post-exposure prophylaxis for people who inject drugs, directly observe therapy, structural racism, three episodes on improving methadone access, hepatitis C care, new HIV infection, and initiating antiretroviral therapy, making the case for safe consumption spaces, and two episodes on the care for people who are incarcerated, addressing discrimination in care via the Americans with Disability Act, and most recently youth and emerging adults. Again today, I'm joined by my co-hosts and good friends, Jess Taylor and Sim Kimmel. Hi, Jess, and Hi, Sim.

Dr. Jess Taylor:

Hi, Alex. Good morning.

Dr. Sim Kimmel:

Hi, Alex. Excited to be here.

Dr. Alex Walley:

Today, we have a great episode focused on a tough and important topic, open drug scenes and encampments, and we have a true expert joining us to think and learn about what we can do better, Jessie Gaeta, who has been a primary care and addiction medicine physician at Boston Healthcare for the Homeless Program since 2002. She's a national expert and key leader of the BHCHP.

Dr. Alex Walley:

She has been on the frontline of improving the healthcare and wellness of people experiencing homelessness. These innovations include the development of the supportive place for observation and treatment and Boston healthcare for the Homelessness' transformative efforts to address the COVID-19 pandemic. She's been a tireless advocate and ally for people who use substances and experience homelessness. Welcome, Jessie.

Dr. Jessie Gaeta:

Hi, Alex. Thank you. I'm so glad to have a conversation about this hard topic, one that we don't often get to talk about in clinical circles.

Dr. Alex Walley:

Yes, an important topic. An important topic for clinical care, for public health, and for many of our communities today. So I want to get right into it, and we got to start out with some definitions. Jessie, from your perspective as a primary care provider, describe for us what an open drug scene and encampment is. What is the experience of your patients living in encampments, and what is your experience delivering care there?

Dr. Jessie Gaeta:

This term, open drug scene, which we've used the most, has been used to describe public, usually outdoor spaces, where people congregate to use, trade, and/or sell drugs. I saw one older research publication define open drug scenes as all situations where people are publicly confronted with drug use, but I think open drug scenes can take many different forms.

Dr. Jessie Gaeta:

They can be very concentrated encampments, like we've seen in recent years in Boston, but they can also be dispersed or decentralized throughout a large region. There can be many smaller open drug scenes across a city. They can be hidden and out of sight.

Dr. Jessie Gaeta:

In Boston, we had a large open drug scene begin to take shape over the course of the past four years to become a pretty massive tent encampment of a few hundred people. That's located near the hospital and the clinics where all of us work. I think that's been happening in many cities and towns across the United States in recent years and probably escalated during the pandemic.

Dr. Jessie Gaeta:

Several of the nurses and case managers and doctors at Boston Healthcare for the Homeless Program have been working in this encampment since it started forming, and my observations come from that work. I guess I'd say that it's pretty common for me to have very mixed feelings about people's experiences staying in the encampment. On one hand, I see a real community formed. The community serves a purpose for some people staying there. I witness people taking care of each other, keeping each other alive, holding each other up, especially as so many people I've met there have been rejected by important people in their lives and society as a whole.

Dr. Jessie Gaeta:

But on the other hand, we've also witnessed a lot of harms in the open drug scene. I think of those first and foremost as kind of policy harms. So we've seen a lack of running water and bathrooms. We've seen pretty terrible food options for the people staying in the open drug scene. We've seen really inadequate social and medical services. Then some of the harms come from stigma. I've seen a lot of harsh treatment from passers-by who stigmatized people staying in this encampment. Then another harm, of course, is extreme violence. So in the encampment, especially as it's grown larger and larger, we've seen more trafficking of people, fights, sexual assaults, even stabbing.

Dr. Jessie Gaeta:

And so delivering medical care in this environment, I guess for us, has really become a lesson in what I only can think of to describe as disaster health. We've found ourselves necessarily needing to focus on just a few top-of-mind clinical issues for folks in the encampments. Those have included responding to drug overdoses several times a day, as well as responding to and trying to prevent further HIV spread during the outbreak, and finally, ubiquitous trauma that people experience there. With limited resources, our efforts in the encampment itself have really largely had to be focused on those few clinical issues.

Dr. Alex Walley:

What brings people or what concentrates people in these scenes or encampments?

Dr. Jessie Gaeta:

That is such a great question. It's one that I think all of us have been asking ourselves and each other in recent years. My first answer to that question as I've come to think of it is politics and policing. I think there can be many deliberate tactics that municipalities take to literally push people into a certain geography, people who are neighbors, but who are publicly and visibly experiencing homelessness and using drugs, into places that are less visible and out of the way of people in our community with more power.

Dr. Jessie Gaeta:

Some of us have kind of likened this phenomenon to the local creation of refugee camps that you may see in other countries. It's felt like that at times. So policing strategies, I think, can take the shape of forcing people off of certain streets and into other areas and really concentrating people deliberately. While politics and policing are central to establishing open drug scenes, I think I often hear from frustrated neighbors, and I'm sure that you guys do as well, this notion that it's the services that have been established in a place that cause these types of scenes and encampments to form.

Dr. Jessie Gaeta:

I don't believe that that's true. At very least, I think it's much more complicated than that. To me, even where services are formed, where addiction programming can be cited, where homeless services are able to be cited, these are also political decisions. In my view, undesirable people and the services for them are deliberately concentrated within cities in certain geographies based on political decisions that are made and policing tactics that support those decisions.

Dr. Jessie Gaeta:

I have to add that where we ask this question of how did this concentrated encampment and open-air drug scene form, we have to start thinking way upstream from just how we physically concentrated people in recent years. I think we have to be thinking way upstream in terms of the reasons that these spaces form. So even before, policing tactics are literally pushing people. In the US and in Boston, the context for encampments, we have to remember and constantly surface.

Dr. Jessie Gaeta:

That is systemic and intertwined issues that are very deep in our society and come back to systemic racism, poverty, the overdose crisis, the failed and racist war on drugs, even drug prohibition as a policy, insufficient mental health and addiction services, and, of course, unmet housing need. These are the real core reasons that we have encampments and open drug scenes.

Dr. Alex Walley:

You made me think of two examples that I have experienced through my patients or they've experienced, and I've heard them. One is the change in access to just public restrooms during COVID-19 pandemic. So there just aren't places for people to take care of basic needs elsewhere, and essentially, many neighborhoods have become even less welcome to people who need to use public services. That then concentrates people.

Dr. Alex Walley:

The other example is, and we had three episodes I mentioned on methadone... For me, as many people know, it often comes back to methadone. There's three methadone clinics in Boston, and two of them are in this particular area. We have to provide methadone in this area because it's lifesaving, and it's where just some of the people who need it are in the city, but the reason those clinics are there... The encampment's not there because the clinics are there. The clinics are there because nowhere else in the city can we cite methadone clinics. They're not welcome anywhere else.

Dr. Alex Walley:

And so not only is the drug use excluded from the rest of the city, not only is public drug use and people who use drugs, but even the treatments that are going to make people better, are going to save their lives are concentrated and excluded. That's not an accident. I think that's part of what you're saying. This is not an accident. This is part of a longstanding structural setup in our community.

Dr. Alex Walley:

So your metaphor of the refugee camp is really striking. I do remember walking by and talking to folks, my own patients about the fact that they were sleeping in tents on the street right outside of a homeless shelter that had beds that were available. And so I wonder if you could talk a little bit about that. Why would people sleep on the street when there's a place to stay that's feet away?

Dr. Jessie Gaeta:

I think that's so ironic to people, but by having worked in the shelter system a lot and having talked to a lot of people who stay in shelter and who won't stay in shelter, I think the answer is fairly simple, not that the fix is simple. The answer, I think, is that it's because of the ways that the services in shelters are often provided are especially stigmatizing to people who use drugs, people who have been incarcerated, people of color.

Dr. Jessie Gaeta:

Our model of sheltering typically isn't one that necessarily recognizes intersectional identities and issues that people have. It isn't one that incorporates harm reduction. I think rather shelters often approach addiction very punitively. I'll give you just a couple examples of... For instance, it's pretty common in traditional shelters that people end up going through a pretty lengthy intake process that involves metal detectors and sometimes even searches of belongings in order to remove, confiscate anything associated with drugs. That's included, I'm sure for all of you as well sometimes, the buprenorphine prescriptions that I'm writing. The medications, the treatment that people have in their possession can be confiscated.

Dr. Jessie Gaeta:

Another example is shelters are, I think, fearful and desperate to not have people overdose inside. When that does happen, I think a very punitive approach is to say, "You can't come back. It's not safe for you here," which of course doesn't take into account the fact that an overdose elsewhere is likely even less safe for that person.

Dr. Jessie Gaeta:

I think it's also important to say that the shelters often lack funding or they're very poorly funded, lack the resources that they need to serve people in better ways. So I think it's not fair to kind of demonize the shelter system necessarily until you really begin to understand that we spend very little on sheltering people or better yet housing people. I think that's the reason though.

Dr. Jessie Gaeta:

It's really stark sometimes to see, like in our neighborhood, that you've got a large encampment literally on the doorsteps and in the same street, the same block as a large shelter where people might receive some protection from the elements, and bed to sleep on, and food that's made in a kitchen, some very positive things. And yet, they are so, I think, often stigmatizing and punitive around addiction, in particular, is I think probably at the core of why people won't go into shelter.

Dr. Sim Kimmel:

Jessie, it's so powerful hearing you talk about your experiences and the multi-layered dynamics that have resulted in these encampments. You're obviously very careful and attentive to the kind of language you use, and language is really important because it conveys our values, and it can discriminate. In allying and advocating for people who experience homelessness, how do you best refer to people who experience homelessness? What terms should we avoid, and why?

Dr. Jessie Gaeta:

Depends on who you talk to. We've thought about this a lot, and I think we're always trying to evolve and learn more from people experiencing homelessness about how they might refer to this particular

issue. I guess I would say I, first and foremost, would just avoid a term like the homeless. I mean, I think that's a term that really describes a whole population based on just this one characteristic of not having homes. It's very dehumanizing, I think. It doesn't even get to the fact that these are human beings.

Dr. Jessie Gaeta:

And so I think a better alternative to the homeless as a kind of catchall phrase, it would be at least to use the word people there somewhere, or person or persons, so homeless people, homeless persons. I think a lot of people appreciate even better yet using that word first, so it's people, first and foremost, who happen to be experiencing homelessness and many other things, have so many other attributes, but it doesn't necessarily define everything about them.

Dr. Jessie Gaeta:

And so I think more often, you'll hear us using a term like this, people experiencing homelessness. It's one of many things that they experience, but I think generally people don't want to be defined by their lack of housing. We've seen more and more people use a term like unhoused. Again, I think you want person-centered language, and you want to recognize this is one characteristic of many. It has a lot of implications on a person's health and well-being, but it's one of so many other characteristics. So I think that's the term I'm using at the moment more.

Dr. Jessie Gaeta:

I don't know if others have other ways. I was thinking about, especially for clinicians, how do you talk to patients about homelessness. How do you even ask about homelessness? And what I am most in the habit of doing is trying to take a housing history, so to speak, at some point when I'm getting to know people. I usually start off by simply asking where do you stay at nighttime rather than where do you live. Some people, when you ask it that way, they assume that what you mean is where's your home. And if they don't have one, it may be harder to answer the question, like where do you live.

Dr. Jessie Gaeta:

People also don't really feel like they live in the shelter or they live on the street. They stay there. It's temporary, and so I usually open with where do you stay at nighttime. Some people are like, "What are you talking about? I stay at home. I live at home." I'm like, "Great. Tell me about your home and who you're living with. What neighborhood is that in? Let me learn a little bit more about that context."

Dr. Jessie Gaeta:

For other people, it's just a slightly less, maybe less stigmatizing way to imply that I understand that you may not have a brick-and-mortar home of your own to describe. It just opens the door maybe a little bit more for someone to feel comfortable disclosing the fact that they don't have a home currently. I don't know if, Jess or Sim, if you have other common language that you're using.

Dr. Jess Taylor:

Well, I was actually going to ask what you do. Just thinking about my work as a clinician and the reality that people experiencing homelessness who stay outside experience completely different risks and often very serious risks that I want to be able to address and ask about. I'm wondering how you talk about sheltered or unsheltered homelessness, if those are even preferred terms anymore, or sort of how you open a conversation about addressing risk when people do disclose that they tend to stay outside, other follow-up questions that would be good for providers to think about.

Dr. Jessie Gaeta:

Yeah. I mean, how do you kind of dissect along the planes of a conversation about a living environment and the implications for a person's health, which I think is the reason why it's really helpful for clinicians to try to understand as much as they can about someone's living environment? We still do use the term sheltered and unsheltered.

Dr. Jessie Gaeta:

I think one of the reasons is that people who are staying in shelter long-term versus staying in unsheltered settings long-term... There are many of them, by the way, not just the street, their cars, and abandoned buildings that don't have any infrastructure, and under bridges, and in tents. That's even just such a rich set of living environments unsheltered.

Dr. Jessie Gaeta:

The reason why it can be helpful for clinicians to understand some of these nuances of the living environment is that people tend to have different risks in these different environments. And so you ask about how do we talk about it. So opening up often with where do you stay at nighttime. Sometimes that question can even be a stumbling block for people, but most people will at that point say, "I've been staying at this local shelter." Then I've got lots of questions about what that local shelter environment is like for them and how it impacts their health.

Dr. Jessie Gaeta:

You asked about unsheltered folks. Most often, I'll get answers like, "I stay outside," and it's vague. It's purposely vague. People don't want to be found. They don't want to disclose a specific location, which I want to honor. The reason they don't want to disclose a specific location often is they're afraid of sweeps, which is something we're going to get back in a minute.

Dr. Jessie Gaeta:

So I honor that, but I just say, "Is..." I'll often be trying to understand from a public health point of view what that environment is like. So I'm really interested to know in that environment, first and foremost, are you alone or are you with other people? There really is safety in numbers in so many ways, including, of course, around overdose and drug use. I want to know the answer to that, and if they are staying with someone, who that is and how they work together to keep each other safe. That's a question I'll ask often. I'm interested to know how close you have running water, and bathrooms, and access to food, and what those food sources are. So those are the types of things I'm usually then asking about.

Dr. Jessie Gaeta:

Sometimes I have to back up and explain to people that the reason I'm interested and really want to understand their living environment is because it does have impact on their health, and there may be things that I'm thinking of in terms of their health and their healthcare related to living environment. An example is we recently had an outbreak of Shigella gastroenteritis among people living in a small encampment in Boston. The tip-off that this might be the case is that they're sort of living on the edge of a small bank of a river, very hidden in Boston. They were using the river water, and reusing the river water, and even having to defecate and urinate in the river, and then using the water just downstream from there. It was sort of a tip-off that the type of infection that we might be worried about with people who had a collection of symptoms.

Dr. Jessie Gaeta:

So it's a long answer, but I guess as much as you can, try to understand people's living environments. You'll really get to sort of draw connections between poor health, and health conditions, and outcomes with their living environment. Some quick ideas...

Dr. Sim Kimmel:

One of the things about the term, people experiencing homelessness, too is it makes it seem like it's not fixed, right? That I have patients who, when they're using substances, they don't have a place to stay because their families won't let them stay with them. But when they're not using substances, they have access to housing. So it's a little bit cumbersome, but I think it is a powerful way to convey something there.

Dr. Sim Kimmel:

I also wanted to ask about the role of police in these open drug scene encampments. Many people in the community look to law enforcement to solve this problem. You alluded already to the concentration of these services in one location, and then people who live in the surrounding areas can be frustrated. They often turn to law enforcement, and our policies then end up focusing on law enforcement responses. So can you tell us about how law-enforcement-focused responses end up impacting people in these encampments? What happens?

Dr. Jessie Gaeta:

Sure. I mean, I feel like I have limited experience of one city, and yet this is an issue that's so much broader. I guess what I would say just from my limited experience is, generally, I think the law enforcement response to encampments and open drug scenes in the US is characterized by pretty aggressive criminalization of the drug use and even the homelessness at the core of the encampments.

Dr. Jessie Gaeta:

And so by criminalizing, I mean that often the law enforcement approach that I'm witnessing or that I witnessed is very aggressive. It's physically violent. Sometimes it's based on arresting people for non-violent offenses. I guess that's my quick description of how enforcement is often responding to these encampments. It's harmful in so many ways to people in the encampment to have a kind of primary law enforcement response to encampment.

Dr. Jessie Gaeta:

The ways that it's harmful, I think, we could spend a minute talking about, and we should. I think, first of all, that this constant work of doing what are sometimes referred to as warrant sweeps, where you can go in when things seem like they're really escalated and with more and more people, and you go in with this goal of clearing out an encampment by looking back at warrants that people may have or any type of offense, sometimes not even violent offenses, but just run of the mill drug-related offenses, and then sweeping people into jails around those warrants.

Dr. Jessie Gaeta:

People are so afraid of those in the encampments that there's sort of a tendency that's coming to try, obviously, to spread out, to hide, to disperse. That's kind of what the intent is actually, but there's so many harms of that dispersal. Not to mention, I'm thinking specifically of HIV injections rates, people

having less access to some of the very core services, like syringe access and pre-exposure prophylaxis, for example. That might be more possible in the concentrated encampment than it is in hidden spaces.

Dr. Jessie Gaeta:

I'm also thinking about harms of criminalizing drug use in general, like sending people repeatedly through courts and jails related to drug offenses. Those harms, I just... day in and day out in how difficult it is for people to eventually make their way into permanent housing or to have employment or even to have relationship with important people in their lives.

Dr. Jessie Gaeta:

It feels like there's just so much harm to people when we approach an encampment primarily from a law enforcement perspective with the criminalizing of drug use and homelessness. I wonder, Jess, and Alex, and Sam, what other harms you've noticed from law enforcement approaches in encampments?

Dr. Jess Taylor:

Yeah, you said it really well, Jessie. I think we started to be more aware of these harms, at least in our Bridge Clinic, Faster Paths, at BMC back in 2019, which was one of the first times in the era of our Bridge Clinic that we experienced an organized law-enforcement-directed action against people experiencing homelessness and using substances in the community immediately surrounding our hospital. Thinking back to that time, we were in the Bridge Clinic, and I was actually also on inpatient addiction consults at the time.

Dr. Jess Taylor:

As a provider, there was sort of an eerie feeling where we'd been busy. Our volume had been increasing. We were seeing more people. At the time, we were mostly doing buprenorphine, and then this law enforcement action started. We were suddenly as quiet as could be. No patients were coming in to see us in the Bridge Clinic, at least that was the feeling that we have, that we couldn't find our patients. People were out of the area. People were missing key services, follow-ups to get medication refills or to follow-ups to get medication refills or to follow through on plans that they had worked so hard to put in place to link to long-term care.

Dr. Jess Taylor:

It felt different to us. Recently, we've been able to look at some of the data from our Bridge Clinic. What we saw was that there actually was a significant decrease in the number of visits in our Bridge Clinic, which is a low-barrier setting that really depends on walk-in access, and so is so vulnerable to actions like this that push people out of the area, that interrupt those sort of spontaneous or spur of the moment or serendipitous connections we're able to make when someone's ready to come to see us and we're available.

Dr. Jess Taylor:

We know that that drop-off in visits didn't happen in other clinics at our medical center. So it really seems to have impacted our specific patient population. As far as why we looked at that, I think as clinicians, as researchers, we have an advocacy role to play in documenting what we see and really leveraging it for policy change.

Dr. Jess Taylor:

We were hearing these stories from our patients about being moved around every 20 minutes with a bullhorn, being asked to move here or move there, about being in neighborhoods that were new to them, about not having access not only to medical care and harm reduction, but actually to regular suppliers of drugs, and thinking about the risks that are associated with trying new supply, and being in unfamiliar territory, and not knowing about potency of sample.

Dr. Jess Taylor:

We were hearing a lot about reuse of syringes, and lack of access to injection equipment, and sharing within partnerships or groups that were together, and really just hearing a lot about the trauma too. As providers, we got the smallest window into that, but we know that many of our patients are still impacted by the trauma that they experienced in that particular example of a law enforcement action, but also in ongoing actions that have followed and in their past experiences.

Dr. Alex Walley:

There's this compounded discrimination stigma of using substances and experiencing homelessness. You already talked about the war on drugs and how that disproportionately affects particular populations, Black, Latinx, Native people, and also the gender-minoritized or trans community. Can you talk a little bit about how you think about the intersectionality?

Dr. Jessie Gaeta:

Sure. This is so important and something that I think we're not routinely enough incorporating into discussions, and programming design, and planning, and even looking at outcomes. I guess I'm thinking about intersectionality sort of within encampments and open drug scenes. One way to think about this is to really force ourselves to be trying to identify special populations within this very heterogeneic and diverse, larger population.

Dr. Jessie Gaeta:

I was thinking about the encampment. As it grew in Boston, there were several special populations that became really clear to us. Of course, you've named some of them. I would add people who are using drugs and engaging in survival sex or transactional sex. I think people exiting from incarceration, young adults who are under the age of 24, people who are not documented immigrants, people with limited English proficiency. This has been something really striking to me in the Boston encampment is the number of people for whom English is not preferred language. People with severe mental illness, physical disabilities...

Dr. Jessie Gaeta:

I think one approach is to, first of all, try to very deliberately make sure that we're thinking about special populations and how much there's an intersection on that. Some people belong to many of these different populations. So I think we've got to constantly force ourselves to be thinking not as this large group population, but about special populations. I think that's maybe a first practical idea.

Dr. Sim Kimmel:

This is really complicated, multiple layers of... as you've described, leading to concentrating people in these areas and with all these risks. So is the answer just housing? Is it more complicated? How do we keep people who use drugs safe?

Dr. Jessie Gaeta:

The answer is housing, and it is more complicated, at least in my view. I think we first need to decide that, as municipalities, that we are not going to simply close down sites and disperse people through repressive measures, that that is not effective. And then, in fact, does increase drug risk behaviors and other risk behaviors.

Dr. Jessie Gaeta:

I think that even before housing is in front of us, within encampments and open drug scenes, that we should really be aiming to use harm reduction strategies as very central to our approach. Even as we're pulling together a better response that involves housing, we need to provide basic food, and water, and sanitation, bathrooms access. We really should be thinking about harm reduction is central, and there's so many different harm reduction strategies that we can use in an encampment while we're working on a better policy solution.

Dr. Jessie Gaeta:

Those things, of course, include very good and strong syringe access. We just can't have enough syringes in circulation right now, and we need to have good ways and easy ways for people to dispose of syringes obviously. We need very low threshold, easy access to treatment for substance use disorders. We also really desperately need the ability to provide supervised consumption, which is happening anyway in encampments by peers, thank goodness. We need to increase that, increase our capacity for that.

Dr. Jessie Gaeta:

But let's get to housing. So this is most important, and it's just fundamental to why this issue even exists in the first place. I think there's so much to say for this that we're going to need to talk about this specifically, is what are the types of housing and housing models that municipalities can create to best serve people coming out of encampments and open drug scenes, people who are actively using substances? Boston is beginning to get experience with that, which is just so exciting. So it is more complicated though, I would say, Sim, than only housing. I think although housing is absolutely central. That's my quick answer.

Dr. Jess Taylor:

Jessie, in thinking about municipal approaches, and policy solutions, and public health approaches, what are the best practices for elevating the voices of the people who live in open drug scenes, and their perspectives, and needs, and ensuring that as clinicians, we don't do what we've often been trained to do, which is work in hierarchy, and really impose our own value system and beliefs without the right input and really the input of those people that are experiencing everything that you've just described today?

Dr. Jessie Gaeta:

I'm so glad you brought that up. Maybe we should have started with that at the beginning of our podcast. That's such a central question. We're not very good at it. I would say we're not great at it in Boston. We're not great at it across the US.

Dr. Jessie Gaeta:

What are some ways that we can really try to elevate the voices of people being affected by the policies that have created encampments, people living in encampments? I guess some of the things I've learned

from other countries and increasingly from groups in the US is that people need to be able to organize. They need the time, and the space, and the ability to organize, and if there's anything that we can do to promote that, providing space and any resources that people living in an encampment need in order to organize, to be a part of the discussions about policy solutions, and programming, and research that happens in the encampment. All of that is really important.

Dr. Jessie Gaeta:

So what can we do? We can make sure that people affected by this issue are central in conversations that are policy, research, programming, clinical services, all of the above. I think we're not in a habit of doing that enough, and that is probably the most important thing we can do.

Dr. Jessie Gaeta:

I wanted to put a plug in for the New England Drug Users Union and the Boston Drug Users Union, which are organized groups of people living through all the things we just described, who are really desperately trying to have a foot in the door and a seat at the table in policy discussions, especially. There are a lot of barriers to that, and so if there's anything that we can do as clinicians to decrease the barriers to people being at the table for policy discussions, that's what our aim should be.

Dr. Jess Taylor:

One tension that I've seen in some cross-discipline, cross-sector, and community-based meetings... Really, it's to stigma. It's a primary tension in criminalization of substance use. I wonder about any best practices for creating safe spaces for people to talk about their substance use with other stakeholders that can include law enforcement, that can include city, state, municipal stakeholders. How do we do that in a way that both partners right... and create space, and also doesn't put people at risk of personal harms or prosecution or even mistreatment when we think about some of the stigmatizing statements that we sometimes hear about people experiencing homelessness or using substances in public places? How do you navigate those waters?

Dr. Jessie Gaeta:

I wish I knew better than I do. I can maybe describe some of the ways I've seen that done in Boston. I think you're right to worry about mistreatments and risks involved in those conversations for people with the lived experience, especially if they're in the room with people who have fairly hostile notions of what's happened.

Dr. Jessie Gaeta:

Some of the best practice I've seen are bringing people together in spaces where people who use drugs are most comfortable, and those are often drop-in centers for syringe access programs, for example. I think in so much as what I've seen in other cities, and I'm thinking about the history in Vancouver of this just amazing drug users movement that has really led policy change there, is that it had to be forced.

Dr. Jessie Gaeta:

It had to be forced by people who use drugs, and that there really wasn't anyone else, clinicians, addiction service providers, policy-makers. There wasn't anyone else who was able to create the space that was needed, and so people did it themselves. This is at the heart of harm reduction. They had to do this themselves. They did it through direct action protest in Vancouver to the point where it was impossible to not include them in conversation. They made it so through great risk to themselves.

Dr. Jessie Gaeta:

I guess I would really love there not to have to be that great risk. I think all of us have a lot to do to think about how we can make it possible for people who use drugs to be at the table, actively use drugs, not just in long-term recovery, but people who are actively using drugs to be at the table in important decision-making conversations. How can we do that so it's not at great risk and that it doesn't have to be direct action protest? To me, it feels like that is one of the only ways at the moment. We have not done a good job of this.

Dr. Jessie Gaeta:

I also feel like we've lost a tremendous leader in Aubrey Esthers in Boston, who led up so much of this work, when Aubrey died of an overdose not too long ago. So far, I feel like the community of people in this encampment, for example, who are using our syringe access programming and harm reduction programming, are just constantly faced with loss. I can think of so many other members of the Boston Users Union who have passed away from overdose. It's so hard. It's a group that is really struggling to organize right now. I would really like us to be thinking more about how to answer that question better. Jess, I feel that's such an unsatisfying and frustrating answer to that question.

Dr. Alex Walley:

Well, Jessie, I can hear your frustration. I just will say that we can do better, but there are some very concrete steps, which actually I've learned from you. That includes genuinely including people who use drugs, who experience homelessness in hiring decisions, like who you hire, particularly those folks who are going to be directly working with people, in the way you design not just the program, but the space where the program exists, whatever program it is.

Dr. Alex Walley:

Then the one I think really where we continue to struggle is creating a sustainable, welcoming environment for people to organize on their own. That one, I think, is very difficult, but it exists, and we should be supporting those groups who are doing it and making it possible for others. But as you mentioned, the historic structural war on drugs conspires against that, as well as the decimation of the population from the harms from drug use and its criminalization.

Dr. Alex Walley:

So there are concrete things that we are doing, that you are doing, that can be done that do make a difference. I think we can see that in the programming. So one of the reasons... Just to go back to the shelter example. Shelters were not designed from the outset with the voices and perspectives of people who are experiencing homelessness. That's one of the reasons they feel unwelcome to many people, whereas harm reduction housing, housing people in supportive ways, which perhaps should be the next topic of our next podcast, bringing those perspectives in, and then creating a flexible environment so you can actually adapt to the needs of people as you learn what they are, as they exercise their voices, as they understand what they need.

Dr. Alex Walley:

So I think we need to do better, but we are learning. There are concrete things we can do now. I feel we need to address one more question at least, which is is there any role for police in open drug scenes and encampments? And if there is, what is it?

Dr. Jessie Gaeta:

My feeling is that there is a role for law enforcement and police, but it's limited. That role is that we really need police and law enforcement to respond when violence takes place in encampments. We need that response. It can't be the case that police don't respond to violent incidents in encampment. We do need that response.

Dr. Jessie Gaeta:

Beyond that, I think the role really though is very limited, and I hope instead we're leading with programming designed by public health experts. We need, of course, a balance between harm reduction, and public health programming, and safety, physical safety in an encampment. And so I think there probably is a role with a balance that is mostly public health. That is my opinion. I would really like to see a response that is completely centered around public health with police helping to manage when violent incidents come up and to swoop in and help when there's violence.

Dr. Alex Walley:

Do you think there's examples of that in other communities or other countries from your review in thinking about this?

Dr. Jessie Gaeta:

Yes. I think there are. Some of the cities in Europe that I've been lucky to read about include Amsterdam, and Lisbon, and Zurich, and others. In these places, these municipalities were able to adopt a combination of strategies and, this is probably at the crux of it, to bring together a coalition of people from the municipality to design a response that has law enforcement at the table, but that is really led by public health people who are using harm reduction approaches as central in the programming.

Dr. Jessie Gaeta:

So I think there is a role, and I think we have a lot to learn from some cities in Europe where there's a bit more harm reduction infrastructure and a lot less criminalization of drug use. Those are the places that I'm looking to for examples of what we might do here.

Dr. Alex Walley:

Well, thank you all for this great discussion. We scratched the surface. I think we got deep at times, and I learned a lot. I'm particularly grateful to Jessie for joining us today, for her ongoing inspiration in her work, and sharing her experience and wisdom with us. We described open drug scenes and encampments, the harms of law enforcement sweeps, and highlighted opportunities to improve the resources, access, and care of people living in open drug scenes and encampments. Thank you so much for joining us. Please check us out at our podcast website and come back next time.

Dr. Jessie Gaeta:

Thank you, everyone.

Dr. Alex Walley:

You're listening to Connecting Care. Our program was produced today by JSI and Boston Medical Center. Connecting Care is supported by the HRSA-funded project, Strengthening Systems of Care for People with HIV and Opioid Use Disorder. The project aims to enhance system-level coordination and networks

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