very time I’m asked to discuss methadone I’m faced with the same dilemma. Do I emphasize methadone the medication, the drug to which I owe my life, my freedom and my relative good health? The methadone which represented the first rollback of fifty years of laws criminalizing the very existence of the opioid dependent? The methadone which has no discernable effect on me, but which I will need and will take (happily) for the rest of my life? Or do I emphasize methadone the institution—the system of chemical parole that endeavors to keep tens of thousands of the most vulnerable under the thumb of perverse and avaricious bureaucracy? (continued on page 4)
This issue of Harm Reduction Communication is dedicated to Marty Prairie and Dante Brimmer.

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HARM REDUCTION COMMUNICATION

THE HARM REDUCTION COALITION (HRC) is committed to reducing drug-related harm among individuals and communities by initiating and promoting local, regional, and national harm reduction education and training, resources and publications, and community organizing. HRC fosters alternative models to conventional health and human services and drug treatment; challenges traditional client/ provider relationships; and provides resources, educational materials, and support to health professionals and drug users in their communities to address drug-related harm.

The Harm Reduction Coalition believes in every individual's right to health and well-being as well as in their competency to protect and help themselves, their loved ones, and their communities.

Editorial Policy

Harm Reduction Communication provides a forum for the exchange of practical, “hands on” harm reduction techniques and information; promotes open discussion of theoretical and political issues of importance to harm reduction and the movement; and informs the community through resource listings and announcements of relevant events. Harm Reduction Communication is committed to presenting the views and opinions of drug users, drug substitution therapy consumers, former users and people in recovery, outreach and front-line workers, and others whose voices have traditionally been ignored, and to exploring harm reduction issues in the unique and complicated context of American life.

Since a large part of harm reduction is about casting a critical eye toward the thoughts, feelings, and language we have learned to have and use about drugs and drug users, Harm Reduction Communication assumes that contributors choose their words as carefully as we would. Therefore, we do not change ‘addict’ to ‘user’ and so forth unless we feel that the author truly meant to use a different word, and contributors always have last say.

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LETTER FROM THE EDITOR

This issue of Harm Reduction Communication is our bi-annual conference roundup: a collection of representative presentations that summarize the conference’s mood, and reflect the current state of the North American harm reduction “movement.”

At the first two national conferences, and at HRC’s 1995 Northeast regional conference, “Sex, Drugs and Harm Reduction,” users and user activism occupied prominent positions on the agenda. While users were present in Miami, drug user activism was not a defining issue for this conference: the words “drug user organizing” and “drug user activism” appear once in the agenda. Once! I’m not faulting HRC. Hell, if any one agency—and any single individual in the harm reduction “movement”—has advocated for the inclusion of drug users in policy making and program design, it’s been HRC and its ED, Allan Clear. Still, the question begs—why were there so few presentations (one of which is included here, Pete Morse’s “Clinical Trials,” p 17) addressing this topic?

First, you have to look at the big picture. Ostensibly the entire conference was about the needs of drug users. But dig a little deeper, as Charlie Seller says in his article, “Treatment Denied” (p. 14) and you’ll find that most of the presentations were made by people who think they know what users want, or what’s good for them, or what will keep them healthy. As opposed to the needs of users, defined and stated by users.

Policies and programs designed by non-using professionals will not meet the needs of active drug users. They will meet the needs of professionals concerned about the lives of others: users and their families, loved ones and communities. Policies designed by ex-users will meet the (legitimate) needs of ex-users, and the needs of current users—as perceived by ex users; this is an improvement, but not good enough. Even if they address the issues users identify as important—employment, housing, healthcare, treatment, welfare, the criminal justice system and last, but not least, the drugs—the perspective will be very different. The authority that comes from experience, from shared pain and hardship, and shared good times, too, gives you that unique perspective. While anyone who’s used has this perspective, to varying degrees, once you stop using you lose the edge that comes from knowing that at any moment your whole life can blow apart. Current use gives that perspective the necessary immediacy, and this is what active drug users bring to the equation.

As our movement transforms itself into a profession, the needs of multimillion-dollar agencies come into conflict with the idealism of just a few years ago; a strong user movement can ensure that we don’t stray far from the original path. Yet, if HRC’s conference is any indication, it’s easy to conclude that we have given up on drug user organizing in the US. Why?

Drug user activism requires the organization of active drug users (pun/joke intended). Organizing active users requires three things: users must have the money to pay for the drugs that sustain their habits, they must have time to organize and they need to be able to do so without endangering their income, their drug use and their freedom. Guess where those conditions are most likely to be met? (It’s not Barnes and Noble.) If user organizing isn’t happening here, that leaves me asking, “Where are the active users working in our field? And how are we handling the impact of personal drug use on harm reduction workers?”

Interestingly, a plenary dealing with users working in the movement was mixed—not by HRC, but by users. There was real fear about possible repercussions that could come from this topic’s mere presence on the agenda: organizations getting defunded, finances getting extra scrutiny, people losing jobs. People were afraid that an agenda item like this would be equivalent to saying: “there are users all around us, and maybe in the organization that you run or fund.” (This debate exposed an interesting divergence of opinions among user activists, between those who work for agencies and those who run their own, or are administrators: the former nervous about employment issues, and the latter about funding matters.)

In November 1999 a forum was held at HRC’s New York office, entitled “Drug Use in the Workplace.” The experience was very unpleasant for attendees who identified as users, or as their supporters. There were enough harm reductionists in attendance voicing their doubts about the right of active users to work in this field to unnerve quite a few of us. Almost everyone who’s used while working in harm reduction has some unpleasant tale to tell. Or they know of someone else who has suffered some sort of indignity or penalty—or worse—directly related to their use.

Yet, there are also many agencies that have struggled with issues—financial, performance and health, just to name a few—raised by an actively-using staff member. The point is that no-one has figured out how to get around the fact that there’s a drug war. The deck is stacked against an agency trying to hire and retain active users. Add to this the power inequities that exist between any employer and employee (or funder and the funded).

These are difficult problems that demand innovative solutions. But if we want to see active users organize, then we need to create a safe place for them to do so. Next issue, I’ll offer some suggestions.

—PAUL CHERASHORE

Harm Reduction Communication

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1 When I got involved in harm reduction, in 1993, I wouldn’t hesitate to describe the collection of activists, junkies, researchers, public health advocates and service providers on the scene as a movement. Now it’s beginning to look a lot more like a profession, a noble one mind you, but still a profession.

2 I’m referring to the organizing of hard drug (read cocaine, heroin, speed) users, mostly injectors, in order to change drug policy and services.

3 There was one presentation (a major session) on users working in harm reduction, “Drug Users in the Field.” Prior to the session, attendees were asked to honor the wishes of those users who wanted to keep what was said “in the room;” if anyone felt they couldn’t abide by those stipulations, they were asked to leave (or at minimum, let us all know). After the session, some of what was said made its way to other conference goers. And a few months later, one of the presenters, who was quite stoned during the session, lost her job. Whether or not there was any connection, you can see why users are so anxious about public disclosure.
There’s no question of the need for this discussion: methadone is one of the most misunderstood and stigmatized chemicals on earth. Even amongst the harm reduction community myths and prejudices about methadone abound. Yet in the last few years methadone has also been undergoing a dramatic revival of reputation, and it seems that every day brings people with no previous experience of the subject onto the bandwagon. This group comes full of accurate, well-intentioned reviews by research panels and overviews in textbooks, where only the mention of “over-regulation” gives any hint of a downside to this wonder drug. To understand my dilemma, one must appreciate the depth of the harm created by the system that controls methadone.

The reality is this: methadone is a safe and effective medication which has provided immeasurable benefit to hundreds of thousands struggling with the consequences of opioid dependency in a society which has labeled the opioid-dependent criminals. For chronic heroin users living under prohibition, methadone represents the most effective means known of reducing risk. It reduces risk of death due to overdose, disease or violence. It reduces risk of incarceration and homelessness. It can be used at a moderate dose to enable greater control over heroin use, or at a higher dose to cease use altogether.

The reality is also this: the system through which methadone is provided is a uniquely oppressive bureaucracy that greatly reduces the benefits of the medication and generates harm where none existed before. Methadone itself is a tool of harm reduction; the system that controls methadone is a system of harm production.

There are no other medications in the U.S. pharmacopoeia subject to the restrictions applied to methadone hydrochloride and its cousin LAAM. No other prescribed drug is administered only through federally licensed clinics. No other medication is so restricted that most patients must ingest it daily under the scrutiny of suspicious staff. No other substance can be prescribed only under the condition that the patient submit to “counseling” and screens for illicit drug use—in perpetuity. No other medical treatment is used as the means to ensure a captive population of subjects for research. In short, no other system takes a medication of such potential benefit, and uses it to cause so much harm.

The most obvious harm caused by the clinic system is due to the attendance requirements. The entire system is designed around observed ingestion and continual monitoring. Before they can get home doses patients are required to attend their clinic six or seven days per week for a minimum of three months. Even under ideal circumstances, a patient is required to have been in treatment for three years before they can reduce the frequency of their visits to once per week. In reality, though, both state regulations and clinic policies combine to ensure that the vast majority of patients continue to attend at least three times weekly, and often daily, indefinitely. The consequences of this chemical tether affect every aspect of patients’ lives.

The damage begins with the actual need to travel to the clinic. In many parts of the country the nearest clinic is hundreds of miles away but even in cities like New York it is common for people to have to travel for an hour or more to their clinic—virtually every single day. Limited hours of operation make the situation worse still. Many clinics only allow patients to be medicated in a narrow window of opportunity, usually in the morning. Some clinics do not begin medicating until 7 or 7:30am. Combine this with the common exclusion of patients without regular, tax-deducted pay stubs or bursar’s receipts from the first hour’s medicating, and we are left with a system that does everything possible to prevent people from attending to their responsibilities. This is particularly damaging given the disproportionate number of patients who work odd hours or in the cash economy, receive training in informal apprenticeships or care for children in extended or non-traditional family structures.

The net result of these and a host of similarly restrictive policies is to make it very difficult for patients to find and sustain employment. A roster of perpetually unemployed patients is not such a problem—for the clinics, at least—when one realizes that whereas a working patient might be charged
$25-$240/month, a patient on Medicaid is worth upwards of $400 to the program in the big states where it is reimbursable.

People go onto methadone maintenance for a variety of reasons, but one of the more common is the desire to reduce or eliminate street drug use. Most users I know would agree that avoiding “people, places and things,” while not sufficient by itself, certainly makes abstaining easier. The methadone clinic system ensures that this will never be possible. No matter how long someone’s been abstinent, no matter how far they’ve come from “The Life,” as long as they’re on methadone they’ll be forcibly exposed to the drug scene on close to a daily basis. The nature of this drug scene, moreover, is also negatively impacted by the clinic system. Patients are commonly forced to accept methadone dosages that prevent them from feeling heroin. Many then turn to benzodiazepines or alcohol as a substitute—a switch that greatly increases the likelihood of overdose and accidents. This pill culture thrives in the clinics, and many patients find it impossible to resist. The clinic system then encourages both continued street drug use and the substitution of more dangerous drugs for less dangerous ones.

The nature of the clinic system ensures that patients will have to contend with the least qualified and most hostile staff imaginable. Clinics are generally required to have a fixed number of staff available but can only bill Medicaid at a flat, per-patient, rate—keeping salaries low and the incentive to offer services minimal. Counselors with “life experience” are almost exclusively anti-methadone graduates of “therapeutic communities” (TCs), whose personal difficulties with abstinence frequently add resentment and envy to their pre-existing hostility to methadone. These TC staff predominate due both to clinics’ reluctance to hire former (or current) methadone patients, and to the fact that TC graduates are frequently credited with “work experience” for their time in treatment—which gives them artificially inflated resumes and also serves to channel them into the treatment field.

Training for all staff is minimal and consists almost exclusively of psycho-social approaches to substance abuse that frequently stand in direct contradiction to the neurophysiological model addressed by methadone maintenance. This should not be surprising, though, as it is exactly this psycho-social approach which the clinics use to justify their “comprehensive” model and stave off their replacement by doctors and pharmacies. This general lack of understanding of methadone maintenance or its basis in medicine serves the system well, since knowledge would threaten the irrational status quo. The result of all this? An ignorant and hostile staff who regard methadone as merely a means of forcing a child-like patient population to accept “real treatment.”

It would be difficult to design a more stressful and traumatic system if one tried. First, patients are doled out only the smallest possible supply of a substance that they need like food or oxygen. Then they are placed under constant scrutiny by a hostile and distrustful staff and regularly threatened with loss of access to their medication. The expectations of staff and the rules of conduct are vague and ever shifting. Patients are subject to continual reinforcement of their “junkie” identities or, worse still, find that they have been transformed from streetwise, independent dopefiends into institutionalized, dependent “methadonians.” It is a system that reminds many patients of prison or parole, except that methadone status quo shafts the taxpayers as well. The average dose of methadone costs less than $1/day. The average cost to keep a patient in a clinic is around $5,000/year. The clinics argue vociferously that this money goes for essential psychosocial services. In reality, there is little evidence that ancillary services improve outcomes in general, but a great deal of evidence that the services provided in the clinics are of the absolute lowest quality—and that the prospect of being subjected to such interventions keeps many from the system. The indirect cost to the public of the clinic monopoly is also tremendous. Every person supporting a street heroin habit under prohibition is most prison or parole terms eventually end. Patients aren’t the only ones to suffer as a result of the clinic system. Local communities suffer. Taxpayers suffer. And access to methadone suffers, a fact that generates further problems for taxpayers, communities and patients.

The communities in which clinics are located suffer, and it is wrong to dismiss their complaints as knee-jerk “NIMBY-ism.” By requiring daily attendance by their patients, the clinics serve as the nexus for a variety of street scenes. Patients who are frustrated in their attempts to leave “The Life” by clinic-generated roadblocks are often forced to make their someone the public is potentially going to have to pay to incarcerate, hospitalize, prescribe HIV medications to and, frequently, to bury. Tying up limited funds in an overpriced clinic system means that hundreds of thousands who would accept and benefit from methadone will not have the opportunity.

In brief, the methadone clinic system is a cynical sham that keeps patients mired in the street life and on welfare, prevents people from working or getting an education, encourages misunderstanding about methadone and hostility to methadone patients on the part of the public and flagrantly wastes taxpayer dollars in the process.

**Methadone is a safe and effective medication which has provided immeasurable benefit to hundreds of thousands struggling with the consequences of opioid dependency.**
What Can Be Done? Educate, Subvert and Survive

The methadone clinic system must go. Thankfully, we don’t need to search far for the means to replace it. All that is needed is parity with other medications. If the regulations unique to methadone are repealed, if the laws prohibiting maintenance of addicts are rewritten, then methadone becomes just another medication, prescribable by private physicians, dispensable in clinics—in short available in whatever venues users and prescribers deem appropriate.

Putting methadone on par with other controlled substances seems a reasonable and achievable goal, but the forces dedicated to preventing it happening are formidable. We must recognize that it may be years before the medication ceases to be a tool of oppression. As we work towards this eventual goal, there remains much that the harm reduction community can do to reduce the damage caused by the methadone clinic system.

The system through which methadone is provided is a uniquely oppressive bureaucracy that greatly reduces the benefits of the medication and generates harm where none existed before.

Just as with substance or paraphernalia prohibition, ignorance is the most valuable weapon of those who support the current restrictions on methadone. The first and most important task facing those who would challenge the status quo is to attack ignorance regarding methadone and the methadone delivery system, wherever it is found.

For many harm reduction-oriented service providers this means not only challenging bias and myths common in the community, but also having the courage to recognize that being marginalized and persecuted do not in themselves make experts of methadone patients. Most of those maintained on methadone have, if anything, received more misinformation from staff and fellow patients than has the general public. Few things are more painfully ironic than seeing the abuse and ignorance foisted upon methadone patients reflected back at well-intentioned advocates and used as the basis for more stigmatization of methadone.

Another common danger lies in our attitude towards research. The harm reduction community must avoid the temptation to dismiss solid research from NIDA because of feelings about their political agenda and the biased research it often produces. Similarly, we cannot allow our longing for “easy” solutions for those with heroin problems to blind us to the ever more clearly demonstrated fact that most chronic addicts appear to have significant brain changes that will not resolve with time.

Prohibition, and the drug war used to advance it, are not political abstractions for the hundreds of thousands of us who need opioids to survive. The methadone clinic system is a weapon of the drug warriors, and as long as it exists it will be used to control, degrade and injure. It is incumbent upon the harm reduction community to do everything in our power to assist people in gaining/ maintaining access to methadone even as we help them survive the system that perverts it.

We must obtain and share as much information as possible, not just about the medication, but also about the clinic system itself. Keeping patients ignorant is a vital part of this bureaucracy’s agenda, and encouraging their isolation is an important way of maintaining that ignorance. We must share with patients the weapons with which they can defend themselves. Every fact is a potential tool to be shared and spread: Federal and state regulations, contact information for regulatory agencies, program policies, the personal and professional backgrounds of staff. Harm reduction professionals have the means of accessing information about the clinic system not readily available to patients. We can share our resources with them just as we can act as conduits for patients to network and share their own survival tips with each other.

Let the patients know that the programs are not there to help them. Assist those who want to obtain truly supportive services from agencies that cannot exert control over them.

Make sure that patients understand how the once largely confidential nature of the patient-program relationship has been destroyed by welfare reform, drug courts, infectious disease reporting and so on. Help them understand how information is shared amongst staff within the program. Let them know what the program defines as success and advise them on promoting a compliant, successful image while keeping as much actual information from their charts as possible.

Urine screening is everything in methadone programs, but knowledgeable patients can keep it from controlling them. What is and isn’t this program screening for? What causes false positives? Which adulterants are detectable? How do they detect substitution? Would their collection procedures stand up in court?

Use your professional status and the weight of your agency to assist the patient. Do they need a letter documenting their volunteer participation? A statement of their medical disabilities? Many times clinics will yield if they think a patient has outside support. Few who have not been there can fully appreciate how difficult it can be for a methadone patient to both clearly understand the forces with which they contend and then stand up to them. Deprived of knowledge and sustained by mythology, simultaneously labeled criminal, diseased and weak-willed, ashamed about street drugs and even more ashamed about methadone, beaten down by providers, family and the criminal justice system, it is no wonder that so many internalize the stigma. What is a wonder is that so many have not only survived, but are going on to challenge the status quo.

As both patients and harm reduction professionals come to understand the distinction, we can work together for the normalization of a medicine which reduces harm and the destruction of a system which produces it.
Harm Reduction in Mental Health: The Emerging Work of Harm Reduction Psychotherapy

BY PATT DENNING AND JEANNIE LITTLE

Harm Reduction Psychotherapy (HRP) is a term that is being used to describe several clinical models to treat addictions that are based on the international public health movement termed “harm reduction.” Ours is a biopsychosocial approach using research and clinical wisdom from the study of neurobiology, sociocultural forces, psychodynamic and cognitive/behavioral theory to create a holistic assessment and treatment model. Harm Reduction Psychotherapy represents a radical paradigm shift, one that we believe is necessary if we are to confront our own attitudes towards addiction, as well as those of the society in which we live, and make our clinical interventions more effective.

In this country, we have been fighting over how to help people with drug problems for more than 200 years. Because of the War on Drugs with its emphasis on zero tolerance, and the widespread use of coercive measures (incarceration and treatment), HRP is an intensely political endeavor. To separate out the politics is to render it just another eclectic bag of techniques, however sophisticated the bag.

Drug treatment in the U.S. is currently based on what is known as the American Disease Model, which states that addiction is a primary disease: not caused by any other condition, characterized by loss of control and denial and only treatable by abstinence. (The 12 step program of recovery is the practical application of the disease model.) Requiring abstinence as a condition of entering treatment, and terminating clients who relapse, are two examples of setting the threshold for treatment too high. By doing so, we dramatically limit the range of people who can and will come to treatment. Substance abuse is the only field in mental health where the client is required to give up his symptom (drug use) before entering treatment.

HRP is founded on the basic principle of the harm reduction movement—respect for peoples’ choices, with an active involvement in their lives. It is based on the controversial concept, learned through research and our own experience with clients, that people can and do make rational choices about their drug use, even while in the throes of addiction. One of the clinical principles that derives from this basic stance is to meet clients “where they’re at,” and offer “low threshold” treatment. This means removing barriers (such as lack of childcare) or eliminating the traditional hoops (requiring abstinence prior to entry, for example) that people have to jump through in order to access services.

Psychological Theories of Addiction

In contrast to the disease model’s insistence that addictions are diseases, many psychological theories offer more complex ways of understanding why people use drugs or alcohol and why they may get into trouble with these substances.

Morgenstern and Leeds (1993) have provided a summary of the major psychodynamic theories. Edward Khantzian was the first person to describe the self-medication hypothesis, stating that people use particular drugs to deal with specific difficult feelings. Leon Wurmser believes that drugs can be used to silence the voice of one’s harsh inner critic. (Unfortunately, drug use may also silence the nurturing voice that helps us take care of ourselves.) Finally, Henry Krystal used the term alexithymia to describe the difficulties with identifying feelings that plague many drug users.

One of the most useful models, and one that is at the heart of harm reduction therapy, is Attachment Theory. People develop relationships based on experiences with early caregivers. Problems of attachment in the interpersonal sphere often lead to an attachment to things not human. Drug users develop complex relationships with the drugs that they use, which are reflective of their relationships with people. Interestingly, Karen Walant (1995) asserts that Americans’ value of autonomy over our need for attachment is a primary cause of the high rates of addiction in our culture, and stands in stark contrast to most non-Western cultures.

Probably the most troubling work has been done in the area of trauma: up to 80% of people with a history of significant trauma will abuse substances. (See Let’s Get Real: Looking at the Lives of Pregnant Drug Users, p 22.) The sheer numbers of people with substance use problems who have been traumatized as children is staggering and demands that we pay attention to the literature on the psychological and physiological aftermath of trauma.

Trauma damages neurotransmitter systems most affected by street drugs and alcohol: the dopamine system so responsible for pleasure is disabled; the serotonin system may be damaged, leading to problems with mood and aggression; norepinephrine pathways of the fight-flight response become chronically activated, resulting in anxiety and the endorphin system may also be harmed, leaving the individual unable to tolerate normal physical or emotional adversity. This goes a long way towards explaining why we hear so many chronic drug users complain of depression and anxiety and a poor ability to tolerate feelings.
Concepts of Harm Reduction Psychotherapy (HRP)

HRP defines addictions as biopsychosocial phenomena. A general framework for this comes from Norman Zinberg's Drug, Set and Setting model. (1984) Drug refers to the class of drug, its cut and the route of administration; Set to the person and her unique psychology, psychology, as well as motivation and expectation of drug effect; Setting is the environment in which the drug is used, with whom one uses and in what cultural context. The relative importance of drug, biology, psychology and culture and environment varies. In treatment, each person needs to be individually assessed and her unique circumstances understood.

Knowledge about how people make changes in behavior is essential to any treatment process. Prochaska and DiClemente's Stage Model of Change (1992) provides this. Precontemplation is the stage that refers to not knowing that one's problems are related to drug use. In the Contemplation stage (the "yes, but" stage) the person is aware of certain drug-related problems, but also wants to keep using and has good reasons for doing so. (They may decide to make a change, or not.) In the stage of Preparation, the person decides to make some preliminary changes to reduce harm, while in the Action stage, he or she is fully engaged in making major changes in drug using behavior. Maintenance refers to the hard work of changing one's life in order to support the change in drug use. Of course people often relapse, hopefully learning important lessons that will help them in the future. Once this hard work has been done, the person exits the addictive process—meaning whatever change they've wanted to make, be it abstinence or moderation, has been accomplished—and enters the stage of Termination.

The above concepts and strategies are central to HRP and are especially useful when engaging a person whose drug abuse is intertwined with significant emotional problems.

Dual Diagnosis

The term dual diagnosis (co-existing mental and substance use disorders) encompasses a large and complex group of people. It is a group that, for a number of reasons, including the design of our treatment systems, is extraordinarily difficult to serve. Dually diagnosed people usually come to treatment with many other psychosocial problems such as poverty, social isolation and hopelessness. Their need for social and economic support is so great that these clients often overwhelm our treatment resources.

Dually diagnosed people often have difficulty establishing or maintaining abstinence. In addition to using drugs for the same reasons that we all do—to relax, to socialize, to escape reality, to feel more energetic and so forth—people with serious mental and emotional disorders often use drugs to "self-medicate." (Khantzian, 1985) Even if, in the long-term, one's drug of choice does not improve one's mental health, the short-term perceived benefits can be profound. For example, the same stimulants that can cause acute psychosis can also relieve the negative symptoms of schizophrenia or the side effects of anti-psychotic medication, such as emotional blunting, inability to experience pleasure, depression or social withdrawal. Many individuals with a history of emotional, sexual or physical abuse or trauma develop dependence on a variety of drugs—especially opiates, alcohol and marijuana—to relieve traumatic memories and other symptoms of Post Traumatic Stress Disorder. Given this, one can begin to see that abstinence poses the potential loss of a supplement to a person's quality of life, or to his/her regular treatment regimen.

We have a series of system-based problems in the treatment of co-existing substance abuse and psychiatric disorders. For a number of reasons, especially related to theories of addiction and recovery, we have developed separate treatment systems for substance abuse and psychiatric disorders. In spite of the difficulty of accurate diagnosis, we have attempted to assign the substance use or the mental disorder as primary so that we could then refer clients into the "right" treatment. As a result, mentally ill persons have historically been excluded from substance abuse programs, and vice versa. As many authors have argued (e.g., Drake, 1993, Minkoff, 1989), we must provide integrated treatment for dually diagnosed people. Although we have gone some way toward breaking down traditional barriers, we still need to create better marriages between mental health and substance abuse treatment providers.

Arriving at a firm diagnosis is difficult. Intoxication from street drugs or alcohol can exacerbate underlying psychiatric symptoms or mimic various psychiatric disorders. For example, if a person with schizophrenia also uses stimulants, this may either precipitate or present as an acute psychotic episode. Until a detailed history is obtained, it is impossible to know whether this is a drug-induced psychosis or a substance-exacerbated psychotic episode. In the case of a Valium-dependent person, if that person presents in an agitated state, you may be seeing an anxiety disorder, which is not well medicated, or a case of Valium withdrawal. These diagnostic difficulties can make treatment providers reluctant to prescribe treatment, whether medication or therapy.

When assessing and treating dually diagnosed persons, I find it useful to avoid the diagnostic argument and to look instead at other ways of assessing someone's appropriateness for a particular treatment. Instead, I propose that we ask three questions:

1. Can a given client participate in any of the available treatment programs?
2. Does that client want to participate in treatment?
Harm Reduction as an Approach to Treatment

The question is then, how do we serve people who need treatment but do not fit into existing programs? Harm reduction offers us a means of conceptualizing and designing treatment that reaches vulnerable populations—treatment that lowers the threshold so that people who are unsure of what to do about their drug and alcohol use, or who have complicating factors such as mental illness, can have access to treatment.

The goals of harm reduction-based treatments are flexible and are established in collaboration between client and treatment provider. Abstinence is never a condition of harm reduction-oriented treatment, and may or may not be a goal.

Harm reduction principles demand that we negotiate a treatment plan that is congruent with what a person perceives his or her needs to be. We should also be careful about expecting abstinence or change in drug use until we can offer something to replace the function of drugs and alcohol, whether it is more effective psychiatric medication, a therapeutic relationship or relief from social or economic distress. It is important to respond to the problems that a person identifies as priorities, rather than to define all of a person's life problems in terms of addiction. In other words, we must understand and attend to the client's "hierarchy of needs." (Denning, 2000)

The best treatment strategy also includes addressing ambivalence, or a person's mixed feelings about giving up his or her drug of choice. (Miller, 1991) Ambivalence is a normal state of conscious or unconscious confusion that we all experience when faced with pressure to change something important about ourselves. It is the core of harm reduction therapy—the work that focuses on helping someone resolve ambivalence and make a decision. The decisions could range from using sterile syringes at all times to using condoms in some sexual encounters to quitting alcohol and smoking marijuana instead.

The treatment process can be broken down into four parts:

**ENGAGEMENT**

According to Miller and Rollnick (1991), motivation is not a stable trait that exists within the person. It is more often a product of the relationship between a person and whoever or whatever is demanding change. We do not need to wait for someone to get motivated or hit bottom. We can and should use techniques that create a relationship of trust and collaboration, while acknowledging the compelling reasons why a person continues to use drugs or alcohol.

The primary tool in the engagement process is to use the five principles of motivational interviewing:

- **Express Empathy**—The therapist must see the world from the client's point of view and communicate to the client, "I get it."
- **Develop Discrepancy**—The client needs to see the discrepancy between her goals and the reality of her current situation in order to create pressure to change. Note: it is the client's job to gradually see the discrepancy, not the therapist's to point it out.
- **Avoid Argumentation**—The client has the right to tell his own story and is always right.
- **Roll with Resistance**—Resistance to change is natural; it is the mind's way of saying, "wait a minute, how do I know I am going to be better off if I...?" If you hear "yes, but...", the proper response is to back off, go back to where you were and check out what you did to arouse resistance.
- **Support**—Self-efficacy is the sense that one can accomplish one's goals. The therapist must take every effort to build self-efficacy in the client by supporting all efforts the client makes toward healthy change, and by congratulating the client on the adaptive nature of her drug use.

3. If the answer is no to both of those questions, we then need to figure out what type of programs we should create to accommodate the needs of dually diagnosed persons.

On the question of whether a person can participate in (traditional) substance abuse treatment, I would argue first that a person's level functioning is more important than diagnosis. Functioning refers to having the social skills, emotional capacity and interest to cope with group and individual interactions, which may at times be highly personal, if not confrontational. In other words, a person needs to be able to be self-reflective and to be challenged with new perceptions about him or herself without becoming excessively confused or injured.

Regarding the second question, that of someone's desire to participate in (traditional) substance abuse treatment, the real issue is the willingness to be abstinent, rather than a willingness to engage in treatment per se. The strict requirement that abstinence be a condition of entering or continuing treatment may be too high a threshold for people who perceive real benefits from drug and alcohol use. Nevertheless, dually diagnosed clients may be interested in other benefits of treatment, such as attending to their psychological and emotional problems, and may also be interested in changing or reducing their use of substances.

Dually diagnosed persons help us to understand and remember that people use drugs and alcohol for reasons. Even if those reasons have gotten blurred over time with habitual drug use, drugs and alcohol often still serve a protective and defensive function. Without them, a person may experience overwhelming emotional states or unbearable physical or mental pain. Thus, reasons for continuing to use drugs and alcohol are often more compelling than reasons to stop.
pressed finds that solo drinking soothes the isolation that comes with solo drinking is a blessing. For some-one who avoids social contact, the isolation the direction of positive change. For some-one will be other factors that influence her in one person's "bottom" that swings the bal-

sult of unresolved drug problems may be children to Child Protective Services as a re-

plexity of the change process—and makes it more real.) In decisional balance work it's

mance about the extent of a client's use of drugs, or need to eventually consider com-

mation about the extent of a client's use of drugs and their effects; the therapist has an obligation to provide such information. This information must be balanced, correct and not based on general-

sues and investment in each issue will pro-

عال work will need to take place in order for the client to reliably make and maintain be-

The result of this assessment process is the creation of a hierarchy of needs that be-

ON GoING TREATMENT

The Decisinal Balance, a type of cost/bene-

factors influence her in the direction of positive change. For some-

the pain of social isolation but maintains isola-

ation in ways that are also uncomfortable. Once the pros and cons lists are developed, the therapist must help the client explore the importance of each item. As might be imagined, this is a very delicate and often painful task—one that can take months or even years.

The therapist must remain neutral in the deci-sional balance. The client's own life is-

For more information on use management see the article “How to Run a Substance Use Management Group” in the Fall '97 Harm Reduction Communication-ed."

ATTENTION TO THERAPIST PITFALLS

Therapist pitfalls fall into the category of countertransference. The most common re-

• Bringing a moralizing tone to the ther-

• Being overeager to capitalize on a client's

• Not eliciting enough detailed informa-

• Colluding with the client's resistance to

the therapeutic alliance, being afraid to be challenging enough.

• Underestimating the negative aspects of a client and his life. In an effort to support the client's strengths and self-efficacy, not acknowledging and giving space for the depth and extent of his hopelessness and despair.

By combining theory and technique, and by being wary of our own biases, we can cre ate treatment that will be both acceptable to the client and successful in whatever way she or he defines success. It's obvious that HRP can take as many forms as the clients it serves.

In Conclusion

We offer these ideas to inspire others to join in the development of Harm Reduction Psychotherapy and to acknowledge the debt we owe our clients and colleagues for years of support and patience as we find our way over to more humane treatments.

Patt Denning and Jeannie Little practice in the SF Bay Area, where they are developing the Harm Reduction Therapy Center. Patt is the author of Practicing Harm Reduction Psychotherapy (Guilford Press, © 2000).

References


Since November 9, nine women prisoners (some with recognized chronic and serious illnesses and some suddenly) have died at the Central California Women’s Facility (CCWF). At least four of the nine women were HIV+, and at least two were co-infected with Hepatitis C. Two of the women died at Madera Community Hospital after a long illness.

However, all of the women shared the same circumstances. They were incarcerated at CCWF, the prison that is well-known for providing substandard medical care for women prisoners. And clearly each woman had her life shortened due to callous and inhumane treatment by guards and medical staff.

As if nine deaths (since November 8, 2000) were not enough. As if nearly ten years of medical neglect were not enough. As if depending upon guards who work as medical technical assistants to unlock the cell door and provide medical care is not enough. As if watching your cellmates writhe in pain and die from outright medical neglect after being refused emergency care is not enough. The California Department of Corrections (CDC) and the local prison administration at the Central California Women’s Facility have upped the ante and are devising new ways to torment and jeopardize the lives of serious and chronically-ill women prisoners.

Last January 25 an elderly woman prisoner at CCWF requested immediate medical care after the women were locked down for the night. CCWF staff responded in force. They apparently got the woman some care. However, they also declared the woman’s cell a “crime scene,” made all the women submit to strip searches and did a major shakedown of the cell. Additionally, CCWF staff dispensed this punishment loudly in front of the cells of hundreds of women, sending a warning that this was the treatment that women could expect if they had a medical emergency after hours.

CCWF’s response to all the deaths has been to blame the women: to spread lies and disinformation that women prisoners died because they ingested illegal drugs or misused their prescription medicine. Thousands of cells were torn apart by guards in January and many women had their life-saving prescription medications confiscated. Toxicology reports and the CDC’s own medical investigation by outside doctors have since disproved the theory that scapegoats the dead women. But the punishment still continues. Women requesting medical care after lockdown may now have their cellmates subjected to the most brutal form of repression and humiliation.

CCWF was the subject of a class action lawsuit (Shumate v. Wilson) which was dismissed by a federal judge on August 7, 2000, after a two year monitoring period. On October 11-12, state legislative hearings conducted by Senator Richard Polanco’s Joint Committee on Prison Construction and Operations were held inside two women’s prisons. The poor standard of care received by women prisoners at CCWF was criticized by many prisoners and outside advocates.

A coalition of advocacy groups is calling upon Senator Polanco to conduct an impartial investigation into these deaths. We cannot allow the California Department of Corrections to “investigate” itself and cover up this latest human tragedy, but we don’t want to let the CDC off the hook, either.

SEND A MESSAGE TODAY TO THE CDC!

WOMEN PRISONERS NEED MEDICAL CARE NOT REPRESSION AND PUNISHMENT

Please call, fax or send a letter to the following people to protest this injustice against women prisoners.

Dear Warden Mitchell and Director Cambra,

We are deeply concerned that women prisoners (and their cellmates) at the Central California Women’s Facility who request medical care after the evening lockdown will be subjected to punitive cell and strip searches. This, in fact, happened to an elderly woman prisoner in January. Women prisoners were told that this is the new policy for dealing with medical emergencies at CCWF. If this is true, this outrageous treatment will deter ill women prisoners from seeking medical care and surely cause unnecessary deaths. We demand that CDC provide appropriate care, not punishment. We will not tolerate any more deaths at CCWF. We demand that you take action to stop these punitive and unnecessary cell searches and provide decent medical care to women prisoners.

Your name
cc: state legislators
human rights organizations
local media

Urgent Alert issued by the Ad-Hoc Committee to Save the Lives of Women Prisoners. Our members include the California Coalition for Women Prisoners, Justice Now, HIV in Prison Committee of California Prison Focus, Legal Services for Prisoners with Children and Prison Activist Resource Center. For more information, please contact California Prison Focus at (510) 665-1935.
want to begin by thanking some gente, Maria y Fernando del Harm Reduction Training Institute of Oaktown, Cali and the staff and participants from the H.I.P., H.O.P. Project and Centerforce Health Programs, for providing me a context in which to think these thoughts.

About my title: “I am a Nightmare Walking” is a line from an old Ice T rap, the theme song to the Dennis Hopper film Colors. The line, sampled for an early 90’s house track, exemplifies the social position of young men who have been back ‘n forth through various state institutions: foster homes, group homes, juvenile hall, camps, and Venice, California; places which to this day find themselves mired in an ever intensifying gang war and police state.

California is the state with the highest percentage of imprisoned people; if it was a country it would have the second highest incarceration rate in the world. According to the California Department of Corrections, there are 162,000 people in its facilities and it has an annual budget of $4.6 billion, with another $5.27 billion going into the construction of more prisons and beds, as the current facilities will reach capacity in April, 2004. The prison population statewide is 29.5% white, 31.2% black, 34.2% “Hispanic” and 5.2% other, meaning, as far as I can tell, Native (Miwok, Pomo, Cumash, Apache, Navajo), Vietnamese, Cambodian and other southeast Asians and a growing Tongan, Filipino and Samoan population. Thirty-eight percent of people on parole and 28.2% of those inside are doing time for drug-related offenses.

San Quentin, the state prison where I work, is mostly a parole violator’s prison: 80% of the men serving time there have committed some kind of parole infractions that have led to re-incarceration. It is this rate of return, or recidivism, we are trying to impact through the research/intervention program H.I.P., H.O.P.—health in prison, health outta prison. For it is the prison system which puts these young men and their older counterparts at the highest risk for HIV and HCV infection and, if already infected, mistreatment and treatment incoherence that approaches the intentionally murderous (as in not receiving meds or medical services if you are in the hole).

We know that sex occurs inside: long term relationships, consensual sex, rape and a form of negotiated but nevertheless compulsory sex that many trade for other goods (drugs for one), or to avoid having to fight and/or kill. All of the men I talk to say there are more drugs inside than on the streets, and most of these men are from embattled communities where the sale of drugs is most highly concentrated. I am amazed at the resourcefulness of brothers on the inside: how they make their own condoms out of rubber gloves, create a bleach out of cleaning fluid, make moonshine they call pruno out of fermented fruit, steal needles or make them from pens and guitar strings. The practice of tattooing, a high art inside, also positions them at risk since HIV and HCV can live in both the ink and the needle. Yet condoms, needles for injection drug use and tattooing, bleach and conjugal visits for the non-married and non-heterosexual are not (and will not) be legalized in California state prisons.

The policy of my prison is that anything that they don’t approve of does not occur. (It is this kind of myopia that leads to episodes like their most recent embarrassment: a correctional officer high up in the union caught running the heroin distribution in one section of the prison.) Furthermore, fighting, which often leads to bloodshed and blood mixing, is often a correctional officer-induced sport.

It is in this context of increased risk in which I try to provide harm reduction, prevention and treatment information, which most of these men don’t want. What they do want is a job, a place to live other than their mother’s or grandmother’s house and a way to make sense of their experience inside without always having to be identified—and therefore made invisible—as the formerly incarcerated. What they need, as essential forms of their contextually specific harm reduction, are family reunification programs, a parole reform movement which would return parole to its pre-1976 status in the penal codes (when it wasn’t a continuation of their sentence and thus their damnation), anger management work, family planning and fathering programs. And, though not necessarily last, a social movement which would work against their coercive collectivization—the lock, stock, store, warehouse and survival modality which has become their day-to-day experience in and out of state institutions.

They need legal advocacy and legislative work to counter the imprisonment of youth in adult institutions, three strike laws, deportation of undocumented persons and those with visas and green cards for felony convictions. And if not the decriminalization or legalization of drug sales and use, then at least an equalization of sentencing terms between crack and powder cocaine. They need a harm reduction movement.
that would work on their homophobia and misogyny as well as their inculcation of white supremacist beliefs and attendant acts towards others and themselves. Help with filling out a job/g.e.d./community and four-year college application, and assistance in interacting with the internet and the latest computer software. They need a reason, beyond client incentives, to care about themselves and those who position themselves as players and cons. In fact, hip hop is probably the only place, along with some forward thinking non-profits and small businesses, where they don’t have to mask all those gaps in their employment records.

The young men I work with—I meet them during their last few months inside—are being released into the epicenter of late capitalist technological advancement, a place where dot-com colonization has dispersed their communities to the point of decimation. Meanwhile, they have not had access to the web inside, and have been the recipients of sub-standard schooling, if any at all. The California Department of Corrections states that its prisoners’ average reading level is the 7th grade, but it seems to me to be more like the 4th grade. To compromise matters, these men are having to reconnect with family and partners who they lost contact with when they began doing their time.

There are many Bay Area activists—I guess they call themselves organizers too—who are calling for the abolition of what they term the prison-industrial complex. They spend a lot of time in meetings with each other, working on the campaign to free a celebrated and deemed revolutionary high-profile prisoner, but they don’t speak enough to those actually impacted by that prison system. I tell them I’ll go to your Mumia rally if, and only if, you go to the sentencing hearing of your local crack dealer. I have yet to be taken up on the offer. But it is precisely this crack dealer, given a felony term and on his/her way to another strike, this petitcriminal whose life is not petty, who needs marches, demonstrations and letter-writing campaigns on his/her behalf. Although they probably won’t be put to death by the state, it is surely killing them. For they are a nightmare walking and none of us—researcher, harm reductionist or radical—is listening hard enough to the force and vision in their dreams.

Ricardo A. Bracho is a playwright, harm reductionist and father. He has worked with youth, lesbian and gay people of color, Latina/o communities and now the incarcerated.

I AM A NIGHTMARE WALKING.
I AM A NIGHTMARE WALKING.

COLORS, by Ice T
I am a nightmare walking, psychopath talking
King of my jungle just a gangster stalking
I don’t need your assistance, social persistence
Any problem I got I just put my fist in
My life is violent but violent is life
Peace is a dream, reality is a knife
With my colors upon me one soldier stands tall
Tell me what have you left me, what have I got?
Last night in cold blood my young brother got shot
My home got jacked
My mother’s on crack
My sister can’t work cause her arms show tracks
Madness insanity living profanity
Then some punk claimin’ they understandin’ me?
Give me a break, what world do you live in?
Death is my set, guess my religion
Actually, the trouble began with the very first blood test back in September: the one which indicated that not only did I have HCV, but that I’d been exposed to HBV, too. Said “trouble” beginning with the fact that no one from Facility Health Services (FCS, the prison’s health care service) even told me I was infected. (This scenario would repeat itself a year later when an abdominal sonogram found an 18mm. hyperechoic solid in the right lobe of my liver. I found out only after ordering my medical records at a cost of 25¢ per page.) In April of 1999 I was transferred to Attica where I immediately began to ask questions about the liver biopsy the specialist had ordered. The doctor I saw told me, “You don’t need one.”

By that time, I’d begun writing away for every free piece of HCV information I could get my hands on. I wrote a Grievance against this doctor, and, while spelled with a capital “G” any impression of power is entirely illusory. A direct result of the 1971 Attica prison riot, Grievance is without question one of the biggest slaps in the face that New York State has ever given her inmates. I wrote my Grievance and offered several pieces of evidence in support of my argument beginning with the gastroenterologist’s diagnosis and his orders for a coagulation panel and a liver biopsy. I offered excerpts from the NIH Hepatitis C Consensus Statement of 1997 including a paper on “The Role of Liver Biopsy” by Robert P. Perrillo, M.D., the NIH’s own Consensus Panel biopsy expert.

No arguments there, right? Wrong. At first, on both facility levels (the first being that of Grievance and the second that of the Superintendent of Attica), and then in a final response from Albany, the Grievance was denied and in each denial I was informed that my case was being followed as per established medical protocol. In several responses the medical staff were referred to as “professional medical health experts.” I asked where I might obtain a copy of this “protocol” and was in turn ignored for 4 months until I sent a Freedom Of Information Law (FOIL) request to the Chief Medical Officer of the New York State Department of Corrections (NYSDOCS). His designee informed me that I could get a copy right here in Attica, and two weeks later I received said copy accompanied by an unsigned note apologizing for the delay.

The Hepatitis C Primary Care Practice Guideline, published March 31, 1999, had, unbeknownst to me, been replaced by a new edition in January, 2000. (The only difference is the date of publication.) The first Guideline is a five page document allegedly based on three references: the same NIH Consensus Statement of 1997 from which I drew much of my evidence, a CDC tract from an October, 1998 Morbidity and Mortality Weekly Report (such a cheery title, no?) and a Federal Bureau of Prisons Treatment Guideline of 1997. Please note that the NIH Consensus Statement is, though not a Federal Government Policy Statement, the Grandaddy of them all as each of them lists the NIH document as a reference.

After reading the Guideline closely, I quickly realized that the only two mentions of liver biopsy within its pages were made solely in reference to interferon (IFN)/Ribavirin therapy. This “information” was taken directly from the NIH info and then employed in a most singular context—that of IFN therapy. There was absolutely no regard for several NIH paragraphs in the same text regarding the value of liver biopsy in judging the organ’s histological health, and in grading the severity of damage it has suffered.

The director of Grievance, in Albany, wrote to inform me that the Facility Health Services Director (FHSD) had final say over all medical decisions. I wrote back to ask if that wasn’t collusion? How can Grievance ask the doctor I am “grieving” his own opinion of the treatment he is giving me? I never got an answer to that one, but Albany ordered that the coagulation panel be taken and that the “need” for a biopsy would be determined based upon its results.

This is wrong. It is impossible to determine the “need” for a biopsy based upon the panel results because they only tell the physician whether or not you can survive the...
biopsy. (The panel is a test that measures the rate at which your blood clots.) Nonetheless, and after many screw-ups on the part of FHS, I gave blood for the panel in October, 1999—seven months from the time it was originally ordered. I was never notified of the results, nor called back to see the doctor. I wrote to Grievance here in Attica and was most tersely informed that I had in fact been given the results of the panel on August 31, 1999. When I wrote back to correct the Grievance Supervisor, I received an arrogant response which stated that, “Dr. orders are not orders but merely suggestions...the FHSD has final say over all medical procedures and has determined that you do not need a liver biopsy at this time.”

Quite frankly, I probably didn’t need a liver biopsy. Although the jury is still out, many doctors cannot agree as to the usefulness of the procedure in particular instances, but, due to the number of “mistakes” by FHS and Grievance, I continued to push because they seemed so incapable of delivering an informed—or even close to accurate—opinion on their own incompetent behavior. I have come to believe that NYSDOCS/FHS run their show a lot like General Motors ran theirs in the ‘60s: they wouldn’t spend $2.50 per car because the cost of law suits that would result from exploding cars was deemed cheaper. (After their liability was proven, one poor widow won $50 million from them!) NYSDOCS/FHS is doing exactly the same thing. There is absolutely no doubt in my mind that when a half-dozen HCV+ inmates all tell me that they were sent to the Mental Health Unit by the physician for “evaluation” there is surely something wrong.

I thought I’d caught them here, but it didn’t matter. Smoking gun, the whole nine yards, it just didn’t matter. I wrote to everyone but the Pope, and I’d be lying if I said I didn’t think of writing to him, too. No help. A few sympathetic ears, but no solid results. I have come to believe that FHS is the biggest open conspiracy I have ever seen. I grew scared. (Not to brag, but I don’t scare too easily.)

When a half-dozen HCV+ inmates all tell me that they were sent to the Mental Health Unit (MHU) by the physician for “evaluation” there is surely something wrong.

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I dug a little deeper. There are only two available HCV tracts published by NYSDOCS—a May, 1999 article in DOCS Today, a NYSDOCS organ whose articles conveniently contain no by-lines (none of them, and with good cause if the article on HCV is any indicator of their fact checking skills) and the Guideline—the DOCS Today article stated that NYSDOCS/FHS would be conducting HCV screening at several reception facilities. On June 2, 2000 I was informed by NYSDOCS that the “total” number of HCV positive test results was 4,441. By itself, that is barely 5% of the entire NYSDOCS inmate population. No time frame (nor context) was ever offered with these “statistics.” And,
Without support from the outside, HCV will thrive in prisons as HCV+ and at-risk individuals are arrested and incarcerated in ever increasing numbers.

Even in a most favorable light or, say, two years worth of testing, it is still an incredibly low number when compared to that of California (32%), Texas (28.6%) and even Maryland, which at 38% has a higher HCV infection rate among her prisoners than New York. I dig even deeper. The Guideline says that testing would be offered to those inmates with a history of high risk behaviors. It is not. In fact, a “Don’t Ask, Don’t Tell” policy seems to be the protocol: they don’t ask, and they don’t tell. There is virtually no HCV education taking place here in Attica. None!

In an editorial printed within the pages of H e p p News/ H IV Education Prison Project, published by the Brown University School of Medicine, Louis Tripoli, M.D., Vice President of Medical Affairs for Correctional Medical Services in St. Louis, Missouri and an Adjunct Assistant Professor of Medicine at Johns Hopkins University (who boads that his organization is responsible for the health care of about 300,000 incarcerated individuals in United States) “begged” his colleagues to pursue a “rational approach to hepatitis C infection … Much of what we believe about hepatitis comes from content-area specialists, such as hepatologists, few of whom have had any appreciable experience treating a correctional population. No long term studies are available to tell us whether those who are selected for treatment in correctional settings will benefit from treatment and maintain behaviors that will reduce the chance of future reinfection.”

Is Dr. Tripoli saying what I think he’s saying? That inmates are mysteriously biologically different from other hepatitis C infected human beings by virtue of their criminal background alone, and, denying them treatment is perfectly okay because who can tell if they will change their “habits”? This “professional” goes on to suggest that we “… are being led down a primrose path by the pharmaceutical companies.” This echoes the DOCS Today article too closely for comfort. DOCS Today even went so far as to state that HCV awareness in NYS DOCS prisons is due solely to the efforts of pharmaceutical companies trying to sell more drugs. And, while that may or may not be true, as a “fact” it does not lend itself to any medical debate regarding infection rates, who should or should not receive treatment and a host of other incredibly suspicious arguments I am sure Dr. Tripoli and his like/ budget-minded contemporaries have at the ready.

All this is just as outrageous, if not more, as a doctor or nurse having to call an HMO or an insurance company before they will give you treatment. It begins a rather tedious question as to who is worth what, and to whom. It should have never happened in the first place and has set a precedent that points in directions most people would rather ignore or refuse to acknowledge. This, of course, does not change the fact that we are most assuredly heading towards them. In fact, in many instances we are already there.

It has been determined that as many as 4 million Americans (1.8%) are infected with HCV. Between 8,000 and 10,000 of these people will die every year from HCV-related chronic liver disease. HCV is now the third leading cause of liver transplant. Intra-venous drug use is the primary source of new HCV infections: sixty percent. As much as 30% of the national total of HCV cases pass through correctional facilities each year. Eighty percent of all U.S. inmates have used illicit drugs, 1 in 4 parenterally. In a recent reader survey conducted by Hepatitis magazine, prisoners’ issues were listed third from last.

Recent trends demonizing prisoners allow men like Dr. Tripoli to suggest that inmates aren’t the same as other patients. His editorial went so far as to state that “we may end up spending valuable resources providing medication to a large number of people who may derive no substantial benefit in order to prevent complications in a minority.” I blink, I do a double take—who is this man? As prisoners become the latest “Two Minutes Hate” ambiguous laws are written and passed, politicians are bought and sold and we forget that we are a democracy, whenever money comes into the picture, that is. Our perceptions of change are being manipulated—not that they were so very keen to begin with—because by either diversion and/or lameness, many will not believe that “it” can ever happen. And when “it” does happen to someone else, that is acceptable because “it” is not happening to us.

If history has taught us anything, it is that it repeats itself. Without support from the outside, HCV will thrive in prisons as HCV+ and at-risk individuals are arrested and incarcerated in ever increasing numbers. And when they are inevitably released, less than aware (as long as current policies continue), HCV will be there with them, returning in greater strength. Litteral HCV factories, that’s what prisons are becoming. These are the trends and directions we are all heading in. For in the words of the great Russian novelist, Fyodor Dostoyevsky:

“The degree of civilization in a society can be judged by entering its prisons.”

Charlie Seller is an aspiring author and harm reductionist. He was recently released from Attica Correctional Facility.

References
6 “What Hepatitis C Is- and differences from A or B.” DOCS Today. NYS DOCS. May 1999
10 Ibid.
13 Tripoli.
This situation is unacceptable. Drug users have been the whipping boys and girls for the medical profession since the end of the nineteenth century, an abjection continued by the post industrial extention of medicine, the pharmaceutical industry. This brings me to my first suggestion for a course of action:

1. Drug users and fellow travelers should demand both an end to the exclusion of drug users from clinical trials and studies, and the development of protocols that take into account the non-prescription drug use of all trial participants, whether or not the individual wants to be included specifically as a user or as a subject who uses drugs. This distinction is crucial, as it weakens the power of exnomination held by pharmaceutical companies and deployed by medical discourse generally. This demand must be made to both the National Institutes of Health and the pharmaceutical companies, decreasing their ability to blame each other. And it goes without saying, although for some reason I feel like I need to say it anyway, that users of drugs should be involved in the implementation of suggestion number one in a real and meaningful way, and indeed anything else that effects their lives.

Suggestion two flows from the first:

2. Clinical trials and studies that focus specifically on the interactions between prescribed and nonprescribed drugs must commence immediately.

Now I don’t want to criticize the drug companies too much. After all, they funded a lot of the folks who are here and have given money to more than a few of our colleagues at the conference. One could say, though, that’s just the logic of capital (where there is no “outside”—we all have some relation to transnational capital) demonstrating its ability to subsume difference in the name of profits. And that’s the name of the game with capital: every move they make is calculated to perpetuate their
No strings attached, though, since the pharmaceutical companies have made mad money off the backs of users and the livesaving position their drugs have in users lives. Poor users should be paid to be in trials. After all, access to the highest standard of health care is a right, not a privilege (or at least it should be). Unfortunately, in the United States, participation in clinical trials is sometimes the only way to receive standard-of-care treatment. If we think of the right to health care in the strongest sense, however, access to health care should never be considered adequate recompense for volunteering for a clinical trial.

So the question remains: how will we accomplish these goals? Armed struggle? Not yet. Instead, and my fourth suggestion for action:

4. Invent and put into practice a new form of treatment activism.

This treatment activism could be loosely based on ACT UP/ NY’s Treatment and Data committee while remaining grounded in harm reduction. In the late 1980s and early 1990s, treatment activists, and AIDS activists in general, changed the way clinical trials operate in the United States. In Impure Science, a text that provides an excellent history of treatment activism, Stephen Epstein writes, “At... times the (treatment activism) movement posed fundamental challenges to the conventional scientific wisdom about who produces knowledge and what social practices ensure its validity.” (Epstein, p234) By gesturing towards the past this new treatment activism would build upon a credibility base already established by AIDS activists. I want to be clear, however, that I sincerely hope that the relationship between the new treatment activists and the pharmaceutical industry will not be acrimonious. On the contrary, I expect the pharmaceutical industry to be drug users’ greatest ally. After all, I’m sure it is not coincidental that Vic Hernandez, formerly a member of the ACT UP’s Treatment and Data Committee and now representing DuPont, the makers of Sustiva®, is our moderator today. I look forward to working with Vic and his colleagues from other pharmaceutical companies with the goal of the total inclusion of drug users in clinical trials. A little subsumption within the logic of capital never hurt anybody.

**SUGGESTIONS FOR ACTION**
(not in any chronological order)

1. Demand the inclusion of drug users in clinical trials and studies.
   A transitional protocol must be included.

2. Clinical trials and studies that test interactions between prescribed and nonprescribed drugs must commence immediately.

3. Funding of numbers one and two by the pharmaceutical industry.

4. The formation of a new treatment activism grounded in harm reduction.

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1 Regarding the myriad justifications for the exclusion of drug users from trials, such as compliance/adherence issues, I’m not interested in arguing about the validity of these justifications. To do so would simply result in a battle over “the truth,” an impossibility in any scenario, especially when considering the ideologically driven discourse around drugs. On the ideological, scientific and historically contingent construction of “the Truth,” see in particular Michel Foucault, *The Ethics of the Concern for Self as a Practice of Freedom,* in *The Essential Works of Michel Foucault, 1954-1984;* Donna Haraway, Simians, Cyborgs, and Women and Paula Treichler, *AIDS, Homophobia, and Biomedical Discourse: An Epidemic of Signification,* in *AIDS: Cultural Analysis, Cultural Activism.*

2 In a strange twist NIDA supports me on this point. The “Recommendations for Future Research” component of the joint NIDA/NIH workshop entitled “Interactions Between Drugs of Abuse and Pharmacotherapeutic Agents Used in the Treatment of AIDS and Drug Addiction” states “Organize clinical trials (sic) networks to study drug-drug interactions.” Relatedly, the recommendations also suggest studying methodological issues in conducting drug-drug interaction studies and examining the pharmacodynamics of drugs and effect of interactions on their therapeutic efficacy. The NIDA report can be found at [http://www.nida.nih.gov/Meetings/International](http://www.nida.nih.gov/Meetings/International).

3 And again, as this February, 2001 report from The Journal indicates: “GlaxoSmithKline PLC, the new merged pharmaceutical firm, posted a 13% rise in annual pretax profit...Sales rose nearly 12%, to £18.08 billion from £16.16 billion.” *The Wall Street Journal,* February 22, 2001, p.A19.
Peer Education for Youth Reduction = Prevention

BY THEO ROSENFELD

I left high school to change the world. After trying a number of avenues, I found working within my own communities the most rewarding. Some of my community members use illicit drugs; I have witnessed and experienced many of the problems with drug use that I now aim to prevent. But drug use (and misuse) raises deep questions and challenges the foundations of academic and social institutions. The arguments throw otherwise intelligent people on all sides of the issue into fits of emotional idealism. In a culture like ours, with such fundamental gaps in our understanding of and respect for nutrition, pharmacology and health, an effective, wide-ranging health initiative must prepare not only the issue (in this case, drug use/misuse) but also the wider social context which embraces it.

Although not in school, I draw much of my inspiration from particular interdisciplinary academic themes, such as popular education, participatory action research and asset-based development. But regardless of how good they seem, theories without application have little value. I use these theories to experiment on my own communities. In the last year I have worked with groups of young harm reduction peer educators in about thirty cities across the United States and Canada. Until now, I have written very little about my activities. The education I advocate relies on participants’ experiences and the process of dialogue. The monologue nature of writing runs counter to the process of popular education. I am open and happy to personally discuss this topic with any of my readers.

Reduction = Prevention

The importance of education and prevention to harm reduction work can hardly be overstated. Access to the right tools and information can and does protect young people from making devastating choices. Yet incorporating a harm reduction philosophy into the realm of drug abuse prevention remains a thorny task. The words “drug” and “abuse” spark controversy socially and academically; the debate has no end, and the immediate needs of our communities are put on hold. Many young people use drugs, and some get hurt. Despite the portrayal by the media and pop culture, young people do not want to suffer or die, and certainly not for “kicks.” We usually get hurt due to ignorance: a lack of the information, tools and resources necessary for understanding drugs and avoiding the associated harms. But what, exactly, do we need to know about drugs to avoid harm?

Process vs. Content

If you are reading this article, I probably don’t need to convince you that the “Just Say No!” approach to drug abuse prevention has totally failed. But recognizing this failure only demonstrates to future educators what not to do. So if we don’t tell young people not to use drugs what do we tell them? What do we say about drugs? At what age do we address this or that topic? What level of prior understanding do we assume the students have? How do we make it relevant? More endless debate. This path dead ends because the question, “If not ‘No’ then what do we say?” has a fatal flaw: there is no single thing you can tell a young person that will prevent drug abuse. In a one-hour class, a two-week intensive or a full-year course, everything the instructor says will pale in comparison to the real life experiences of the young people involved.

Drug use, abuse and health are complex personal issues. A standardized curriculum for understanding and avoiding drug abuse can only come across as arbitrary and superficial. So what can harm reduction offer abuse prevention? How can we use education to provide the information, tools and resources young people need to avoid harm? On a large scale? The clearest answer I have seen reads, “Integrating harm reduction into school-based drug prevention programs would represent a paradigm shift, from the ‘problem of use,’ as viewed by adults, to the ‘problems with use,’ as experienced by adolescents.” (Poulin and Elliot, Canadian Medical Association Journal, May 1997.) [emphasis added]

Education needs grounding in the real experiences of the young people in the room, not the experiences of young people in gen-
Experiences and problems with drug use differ from person to person and class to class—they defy standardization. Inevitably a standard curriculum only expresses “the problem of use as viewed by adults.”

Instead of asking, “If not ‘No!’, then what?” we must ask how to facilitate a group process that illuminates the problems of use as experienced by the people present. We must ask how to start a dialogue that allows everyone in the room to share and learn from each other. We must learn to give sources instead of answers so young people can answer their own questions. In order to succeed in creating such a dialogue, the facilitator must have enough relevant experience to understand—in context—what the participants have to say and enough technical understanding to debunk common myths. (Many, many myths about drugs persist.) Truly engaging the participants and addressing their experiences leaves little room for prepared presentations. The content of the discussion must genuinely arise out of the participants through dialogue. This is the only way to address such a broad topic with small groups of people and be consistently relevant.

Peers make the best facilitators for abuse prevention. Young people generally recognize no authority on illicit drugs. Neither police, nor teachers, nor doctors get any comprehensive training on the subject. Researchers can’t agree on the fine (and not so fine) details of drug effects and health. Money, politics and ideology color any source that might otherwise qualify as “expert.” Although less educated than teachers, doctors and police, young people have another form of expertise: contemporary culture. Only someone close to contemporary youth culture can fluently “speak the same language,” and understand the nuances of context and slang—essential for participants to feel comfortable expressing themselves.

I have faced the question several times, “If young people provide the education for a complex issue like drugs, how can we possibly make sure they are giving accurate information?” Well, honestly nobody can make sure peer educators have all the up-to-date accurate information. And as I mentioned earlier, students of the subject of drug abuse often claim little agreement on what information is up-to-date and accurate. Peer educators should never claim expertise or total accuracy. By admitting a lack of knowledge, the facilitator acknowledges fallibility—nobody knows everything—and demonstrates the need to understand how to find answers when questions arise. After all, the goal of the class is not to provide “everything you need to know about drugs,” but instead show you how to find anything you ever might want to learn about health.

To sustain peer programs, facilitators need to receive recognition for their efforts, by means of inclusion, mentoring and remuneration. Young people who take the initiative to bring health education into their communities have valuable qualities adults should take care to foster. Too often when adopting a “peer” approach in their programs, adults do not recognize the value of community members who are willing to take the initiative. Peer educators may face extremely low wages or the expectation to volunteer long hours, and sometimes get left out of regular staff meetings or decision-making procedures that affect them. Agencies treating their peer components as secondary workers lose out on a vital resource, and lose an opportunity to mentor and nurture community leaders. Because of this, peer programs constantly face the threat of burnout and dissipation in leadership. Considering the amount of effort it takes to support peer programs, letting community leadership burn out and fade away is tragedy.

Abuse prevention is intrinsic to harm reduction; prevented harm needs no reduction. But prevention based on anything other than a “No Tolerance” policy raises two difficult questions: “What is socially acceptable to tell young people other than ‘No’?,” and “What can we tell young people that will help them avoid potential harm?” Nobody can answer these questions other than the people present in the room when the question is asked. The very people being “taught” must participate in steering the direction of the class, or the lesson runs a serious risk of dying due to irrelevance. Although cumbersome to lay down a solid framework for a lesson, facilitators can use the same techniques to generate discussion, preserving the process from class to class, letting participant input dictate content. This way, presentations do not fly under/over the heads of participants. Facilitators close to the age and culture of the participants have an advantage over adults, by understanding and responding within the framework of youth cultures. Few people of any age want death and suffering. Given access to the basic tools for answering questions on drugs and health, young people will use them.

Theo Rosenfeld is a community organizer and drug abuse prevention counselor for Pala Community Development. He travels the US and Canada training young people.

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At the turn of the 21st century, social and economic arrangements in the United States continue to be predicated on the presumption that women assume primary responsibility for childbearing and rearing without the commitment of social resources. While increased access to social and welfare services, the institution of universal health care and guaranteed income for families with children could go a long way in ameliorating some of the problems women face, structural inequality would remain unchallenged. In order to effectively intervene in pregnant drug users’ lives policies that redistribute responsibilities and resources for social reproduction must be a political priority. But until such major social redistribution policies are in place, what can harm reductionists do to help pregnant drug users with the struggles that characterize their daily lives?

**Pregnancy, Drug Use and Violence Study**

Attempting to answer this question, we interviewed 126 women regarding their experiences with pregnancy, violence and drug use, focusing on their survival strategies. Of the 126 women interviewed 79% qualified for a second qualitative interview because they had one or more incidences of physical (including sexual) or emotional abuse (25% of their pregnant days). All but five of our participants had experienced both types of abuse.¹ Our participants’ life stories unfolded during tape-recorded interviews, as they related the violence and humiliation they endured at the hands of drug dealers, pimps, johns, other drug users and—most frequently—their intimate partners. Participants shared common problems with standing on their own two feet in a male-dominated world where women occupied the lowest rungs of the social hierarchy. In both illicit drug-using subcultures and conventional social worlds, our interviewees recounted that being a woman was a strike against them, being a pregnant woman was a second strike and being a drug-using pregnant woman was the third and final blow to their social standing. Nonetheless, interviewees kept going, day after day, beating after beating. Some were able to raise their children, even shelter them from their own drug use and violent experiences. Women’s drug use both exposed them to violence and protected or helped them cope with violence. Drug use eased their pain or increased their endurance. The women we interviewed achieved a very human objective: survival.

Given women’s primary responsibility for childbearing and rearing, the conflicting social roles of mother and drug user created an atmosphere of continuous tension for our interviewees. They were under pressure to juggle their time and energy between the requisite responsibilities of motherhood—like making sure the house was clean, the kids were fed—with drug-related tasks, like selling their bodies or drugs, finding dealers and using. In addition to the ongoing juggling act, they had to deal with the risks of encountering violence during their associations with drug dealers, customers, pimps and johns. Worse yet, those who were involved in abusive intimate relationships had the added burden of having to do everything in their power to make their partners happy in the hopes of avoiding the next violent outburst. As mothers or mothers-to-be who used drugs, they lacked the respect of those around them. The violence they experienced was directly associated with the tension generated by their social roles as partners, mothers and drug users; their drug use was directly associated with the violence. The more violence they endured, the more they used drugs; the more drugs they used, the more violence they experienced. Like other investigators, we found our interviewees’ violent experiences generally occurred within their drug-using circles of partners, relatives, drug sellers, drug users and other males. (Fagan 1994; Sterk 1999) The types of violence encountered by participants varied and sometimes overlapped. Most (91%) had experienced lifelong abuse beginning in childhood and continuing with their adult partners. The abuse they experienced can be categorized into two types: ambient and partner violence.

**Ambient Violence**
Theidon (1995) characterized ambient violence as emotional, verbal or physical abuse resulting from exchanges with people in the streets (e.g., neighbors, drug dealers, johns, pimps). Ambient violence was an integral part of women’s everyday lives, especially since a significant part of their lives involved the acquisition of drugs. The urgency and desperation to obtain drugs often cast women along the dangerous paths of dealing or prostituting. Sterk (1999), studying women crack users in Atlanta, notes that “. . . as the women became cut off from mainstream society, their lives increasingly became entangled in the illicit drug-user subculture. They also reported feeling pressured to begin resorting to illegal routines to fund their drug use.” Thirty-eight percent of the interviewees were involved in illegal income-generating activities (e.g., prostitution, drug sales and theft).

In drug-using social worlds, masculine values, as well as differential physical prowess, relegated women to secondary roles, making them more likely to be dependent on dominant males. As both drug users and women, they were vulnerable to physical and emotional abuse. The repeated humiliation, abuse and rape women suffered at the hands of their partners, customers and men on the street were a direct result of women’s lower positions of power in society. Twenty-year-old Jada² shared her experiences as a prostitute:

Well, I got raped on the streets about four times. Twice while I was pregnant . . . I didn’t know whether I was in the wrong. I blame myself sometimes, how could I be stupid? And you know, I could have done something, but I really couldn’t have done anything; ‘cause I can’t overpower a man. I’ve been tied up, burnt with cigarettes . . . humiliated, talked about . . . I been through a lot.
Monique is a twenty-four-year-old prostitute who generally works under her husband’s watchful eye, though he’s not always around to protect her:

... a guy in a van pulled out a knife on me and forced me into the van ... My husband was home waiting on me ... Three or four hours he had me in the van, ... raped me in all kinds a ways ... He was gonna rape me up the butt and I told him that I had to go to the bathroom first ... and I told him I couldn’t go to the bathroom with him looking at me so he turned around and as he turned around I saw the knife. I picked up the knife, stabbed him in the shoulder. And then, he grabbed the knife from me and out my hand. The tendons of my fingers were torn, so I had to go to the hospital and get ‘em tied together. And I got out of the van ... and I was naked and on my way out of the van I grabbed my clothes and I grabbed his underwear and a towel with his semen on it. From that the police caught him. And with a stab wound and stuff heshowed up at the hospital later on, so they caught him. And I was in the hospital for about a week, trying to get my fingers moving again.

She encountered another violent “john,” even though her husband was supposed to be watching:

... I was walking up the street with my husband and he was on the other side a the street. Sometimes we do it like that so he watches me. I’m okay. He sees what kind of car I get into and makes sure he brings me back. I was walking up the street trying to catch a ride. And he force me into the alley and heraped me. My husband, he didn’t know where I was at ‘cause he didn’t see him haul me into the alley. And then I came out and my husband chased him up the street with a knife. But he never caught him ... I was about four months (pregnant).

Pregnancy often increased drug-using women’s risk of violence. The procurement of drugs became more difficult because some dealers would not sell drugs to pregnant women. If the woman traded sex for drugs, her clientele decreased as her pregnancy became more obvious. Sandra, a twenty-year-old African-American, was asked if prostituting became more difficult during her pregnancy:

... back in the days, I could go out there and meet a guy, and get a hundred and fifty dollars. But now, these guys out here, they wanna give you thirty dollars. And thirty dollars is not enough to take care of me and two kids. I’m sorry, that’s not even a week’s worth of food.

As a woman’s pregnancy became more noticeable, her resources diminished, and she was more willing to take greater risks, like performing sexual acts for a lot less money (or drugs) than she normally would. A reduced pool of potential clients meant she could not be selective about whom she serviced, thereby increasing the risk of being picked up by customers she did not know. Whether she knew them or not, they were often angry with her for using and working while pregnant, and felt she deserved to be mistreated.

Women’s accounts of the ambient violence they were subjected to were horrifying. Women’s guilt and stigmatization were so internalized that they questioned the difference between sexual assault and treatment they deserved. But even more horrifying was that more frequently, the violence participants experienced was at the hands of people who were supposed to love them and protect them—their partners.

Partner Violence

In our sample, of those reporting physical abuse, 80% said it was perpetrated by their partner. Women characterized their abusive relationships as increasing attempts by their partners to expand their control. It was not necessary for the abuser to batter the woman on a regular basis. One severe beating was sufficient to keep the woman in a constant state of fear. The mere threat of another beating kept the woman “in-line.” Abusers, as reported by the women in our study, diminished their self-esteem to the point where they believed they deserved the violence. Many remained silent and therefore protected partners from outside domestic violence interventions, especially from the police. Women’s failure to report assaults was justified by their low expectations regarding interventions, the fear that others would discover their drug use and the belief that they deserved to be abused. The most frequent reason given for not reporting was fear of the abuser. Jenny, a 22-year-old Latina, was asked if she ever thought about leaving her abusive partner:

... I’m really scared. If you could see this man, you would be scared too. He said, ‘If you call, ever call the police on me, I’m gonna kill you.’

Sometimes partners would exercise control by withholding drugs or unilaterally deciding how money was spent. Marie, a white 43-year-old, talks about her struggle with her controlling partner:

... he’d call me a dumb bitch and things really hurtful like that ... and telling me I really fucked things up, you know, it’s all my fault and, he’d get mad at me ... he’d buy the crack. And he would control it.

Not only did he control her money, but tortured her as well by withholding drugs from her:

... he’d buy the crack. And he would control it. He’d sit there and take his couple a hits. And I’d have to patiently wait for mine. And then I’d get mad. I’d say, ‘Goddamn it, gimme a hit! Gimme the pipe!’ And he’d ignore me. It was like this big control issue. To where he’d say (emphatic) when and how much and he would break me off a little piece ... my money paid for it, but he’s control-
Drug use produced euphoric feelings and diminishing daily hardships and suffering. Emotional and physical pain of abuse, di-lems that I was going through. I wanted to leave sometimes he wouldn’t let me out the room. And he would like restrain me on the bed and stuff. I would just freak out and make things worse because of my reaction. If I would have um, been calm and just let him have his little power play . . . everything would be fine.

Do drugs cause these women to remain in violent situations or does violence cause them to use drugs? Some espouse the opinion that these women chose to use drugs, chose to remain with their partners and therefore are responsible for finding themselves in violent situations. But from the participants’ perspectives, they remained in dangerous situations precisely because they did not have choices.

Drug Use As a Survival Strategy

The women in our study used drugs as a resource to endure the myriad of problems they faced as women, drug users and victims of abuse. We found, like other investigators who studied abused women, women self-medicated with alcohol, illicit drugs and tobacco to cope with the abuse. (Campbell, et al., 1993; Lempert, 1997; McFarlane et al., 1996; Ratrow, 1998). Drug use made life more manageable by alleviating physical pain, while acting as an emotional analgesic as well. Drugs were also a source of recreation, a chance to have some “time out” or to party. Women provided drugs for their partners to keep them happy, hoping to ward off or postpone violent episodes. Drug use also gave them a sense of control, if only over their own consciousness, in circumstances where they had very little.

Drugs as Pain Relievers

Carla, a 26 year-old-crack and marijuana smoker, also used drugs to endure the pain from pregnancy and violence.

One a the reasons why I would use drugs is just not to feel the hardships. It’s like, well medicatemyself so I wouldn’t have to go through all the problems that I was going through.

Drug intoxications temporarily masked the emotional and physical pain of abuse, diminishing daily hardships and suffering. Drug use produced euphoric feelings and promoted a sense of well-being. Tracy, a 39-year-old crack user, found that her violent experiences intensified her insecurities. Getting high helped her feel better about herself and was a source of comfort.

It (abuse) brought my self down, very low. . . . He told me I was ugly and I was nothing, don’t nobody want me . . . And I believed him because my mother wasn’t there . . . what else was I to believe? And I just stayed in my own little world, and I guess that’s when crack comforted me the most.

Violet, a 23-year-old-crack user, eased her pain from years of violence with years of drug use. When she was 14, her mother hit her in the back with a hammer; she suffered from back pain that continued through her twenties. Chronic pain, combined with the acute pain inflicted by her severely abusive partner, compelled her to seek the analgesic properties of street drugs.

Using Drugs to Create a Sense of Control

Using drugs gave women some agency over their own sense of happiness. Their living situations were characterized by meager finances, lack of suitable housing, food and care for children, social isolation and ambien/ partner violence. With not much else to count on, drugs became a primary support system that they could manage. Drug use became the only thing they could depend on for fun or to make them feel good. Most aspects of their lives, such as poverty and violence, felt insurmountable and beyond their scope of control, but they could manipulate their intoxications. Thirty-year-old Denise used crack to take the place of her man, introducing some personal agency into her life. “The drugs is my man. My man can’t beat me up! Ha. He can’t do this, that and the other to me!” Drug use was a simple and immediate way to cope with daily hardships of poverty, abuse and poor health. For the 61 percent who were in abusive relationships at time of interview, their partners had chipped away at their personal autonomy. The ability to alter their own consciousness gave them a sense of mastery over at least one aspect of their lives.

Summary

Pregnant drug users suffer severe stigmatiza-
tion and degradation in a policy context that holds them solely responsible for the “bad product” of a drug-involved pregnancy. Clearly, study participants’ needs were not being met by existing services. A third of the interviewees named police services, emergency rooms and doctors (respectively) as most helpful to them; however, it must be noted that these services are designed to provide temporary help. Model therapeutic communities, such as Amity’s Center for Women and Children, in Tucson, Arizona, address the specific needs of drug-using pregnant women. (Stevens and Arbiter 1995) They have taken a holistic approach in helping women with child care, education, housing, prenatal care, drug treatment and domestic violence intervention. They have been funded by federal agencies, like National Institute on Drug Abuse and the Center for Substance Abuse Treatment, but more resources from state and local levels must be allocated to make these kinds of programs more widely available. But pregnant women cannot and should not have to wait for the requisite brick and mortar funding, particularly during an era characterized by workfare. Besides, therapeutic communities do not meet the needs of all women.

The needs of the women we interviewed were multilayered as well as overlapping, making available help inaccessible and insufficient. Their problems were treated individually rather than holistically. Each service area focused on either women’s drug use, pregnancy or violence, addressing only one problem at a time. Our participants were not only drug users. They were mothers, daughters, victims, poor, homeless, malnourished and stigmatized in conventional and illicit drug-using worlds. Drug use helped them to cope and to survive. It also caused them serious problems. They were demonized for their means of survival, but not given feasible or reasonable alternatives.

It is time to get real. To offer real harm reduction services to our most stigmatized drug-using population—pregnant women. Incremental changes must be rewarded and drug substitution and supplementation must be explored. Not just methadone instead of heroin, but, for example, medical marijuana to help a woman decrease or abstain from alcohol use. As harm reductionists we must offer alternatives to interventions that require a woman’s immediate abstinence from all drug use. Help that is predicated on the immediate discontinuance of all drug use is not only cruel, it is unrealistic and inhumane.

Shegla Murphy and Paloma Sales are researchers for Community Health Works / Institute for Scientific Analysis, San Francisco, CA.
Icon/I have a Dream  BY AYA DELEON

Martin Luther King fought for justice, not just integration. Don’t confuse the method of transportation with the destination. But corporations remember our heroes distortedly like black & white kids holding hands is all he ever stood for & completely forgets his opposition to the Viet Nam war & what’s more his ideas are intellectual property & if Gandhi can be an icon for apple computers, then everything in this nation is for sale. I can just imagine what advertisers would do with King’s Letter from the Birmingham Jail. Picture this: it gets bought by corporations in the prison industrial complex & they take it all out of context putting up billboards in the hood that say: “Hey young black men, MLK went to jail; if you’re lucky, you can be next!”

Or imagine this one: let’s say the NBA buys his speech at the March on Washington talking about “I have a team....” “I have a team so the sons of former slaves can sweat and toil up and down basketball courts like modern day cotton fields for the profit & amusement of the sons of former slave owners; it is deeply rooted in the american dream; I have a team.”

Or perhaps it would be bought by developers talking about “I have a scheme. I have a scheme that little white yuppies can live next to little black and brown boys and girls digging the convenience & flavor of their hood. & when the black & brown folks get moved out white yuppies will say in their newly acquired hipster slang Don’t trip peeps, it’s all to the good. Yes, I have a scheme still deeply rooted in the american dream feeling like a déjà vu, except without the smallpox blankets & then developers can go to black church testimony meetings talking about “I’m not here to testify I’m here to gentrify! Can I get a witness?”

Or maybe it would be bought by a multinational pharmaceutical conglomerate talking about “I have a cream...” “I have a cream & even if the red hills of Georgia are nothing compared to the acne on your face, I have a cream. A cream that guarantees that every pockmark will be exalted and every pimple made low, I have a cream. I have a cream that fights against itching, anti-government bitching and encourages snitching. I have a cream that is spermicidal, herbicidal, pesticidal, homicidal & genocidal, I have a cream today! I have a cream that will turn little black boys into little white girls & we sold some to michael jackson & he said White at last! White at last! Thank God almighty, I’m white at last!”

Yes, people, we must be very careful who we let control our past.

Aya deLeon is a trainer with the Harm Reduction Training Institute in Oakland, and a member of the San Francisco poetry slam team to the National Poetry Slam. For info on her poetry: midcdc@gmail.com.
The harm reduction movement formed as an international alliance in the late 1980s. This was a period in which “one-sided class war” (as it was described by Doug Fraser, then the president of the United Auto Workers union in the United States) of business attacks upon workers had been going on for about ten years in the United States, and to a lesser extent in many other countries (though clearly the class war was not one-sided in Brazil and South Africa). This was a period in which the interests of business were increasingly accepted by the media, the middle class, both US political parties (and social democrats here and elsewhere) and union leaders as the interests of humanity. Neo-liberalism was ideologically triumphant, and potential opposition was increasingly seen as partial rather than as offering a total social alternative. The collapse of Eastern European regimes and the USSR was widely interpreted as consistent with these perspectives, perhaps as proving them to be right.

As I have argued elsewhere (Friedman 1998a, b), this has also been a period in which economies all over the world have been under considerable strain due to declining profit rates and the pressures of international competition. These economic strains have been accompanied by increasing pressure for government cutbacks in social services and public health, as well as by increasing income inequality both within the United States and internationally. This has posed a problem for economic and political elites: how to oversee a period of ever-increasing austerity and inequality without being faced by the kind of social movements that brought down the Eastern European regimes? And I have argued that the result has been a combination of police repression of social movements (and of the poor), together with a politics of divide-and-rule scapegoating of racial/ethnic minorities, criminals and drug users.

Harm reduction, as an international movement, has been shaped by this climate. Most fundamentally, the relative lack of other mass struggles from below (such as had taken place in the 1960s and 1970s in many developed countries) has led most of the organized harm reduction movement to orient “upwards” towards government policy and/or wealthy benefactors. (Friedman et al, in press) From its inception, harm reduction was seen by most organizations and researchers as a way to promulgate policies and related services that had been successfully implemented by a few governments, initially chiefly those of the Netherlands, Australia, England and Wales. Perspectives that looked towards users as the agents of their own harm reduction (and towards users’ groups as major components of networks of harm reduction “providers”), were originally held by few. Both perspectives are still marginal within the harm reduction movement.

To some extent, the perspective of diffusing good ideas outwards, and of strengthening what exists through science, has been successful. As a result of considerable bravery and commitment by many community-based organizations, drug users, physicians, researchers, government officials and other concerned citizens, syringe exchange has spread to new cities in the US, and to new countries, including government-funded syringe exchanges in Brazil. Methadone has also spread, as have users’ groups (which have increasingly been seen as a part of harm reduction, although this relationship has often been rocky). But in the United States, we are very conscious of the extent to which syringe exchange, methadone maintenance and other substitution therapies and users’ groups, as well as the spread of the harm reduction “spirit,” have been limited, held back and harassed by drug-war policies and values.

But times change. Although the last 25 years were a time of reduced social activism in the United States and many other developed countries, we may now be in a time of renewed activism in developed countries, decidedly including the US. Examples include the WTO protests in Seattle, May Day demonstrations around the country this year, mass demonstrations against police brutality, anti-sweatshop action in universities and increasing action against drug laws.

Periods of renewed social activism have both behavioral and political implications. We need to work out effective ways to respond to, even anticipate, both.

Behaviorally, we should remember the 1960s. The activism of the ‘60s was accompanied by changes in drug usage, in sexual patterns, in social and sexual networks (such that there were increases in interaction across class and racial/ethnic lines that had previously been barriers to interaction) and in patterns of using drugs while having sex. In an age of emerging infections (which is fueled by the economic trends discussed earlier in this paper), similar changes could have important public health consequences.
We may now be in a time of renewed activism: examples include the WTO protests in Seattle, May Day demonstrations, mass demonstrations against police brutality, anti-sweatshop action in universities and increasing action against drug laws.

Of course, we cannot know in advance whether emerging social movements will spark changes in drug use or sexual patterns, but we do need to be alert for these and to be ready to take appropriate action to reduce harm.

Politically, we need to:
1. Be aware that one response that the powerful are likely to make to activism is to “play the drug card” even harder—i.e., to increase war on drug policies, alarmist publicity and other propaganda as a divide-and-rule, scapegoating diversion that is effective because it draws upon deeply-rooted cultural beliefs. (Friedman 1998a) This could mean that some of the wealthy friends of harm reduction and/or drug policy reform may develop other interests, and suggests that harm reduction organizations may need to develop alternative, non-elite, sources of funding.
2. Make sure that the new movements do not turn to attacking users. Since many residents of poor and/or working-class communities, for example, are quite hostile to local and other street drug users, movements in which they seek to solve their problems could become anti-user.
3. Win the new movements to Harm Reduction. (This is a way to weaken the “drug card” in some of its most important constituencies.) To some extent, this can be done by pointing out similarities between drug users’ problems and those with which they are concerned. (Further discussion can be found in Friedman et al., in press.) If we are successful in this, it should open up possibilities to recruit volunteers for harm reduction projects from the constituencies of other movements; if we fail, the level of interest in volunteering might be reduced due to competing social-movement interests.
4. “Join with them” in common struggles against repression, marginalization, impoverishment, cutbacks, unsafe working conditions—and FOR health and solidarity. A recent example of this has been the activities of the Injection Drug Users Union of Toronto (IDUUT), which has developed working alliances with some of the community organizations involved in fighting cutbacks and poverty. They have developed a close working alliance with the Ontario Coalition against Poverty, which is a militant activist community organization based, in part, on labor unions. Members and leaders of IDUUT and OCAP take part in each others’ activities on a frequent basis. IDUUT has formed a similar alliance with TDRC (Toronto Disaster Relief Committee), which is a less militant group that has exposed the extent of homelessness in Toronto internationally, and which has good access to both media and social service agencies. In many cases, those with whom alliances might be desired may be reluctant to work with stigmatized groups like drug users or harm reductionists. Certainly, the Black Power movement’s experience of trying to build alliances with labor in the 1960s shows that the combination of stigmatization (in that case, racism) by some forces within a potential ally and the perception that such an alliance might alienate other allies shows that such alliance-building can be very difficult, even for a sociopolitical force more powerful than harm reduction will ever be. Thus, ongoing communication, and perhaps formal research, will be needed about what approaches do and do not work. At this point, all I can suggest is to search for the most amenable labor and community groups, develop experience, knowledge and theory from working with them and continue to discuss what is learned with others involved in harm reduction activities.
5. Another set of difficulties may arise as we work with community and labor groups of these kinds. Working with them might strain our existing working relationships with health departments and other official agencies in ways that hurt budgets and endanger other aid to needle exchange or other projects. In addition, there is some possibility that government police powers might be mobilized to repress harm reduction organizations, clients, staff and projects.

All of this will be complicated by its potentially divisive effects on needle exchange and harm reduction movements. One example of this was a somewhat conflictual discussion of how to relate to the police at the Portland NASEC meeting. Furthermore, to the extent that harm reduction forces like IDUUT in Toronto make common causes with community and labor groups that are opposing the policies and ideologies of neoliberalism, some of the wealthy funders of harm reduction and/or drug reform may take a hostile approach to such activities, and perhaps de-fund programs that seem to go too far. This could easily lead to serious debates at conferences and meetings (like Portland), and even to hostilities and splits.

On the other hand, these new times also open up possibilities for greatly expanded audiences for harm reduction ideas, allies in carrying out our daily tasks and, as well, for harm reductionists and others to start dealing more successfully with some of the deeper socioeconomic problems that underlie both drug wars and harmful drug use.

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Sam Friedman is a committed proponent of social change, poet and researcher for the National Development and Research Institutes.

References
Warning: People who are habituated to the use of barbiturates or benzodiazapenes should seek medical advice when attempting to detox. Sudden withdrawal off these drugs can cause seizures and even death, as can sudden withdrawal from alcohol by folks who drink throughout the day, every day. Severe hand tremors when cutting down are one indication that the person needs medical assistance.

**Herbs and Other Allies for Detox and Use Management**

Several years ago, while planning the holistic health clinic for Casa Segura, we asked the folks who used the drop-in center and the needle exchanges what alternative health services they would like us to offer. In addition to the expected responses—massage, herbal medicine, nutritional counseling, acupuncture and so on—over and over we heard some variation of “Give me help with drug detox!” This request came from users of opiates and stimulants, and from people on methadone. Many program participants also told us that they needed ways of controlling their level of use so they could function better in their jobs, family roles and life in general.

Herbs and supplements don’t take away the discomfort of detox. At best, they take off the edge and allow a motivated person to get through the initial adjustment period. They are very useful in the post-withdrawal period, and can be of enormous help in the weeks and months that follow. While the herbal formulas were originally intended to help folks through detox, most heroin users who use them say that they are most helpful for extending the time between hits and for using less. One person told me “I’m using five bags a day and want to cut down to three.” Another needed to reduce the amount of alcohol he was drinking, because he was worried about the effect on his liver. Amalie Cooper, a Casa Segura herb clinic intern, described the effects of the herbs like this:

> Even with a heavy habit, the herbs can help you control your use. You know that feeling you have when you wake up and want to go use a quarter right away? Well, if you take the herbs you can wait longer, and maybe use only a dime.

Opiate users who have managed to kick using herbs have, for the most part, cut down to small, less frequent doses. Some like to use the herbs as an additional aid in conjunction with benzodiazapenes or prescription opiates. Methadone users, especially, have to go slowly and reduce their dose before trying to quit. Detox herbs work best when the person taking them is also receiving daily acupuncture treatments (or stimulating the ear points by using seeds taped in place by the acupuncturist). Chris Vernon, Casa Segura’s acupuncturist, observes that acupuncture also works best for detox when herbs are used as well.

So, what’s the secret formula? There isn’t one. Different herbs help with different withdrawal symptoms, and just as everyone experiences withdrawal differently, they find some herbs more helpful than others. The physiological effects of withdrawal are often the opposite of the effects of the drug, so herbs should be chosen carefully. Some people use valerian for opiate detox, but since this herb stimulates breathing, heart rate and digestion, it is usually a poor choice when someone is coming off heroin or methadone. It may calm the nerves [although it has the opposite effect for a few people] but it makes the digestive distress, heart pounding and heavy breathing worse. It is a better choice for people who have come off stimulants and need some help in the following days.

**A few words of caution.** Some illnesses may cause herbs (and drugs) to behave in odd ways in the body. Liver disease, especially, may lessen the body’s ability to clean itself out after taking drugs or herbs. In addition, herb and drug combinations can be dangerous. This applies to prescription drugs, over-the-counter drugs and street drugs. For example, combining cocaine and marijuana (a useful medicinal currently prohibited by law) can cause the heart rate to rise to dangerous levels. This might also happen when combining cocaine and valerian, but no studies have been done to verify this. Some recent information about the way St. Johnswort works in the body suggests that it is possible that using that herb may cause methadone (but not heroin) to leave the body faster than is desirable. (Chicago’s Marc Shinderman recently posted a warning on the NEP email list that St. Johnswort reduces levels of methadone, other opiates and a host of other medications-ed.) There are many known interactions, with more being uncovered all the time. Please use caution, especially if you like to use more than one drug at a time. If you are pregnant or nursing, check with an herbalist, look in a book or ask at the herb store before taking any herbs or supplements. Some herbs can be more dangerous to your unborn baby than they are to you.

Your kick will be easier if you can arrange the setting so that you have a good friend who can help you, lighting that won’t bother you and control of the temperature, music and other distractions when you want them. Learning some deep breathing exercises and relaxation techniques beforehand will help a great deal. Drinking lots of water before, during, and after will help your body flush out toxins and will keep you hydrated so you don’t feel as sick.

**HERBS AND SUPPLEMENTS WE’VE FOUND USEFUL IN DETOX AND USE MANAGEMENT**

What follows is a brief *Materia Medica* of a few of the herbs folks use for detox and use management. If you are unfamiliar with using herbs, try one or two herbs at a time, or talk to an herbalist or to a friend who has experience using herbs for health and healing. Follow the dosage instructions on the package, unless otherwise noted below.
HERBS TO HELP WITH WITHDRAWAL FROM ANY ADDICTIVE SUBSTANCE

WILD OATS (Avena sativa) have a long history of use. The extract of fresh milky oat seed, 10-20 drops, 3-5 times a day, settles raw nerves and helps to reduce cravings.

MOTHERWORT (Leonurus cardiaca) helps to reduce the raw, exposed feelings that leave us feeling irritated and unable to tolerate stimulation. Tea or tincture.

KAVA ( Piper methysticum) reduces the anxiety that accompanies detox and the period after detox. Small, frequent doses work best: 10-15 drops up to 5 times a day of good-quality tincture. Don’t use kava tea: the active constituents are not very soluble in water. Second best is capsules; one capsule is taken once or twice a day. (Note: Kava is used in some parts of the world as a ceremonial herb and in others as a recreational drug. In large amounts, this herb can impair muscle control and coordination.)

CHASTE TREE BERRY (Vitex agnus-castus) seems to be useful in all kinds of addictive cravings. Take two #00 capsules in the morning, and if needed, one at night. Works best when taken steadily. Use it for up to four weeks. Long a favorite of many herbalists, Vitex should not be used for longer periods of time without checking with someone who understands its hormonal and other effects.

SKULLCAP (Scutellaria spp.) reduces oversensitivity to light, noise and touch, and is useful for people who have tossing, turning, restless insomnia. Combine it with wild oats for use during the day, and with kava and wild oats as a sleep aid. Tea or tincture, follow package directions. Too much skullcap can cause tingling of the extremities, a sign of toxicity.

HERBS TO HELP WITH OPIATE DETOX

CALIFORNIA POPPY (Eschscholzia californica) contains no opiates, but it’s a member of the poppy family. This plant helps with the aches and pains of withdrawal. When combined with mineral replacement supplements (Sports drinks, Calcium/Magnesium supplements), it can lessen the back pain and leg cramps that accompany withdrawal. Folks who have used California poppy tell us that it hasn’t caused urine tract or in capsules.

HERBS TO HELP WITH STIMULANT DETOX

WILD YAM (Dioscorea villosa) is one of the best blood tonics. It calms the nerves while also mildly stimulating the physical functions that slow down during this time: digestion, respiration, cardiovascular function. Some people have an opposite reaction, and get nervous when they take valerian. If that happens to you, find another herb.

BEE POLLEN is also good for restoring energy and calming nerves after stimulant withdrawal.

DANDELION (Taraxicum officinalis) root and leaf help with digestion and stimulate urination and system cleansing.

TOOLS FOR THE LONG-HAUL

In the period following withdrawal from any drugs, the person needs support from friends, family and health care professionals. Here are some suggestions for other things that can be supportive during this period. They can also be tools for active users who are concerned about staying healthy while using (a topic for another column):

Rebuild strength by eating and drinking nutrient-dense foods:

Smoothies, broths, herbal teas, unprocessed fruits, veggies, grains and easily digested proteins (chicken breast, fish, lean meats, tofu, legumes). Eat breakfast every day, and eat frequent small meals to avoid the blood sugar swings that can set off cravings. Gradually, add superfoods to your diet: Miso, yogurt, bee pollen, liquid aminos, sea vegetables and sauerkraut will add energy, normalize digestion and cleanse your system.

Foods high in the relaxing amino acid tryptophan can help soothe nerves and reduce insomnia:

Cottage cheese, beef liver, peanuts, roasted cashews, granola, turkey, tuna, baked potatoes, salmon, wild game, avocado, warm milk.

Regular bodywork:

Massage for circulation, cleansing and relaxation; Reiki or healing touch for spirit and energetic healing; acupuncture for balance, stress reduction and long-term healing.

HERBAL ALLIES

SIBERIAN GINSENG (Eleutherococcus senticosis) for focus, energy and a return to strength. This tonic herb helps the body and mind adapt to stress of all kinds.

Burdock Root (Arctium lapa, A minor) in tea, tincture, capsules or eaten in soups, stews, sushi or stir fry. This herb is one of the best blood cleansers we have: it supports the liver and helps to clear the system of accumulated toxins and restore the body to glowing health.

Stinging Nettle (Urtica dioica) tea. Drink this freely: 3 to 4 cups of medicinal strength tea per day (Put one ounce in a jar, cover with a quart of hot or cold water, steep 8 hours, strain and drink the same day. Make a new batch every day). This is another blood-cleanser, and it gives a deep, calm energy in times of blow-out.

SUPPLEMENTS THAT CAN HELP

First month after withdrawal:

A good multivitamin/mineral
Vitamin C, 500mg with flavonoids, 2-5 times a day (Use less if it causes diarrhea).
B-complex vitamin, B-25 or less.
B6, 50mg, 3 times a day for two weeks, then 25mg 3 times a day for two weeks.
B12, 1000mcg, twice a day for two weeks, then once a day for two weeks.
Vitamin E, 400iu twice a day for two weeks, then once a day.
Niacinamide, 500mg, twice a day for 2 weeks, then once a day for two weeks.
Evening primrose oil capsules, 6-9/day.
Mineral supplements: Calcium, 500-1000mg; Magnesium, 500-1000mg; Zinc, 15mg.

After the first month, the supplements should be reduced. A reasonable daily supplement intake would look like this: Multivitamin/mineral as directed on the bottle; Vitamin C, 500-100mg; Vitamin E, 400iu...
and 2 tablespoons of flax seeds or one tablespoon of flax oil per day. If you have special health concerns or are taking medications, ask your doctor about supplements.

**LAST BUT NOT LEAST**

Get help for any issues that got you self-medicating with drugs in the first place. Insist on proper professional care for chronic pain, depression, attention deficit disorder, etc. Become a political and social activist; become your own best advocate. Poverty, discrimination, homelessness and social injustice keep people down and addicted. Don’t let the bastards keep you down. But most important, be gentle with yourself. Treat yourself with the respect and kindness you'd show a good friend in need. If you don’t meet your goals right away, learn from the process and give yourself permission to make mistakes, reevaluate your goals and when you’re ready, try again.

Donna Odierna is a herbalist, nutritionist, and health educator. She is in private practice and also works with IDUs at Casa Segura in Oakland, CA.

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**HEATING DRUG SOLUTIONS IS GOOD HARM REDUCTION !!!** BY MICHAEL CLATTS

Much of the harm associated with the injection of drugs such as heroin and cocaine comes not from the drugs themselves, but from the way they are prepared and injected. People get viruses like HIV and hepatitis from the infected blood that is passed through the sharing of needles and injection preparation equipment or “works.” Because of the seriousness of these diseases we need to develop strategies that help injection drug users reduce the chance of getting someone else’s blood inside their body. In the past most of the prevention information available to active drug users has focused on needle-sharing’s role in passing infected blood. Other parts of the “works”—such as cookers, cottons and rinse water—have not been studied in detail.

In an effort to better understand how much risk there is from the sharing of injection “works” we conducted a four year, NIDA-funded study of the drug preparation and injection practices of injection drug users in New York and Denver. These two cities were chosen because they have relatively large and diverse populations of drug injectors and dramatically different rates of HIV transmission. Ethnographers observed drug preparation and injection practices in a wide variety of settings and with a wide variety of drug injectors. Data from these observations was used to develop laboratory experiments that examined how easily HIV could be passed through different injection “works” (especially cookers) and how it was affected by different drug preparation practices (especially heating drug solutions).

**Significant Finding:** The length of time that a drug solution is heated directly impacts on the ability of HIV to be passed from person to person. Heating drug solutions for at least fifteen seconds kills the HIV inside the cooker.

**Prevention Suggestions:**

- Continue to heat your drug solutions.
- Heat drug solutions for at least 15 seconds or until bubbles appear (approaching boiling point).
- Use the thin type of bottle cap “cookers” because they heat quickest.
- Continue to use bleach kits and other risk reduction options.

**Note:** Heating does not cause abscesses or decrease the power of the drug.

Additional details about the results of this study can be found in the following publication:


*Michael Clatts is a researcher at NDRI. For additional information about this study, you can email him: michael.clatts@ndri.org.*

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**Kick Juice**

A useful tincture combination for opiate withdrawal used at Casa Segura.

1 ounce of tincture each: California poppy, yerba santa and ginger.

1/2 ounce of tincture of each: wild oats and kava.

Mix the tinctures together; this will make four ounces of Kick Juice. It can be taken while needed, usually the first week after stopping opiates. Some folks use it to reduce symptoms while cutting down, even if they don’t plan to stop using altogether. Put it in a dropper bottle (you can get one at an herb store, natural foods store or a pharmacy, or use an eye dropper to measure it out). Try 60-90 drops of the mixture 3-5 times a day, and once before bedtime. It will take the edge off the nerves, the pain and the nausea. Put it in a little water or juice and drink it down quickly. Do NOT inject it: it won’t work, and if it doesn’t kill you it will fuck up your veins, make you sick and cause an abscess the size of Mount Everest. Taken correctly, though, it is good stuff.
At the dawn of the New Year 2001, fire destroyed Oakland, California’s Casa Segura. Someone broke in, went to the kitchen, spread kerosene around the room, lit a fire and shut the door. Containing the fire in the kitchen allowed it to reach a very high temperature so that it would spread viciously to the rest of the building. The fire burned through all the walls on the second floor, burned through the ceiling, the roof and the floor. Casa Segura, situated in Oakland’s Fruitvale District, had recently been under pressure from the local elected official and business leaders to move. Casa Segura has organized needle exchange in this community for a decade. They exchange 17,000 syringes a week. In comparison to neighboring cities, Casa Segura has kept HIV infection down in Oakland. If any agency has a track record for effectiveness, it is Casa Segura. The agency provides medical care, alternative therapies for treating HIV and HCV, detoxification kits, support groups and counseling. And now arson has reduced their efforts to melted computers, destroyed photocopying equipment, collapsed ceilings and soot tonguing its way out of the windows and up the outside walls.

The Mayor of Oakland, Jerry Brown, a former California Governor and one time Presidential Candidate known for his politically progressive position, has remained silent. Piece of shit. The local Council member, Ignacio De La Fuente, has organized his staff to rabble rouse and issue inflammatory statements (pun intended) about Casa Segura and syringe exchange. There’s another piece of shit.

While local community leaders have responded with a widespread show of solidarity with Casa Segura, some Oakland City Council members have declared their opposition to Casa’s relocation to their districts, particularly the ones who represent the neighborhoods Casa prefers to serve—West Oakland, Fruitvale and deep East Oakland. For now Casa’s moving plans are on hold, and they are currently serving their participants from tents located in their parking lot. Their short term plans are to rent or buy (if they can raise the money—hint, hint!) a van, and lease administrative offices.

The local health department is working with Casa to ensure continuity of care for its participants and has been very supportive. The harm reduction community has responded as best it can. It has secured temporary alternative administrative offices, Berkeley’s NEED provided a mobile van to conduct services out of, a letter writing campaign has been orchestrated to push for a full investigation (arsen investigators claim they have some leads) and messages of support for Casa have been communicated to Oakland’s Mayor, police department and Congresswoman (Barbara Lee). In addition, the harm reduction community has provided mailing and communication systems, has started a fundraising campaign and posted regular updates through the web.

This type of attack could only happen in the United States. And on with the news from Australia...

Western Region AIDS & Hepatitis Prevention (WRAP) was set alight early New Year’s morning. Whilst some local Footscray revelers were welcoming the new year, according to a local press article, others were celebrating the burning of the service, “burn baby burn.” The 1st floor of the building has sustained significant damage; electronic and other equipment has been destroyed and important hard copy files have been left in poor shape. WRAP has been the subject of hostile local opposition by a small but vocal group. Police believe the fire was deliberately lit but admit that catching whoever was responsible is not very likely. Whilst the WRAP staff is trying to keep an open mind many other local identities are less circumspect in their views, placing the blame squarely at the feet of the hard core opposition.

On a more positive note the NSP service and staff work areas downstairs have been spared much of the destruction. Staff ensured that needle/syringe service delivery didn’t miss a beat and hours of operation continue as usual.

Some news on the global harm reduction advocacy front: Sandra Batista is the new Executive Director of RELARD, the Latin American Harm Reduction Network. She replaces Graciela Touze. Sandra can be contacted at Sandraflamarion@terra.com.br. Emilis Subata is the new leader of the Central and Eastern European Harm Reduction Network. He replaces Judit Honti and can be reached at emilissubata@takas.lt.

Good luck and thank you, Graciela and Judit.