Forging New Workplaces: Occupational Health for Harm Reduction Workers

By Lisa Moore

I want to offer some thoughts I’ve been having about occupational health. The reason this issue is on my mind is because very early on in the harm reduction movement, 1990 I think it was, a friend and colleague and a wonderful person who was working in harm reduction and who had been not using for a while started using again, didn’t tell anybody, overdosed, and died. And so part of the framework that I’m bringing to this issue is to ask, “How do we prevent this?” How do we deal with the issues that we need to address in a way that’s helpful to us as harm reduction workers? The framework I have in mind is that we’re starting a new type of workplace. And we may be starting, if we’re not careful, a new industry. One of the things that disturbs me, scares me, and excites me simultaneously about events like the First National Harm Reduction Conference is looking around and thinking, “Is this the next social justice movement or is this the next wave of bureaucrats?” And I think that’s a challenge that we all sit with. Most of us, I believe, didn’t get into this so that we could be the next generation of bureaucrats yet if we’re not damn careful we will be. And we’ll be enforcing bureaucracy on people with all the self-righteousness of people who ten years ago were arrested for doing this work. So the challenge here is to not do that. And part of that challenge is to check ourselves out, check out how we’re doing business with each other as well as with wider communities.

If we begin with the idea that we’re starting a new workplace and hopefully not a new industry, it’s helpful to look at the context in which it all began. Harm

User Organizing and the Birth of the North American Users’ Union (NAUU)

About 50 user activists from across the country and Toronto met on September 17, 1996, in a ground-breaking organizing meeting to discuss some of the many complicated issues users both inside and unaffiliated with the harm reduction movement face. The group was incredibly diverse in terms of sex, race, sexual orientation, class, age, and drug(s) of choice. The meeting resulted in the formation of the North American Users’ Union (NAUU) which, while not believing it can speak for all users, will attempt to create a unified users’ voice to speak out on issues of public policy that impact our lives.

— R.S.

This statement presents the goals developed at the user “town hall” meeting to effect changes in services, policies, and laws that have a negative impact on our lives and the lives of our families. It is important that we increase our knowledge of existing laws and policies in order to use the system to our best advantage. We will continue to develop the networks necessary to share information and strategies and to break the systemic social isolation many users feel. Despite a lack of political, economic, and social resources, user activists have nonetheless been organizing locally, nationally, and internationally for some time now. Depending on where activists live in this world, this organizing has been more or less formal. To this end, the

continued on page 5
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, interventions, and community organizing. HRC fosters alternative models to conventional health care 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. Harm reduction issues are explored 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, we assume 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.

The views of contributors to Harm Reduction Communication do not necessarily reflect those of the editorial staff or the Harm Reduction Coalition.

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LETTER FROM THE EDITOR

Welcome to this special issue of Harm Reduction Communication that focuses on occupational health issues for harm reduction workers. Originally due out in summer, the editor did not heed the advice of many of the contributors to this issue, took too much work on, and got sick, and so we have a winter issue on occupational health.

Many of the pieces in this issue are based on presentations given at HRC’s First National Harm Reduction Conference that took place in Oakland, CA from September 18 to 21, 1996. The plenary session on occupational health was the first time we as a movement raised questions about how we take care of ourselves and each other. Lisa Moore outlines how harm reduction work and workplaces differ from other types of work and the ramifications this has for maintaining our health and sanity on the job. Bart Majoar continues this discussion of the unique nature of harm reduction work, and offers us a new way of thinking about and working through occupational crises. And Ken Vail discusses how our personal beliefs about drug use and drug treatment can prevent us from fully communicating with and supporting each other, and can even result in silencing people who need support. Nelly Velasco’s moving piece discusses what it’s like to live and work as a heroin user in that stifling silence; what she has written is made even more wrenching when one learns that Nelly died of an overdose just several weeks after presenting on the occupational health plenary at the harm reduction conference in Oakland.

Erica Berman and an anonymous contributor address the contradictions involved in being a user and a worker in the harm reduction field. And finally, Steve Arrendell has written about dealing with the ubiquitous loss harm reduction workers experience. We hope this issue of Harm Reduction Communication will spur on harm reduction organizations to find a way to provide meaningful support to all of their workers.

Also included in this issue are a series of pieces that do not deal with occupational health. Not surprisingly, the question posed most frequently to HRC is, “What is harm reduction?” There are many individual service providers from a variety of fields who, when they learn about harm reduction, say, “That’s what I’ve been doing all along,” but lacked a paradigm or term that articulated the approach they used when working with illicit drug users. Other service providers insist that they operate programs according to a harm reduction philosophy when in fact aspects of their work contradict an increasingly accepted set of tenets that are coming to define harm reduction practice.

At the opening plenary of the First National Harm Reduction Conference, Edith Springer shed some light on the question of “What is harm reduction?” We’ve printed in this issue her “Spectrum of Harm Reduction,” a schematic that details where harm reduction has been and where she thinks it needs to go. The “Spectrum” is followed by two sets of questions that should help individuals and agencies decide whether or not they are truly practicing harm reduction. And finally, Edith lists some of the possible goals of harm reduction, illustrating how far-reaching the scope of harm reduction can be.

Also speaking to the question of “What is harm reduction?” are consensus statements from three ground-breaking organizing meetings that occurred the day before the national conference began and which were presented as part of the closing plenary. The three meetings – one of users, one of methadone consumers, and one of individuals in 12-step fellowships who also work in harm reduction – set the tone for the conference and hopefully represent only the beginning of a sustained, constituent-led organizing effort.

— Rod Sorge

PS. This is the last issue of Harm Reduction Communication you will receive unless you are a subscriber to the newsletter. (I know we’ve been threatening to do this for some time now, but that time has come.) See page 4 for membership and newsletter subscription information.

JERRY BAEZ 1956-1996
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Harm Reduction Communication is supported, in part, from advertisements. The newsletter goes out to 10,000 individuals and agencies working in health and human services, civil rights, policy, academia and research. The advertisement costs are based on a two-tiered scale, as follows:

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C.H.O.W./NEEDLE EXCHANGE BAG

Working with our local CARES organization; Rhino Products, a leading manufacturer of high quality strap and bag products for Fire, Rescue, EMS, and Law Enforcement, has designed and field tested two street bags specifically for C.H.O.W.’s and the needle exchange program. Both bags are constructed of 1000 denier nylon Cordura Plus with heavy weight polypropylene webbing and sewn with #69 nylon UV thread. Zippers are heavy duty molded nylon. The concept and features of these bags came from a experienced street worker, we added our bag engineering and manufacturing experience. Black is standard color.

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NELLY IS IN CONTROL

Why do I need support as a heroin user from my workplace? Because for too long the lifestyle associated with heroin has been negative—that using heroin brings on a succession of worthlessness, self-destruction, and chaos inside yourself. I believe a lot of this is due to the fact that drug use is underground and illegal. For society, this illegality creates misconceptions, fear, hysteria, lack of accurate information, and an angry view of the heroin user as dishonest, untrustworthy, criminal, and with no morals, compassion, or self-respect. These views prevent us from getting jobs, renting apartments, getting the respect that we deserve. It forces us to be closeted about our lives, survive through underground and street economies, and lie to people who we interact with. Lying has always been an integral part of my use in the past. Lying to family, friends, work, that I'm not as bad off as I look and that things are hunky-dory. But now I'm trying to make my conscious decisions my realities instead of making a sequel to the next junky movie. I doubt myself a lot, but I do believe this: heroin has been around longer than any heroin lifestyle, and therefore I believe I have the power to create my own heroin lifestyle. A lifestyle in which I rock. At the Street Survival Project/Center for Young Women's Development, I train other young women to do outreach, listen to and advocate for my community, work to create research projects, work as a team to create funding, utilize my creativity to design sweatshirts, and assume the roles of leadership. I could go on and on.

A heroin lifestyle of a stable living situation, food in the fridge, responsible use of the drugs of my choice, and dreams in the woodwork becoming realities. A heroin lifestyle that spells continued on page 7

USER ORGANIZING

continued from page 1

North American Users’ Union (NAUU) was born this past Tuesday, expanding and continuing the work of a smaller, loosely-knit group of international activists who met in Toronto at the Sixth International Conference on the Reduction of Drug-Related Harm in 1994. It is NAUU’s position that user organizing is essential to the development of a pragmatic, community-based harm reduction strategy grounded in respect for our human rights. NAUU demands a legitimate leadership role in the political process of the harm reduction movement and the broader drug policy debate. Wherever policies and organizations are being developed, we expect to be at the table.

Harm reduction has been defined over and over as “a series of practical interventions that respond to the needs of drug users and of the wider community in which they live.” This simplistic definition of harm reduction perpetuates an unequal us-them relationship, however, by assuming that intervention is always appropriate. “Intervention” as it is used in current harm reduction theory and practice is very paternalistic, taking control away from the user and creating an unequal relationship from the start. A radical rethinking of intervention must include users’ perceptions and definitions of harm. Additionally, there is still the belief that harm reduction can and will (and should) lead to abstinence. This disempowering notion leaves no room for a user-directed discussion on drug use management and responsible drug use. Yet users continually develop harm reduction strategies based on day-to-day survival and that meet their needs without any kind of formal intervention.

In addition to creating a users’ definition of harm reduction already discussed, other key issues raised in the meeting included:

- The importance of networking in breaking the isolation among users locally, nationally, and globally. To this end, we see users organizing at all of these levels and one role of NAUU being to keep individuals and organizations in touch with one another and to offer information, support, and organized advocacy. Another key role of NAUU is to serve in an advisory role to the Harm Reduction Coalition (HRC), the Drug Policy Foundation (DPF), and other key institutions that affect users.
- Issues involved in obtaining drugs. As user activists, we must explore ways to control the purchase, price, and quality of street drugs. The fact that we must spend so much time seeking out our drugs of choice disrupts our lives. The absolute lack of quality control, especially with powdered drugs, is a constant concern. Solutions such as buyers’ clubs, testing of drugs (not users!), and drug law reform that ends the prosecution of drug users are all options that need to be discussed openly.
- The need to counter stereotypes about the “lifestyle” of the user so that realistic information about parenting, health care, and responsible drug use can be developed and shared among users as well as with health and other service providers, our families, and the wider community.
- Advocating for the universal availability of safe injection equipment that goes beyond needle exchange and includes distribution and safe places to use.

All of these concerns must be viewed in the context of broader issues of social justice, such as equal access to housing and employment. It is defining these day-to-day survival strategies and therefore providing a user-based definition of harm reduction that users are organizing around. It is here that users will exchange information, develop solutions, and problem-solve our real-life situations. As stated earlier, the NAUU demands a legitimate leadership role in the political process of the harm reduction movement and the broader drug policy debate. This involvement requires a radical change in how harm reduction practitioners and the institutions that have a role in harm reduction define harm. It requires an improved dialogue with the medical profession, service providers, and lawmakers based on mutual respect and dignity.
A disturbing tendency I have seen is that if somebody isn’t hacking it or somebody’s having a hard time, instead of looking at this structurally, of looking at how come it is that people can not have an easy time doing this work, I’ve seen people who are otherwise extraordinarily compassionate and empathetic back off and say, “Well, they just couldn’t hack it,” or “Shit happens.” And I think part of that might be a defense mechanism we use to protect ourselves: “If I don’t get too enmeshed in what’s going on with you, and I just say shit happens but it isn’t going to happen to me, then I don’t have to worry as much.”

Shit does happen and shit is going to continue to happen, and until we start looking at this in ways of taking care of ourselves as well as others, it’s going to continue to happen, and it’s killing us. I am watching harm reduction workers die, and I don’t like it. I don’t think we can afford it. I think that in part what we’re seeing is that we’ve internalized the messages we’ve all heard about our communities, which is that we don’t matter. And I’d like to cop a very big plea that we do matter. That we’re all crucial, as are the communities we live in.

What makes us unique as a workforce is that we do give a shit, and the other piece of it is the fact that most if not all of us use some substances. But the question isn’t whether or not people are using, because we are. The issue is whether or not our lives support us in the decisions we make. For those of us who use, do our lives support us to use in a way that we find most beneficial? If we’re not using, does that get supported? Abstentionism or non-use is a viable option for some people, and that is okay. Within the context of workplaces, though, I don’t always see that acknowledged. I see that we can talk about this issue but we’re not creating an atmosphere where it really happens, because of every harm reduction worker I know who died of an overdose, very few of them talked to anybody about their use. People didn’t know they were using until the coroner took the
"NELLY IS IN CONTROL." So why do I need support? Because this little idea goes against everything I've ever been taught, against my family, against most of my friends, against school and most jobs. People seem to think that the only user who needs or deserves support is the one who's trying to quit. This really makes you feel alone and it's hard to get shit accomplished when you're one of the few people who believes in you. This idea of accepting more than just one heroin lifestyle is so radical, it's like swimming against the current. I need you to be aware how much my life and others like me is a contradiction. The Street Survival Project/Center for Young Women's Development supports me.

Nelly Velasco, a 19-year-old Mexican IDU chick, overdosed and died on October 9, 1996, shortly after the First National Harm Reduction Conference in Oakland where her piece that appears here was presented. Nelly was very ambitious, and very much alive. Her death certainly was not planned. Why did Nelly leave us? Any why have countless other harm reduction workers gone? Who knows the answers to these questions—I know I don’t. What I do know is that people are dying, and we're in such early stages of this movement that as we continue to move on in the direction we’re going—where people are beginning to feel as though they can start an honest dialogue about use—we also really need to watch each others' backs, and we really need to start creating more and more options for each other and for the people we work with. What Nelly was missing was more than one place to work that supported her fully, more people in her life that accepted where she was at and supported and loved her for all that awesome talent and sincere empathy and caring for a hell of a lot of people. If I could see anything good coming out of this fucked up, shitty death, it’s that within the movement we begin to organize around and address the issue of death among us, and how we can begin to take better care of ourselves and each other.

—Erica Berman

needle out of their arm. So I challenge us, as we try to engender community, to engender community amongst ourselves so that these silences don’t swallow people up. We still have more work to do. We have to engender a community that permits us to deal with the fact that we’re not valued, and that this lack of being valued can kill us. This has to be part of the next step because if it’s not, we may not have the movement we envision, and clearly, when we die, the bureaucrats will take over. Fools walk in when angels take a break. If we’re not all here and here fully, there will be someone walking in when we take a break, so don’t let it happen. We need to figure out concretely what we have to do programatically as well as in terms of policy to prevent harm amongst ourselves.

Lisa Moore, Dr.P.H., is an Assistant Professor in the Community Health Education Department at San Francisco State University. She has been working in harm reduction, mostly around needle exchange, since 1989.

ANOTHER DAY, ANOTHER DOLLAR: WORKING AND USING

by Anonymous

I'm writing this as a response to a call for users in the harm reduction movement to write about their situations and struggles around their use and other issues. Unfortunately, I do not feel that we are sufficiently enlightened as yet for me to feel safe in signing my name to this article. However, it's a start. Those of us who have paying jobs within harm reduction agencies carry many risks in revealing our use, and find ourselves in much the same position as those who use in so-called "straight" jobs. In fact, I feel that our position is somewhat trickier in that with conventional employment, the lines are clearly delineated and only a fool would reveal their use to a co-worker.

The mistake I find many activists make is to assume that they are beyond all the prejudices and stereo-
power is not in our hands (and certainly not in the hands of our participants), and
many of us spend an inordinate amount of time trying to appease the same gov-
ernment agencies that are the source of our problems (and for many of us, now
the source of our funding).

Many people who work in harm reduc-
tion do so as a result of some personal
experience, whether that they are in
recovery from drugs, have lost loved ones
to HIV or AIDS or overdoses—the list is
endless, full of death and depression. Not
exactly the most “up” of work environ-
ments. One (at least this one) constantly
has to fight feelings of futility and bang-
ing one’s head against a brick wall.

Besides the frustration of coping with and
fighting against the system is the squab-
bling and back-stabbing that seems to occur in most left-wing groups or agen-
cies. Capitalism is a system that encour-
ages people to view each other in com-
petitive ways. Within this system, an
ego structure is created that becomes very
hard to analyze and break down, and that
makes working within a group structure
problematic. Any idea that starts out on
a very pure, very simple level is apt to
become corrupted over time—as an idea
(such as needle exchange) takes hold,
becomes popular, and attracts money,
things inevitably change. A “movement”
becomes an “agency” with a power struc-
ture. This is referred to as “facing reality.”

Almost inevitably, groups begin to splin-
ter. Of course, everybody involved from
street-inception needle exchange to estab-
lished agency brings their own condition-
ing with them. No one is free from the
tentacles of conditioned attitudes and
anyone who thinks they are is full of it.
The microcosm mirrors the macrocosm
with all its societal divisions and subdivi-
sions duplicated. Anyone who has ever
been in therapy knows that “talk” and
real emotional change are very different
states. Talking about “non-judgmental”
attitudes and concepts like “acceptance”
and “compassion” must be felt and
experienced, not just talked about. The
change must be total—intellectual, emo-
tional, and spiritual—to be real. This is
easily illustrated in the farce known as
“jobs for users.”

Personally, I have learned through
painful observation and some first-hand
experience to keep my mouth shut about
my relationship to drugs, except with
those few people I know that I would
trust in a life-or-death situation. Yes, it’s
that drastic. Any mistake on the job might
be easily attributable in people’s minds to
drug use—never mind the stress on the
job caused by dealing with clients who
are being driven crazy by their circum-
cstances, the stresses between workers,
being broke or in debt, your friends who
are sick or dying, your friends who are
already dead, general malaise, and an
inability to remember the last time you
had any fun at all out of life. I don’t know
about you, but I’m definitely ready to get
high (not an easy task these days!).

I am grateful for any peace of mind and
relaxation I can get, artificial or other-
wise. And to those in recovery who say
that I am mediating my feelings—I say,
“You bet your ass I am.” Perhaps ten
years of meditation would be a cleaner
(and cheaper) way to accomplish real per-
spective and real detachment, but right
now I’d just like to get through tonight,
thank you. I’d like to look around my
slum apartment and find it aesthetically
pleasing and that certainly requires a
drug-induced change in my perception.

Actually in my experience (and I can
only speak for myself on this one) getting
a little high on the job (not falling over
stoned) actually makes me better at my
job in that I’m able to tolerate such hap-
penings as five people talking to me at
once, or the myriad tasks that never seem
to be completed. Being high definitely
helps me cope by taking the edge off
things so that I am not a constant emo-
tional wreck, feeling like a floating head
on the ocean being tossed about by the
waves.

Can I reveal this openly? Not if I want
to spare myself almost constant scrutiny
and categorization. Not unless I want to
hand a co-worker who might not be
enamored of me just the opportunity they
seek to get rid of me. Finally, let me say
that it’s not all bad. We do good work. We
do feel for each other and try to support
each other. I truly love the people I work
for. I just wish I could trust them!
How Many More Deaths Will It Take Before We Come Together?

by Ken Vail

When I first began thinking about how to present my thoughts and feelings about the issue of occupational health, I decided that I needed to say something about my experiences with drug use, drug treatment, and harm reduction. I injected drugs for many years, however, today I choose to be in recovery. Today, I also believe that drug treatment is an important part of harm reduction and that long-term drug treatment is the best step for me! Yes, for me, but not necessarily for anyone else, and this is where my way of thinking about drug use and drug treatment has changed. This is where the concept of harm reduction has provided me with a new framework for viewing this aspect of my world. It has allowed me to utilize what works best for me in my own personal life, while at the same time showing me the importance of not making my beliefs a template for how other people should live their lives. To try to explain to you how people I have encountered over the past six years, even the past six months, have challenged me to re-think the way in which I view drug use and drug treatment would be impossible. My main point is that I have come to respect and learn from the numerous ways in which people perceive drug use and drug treatment, not just my own. For me, this has been the key to helping people help themselves.

I also need to say that I am angry and sad that there are dedicated advocates of harm reduction who are no longer with us because they overdosed. My anger and sadness comes from my belief that many of us involved in harm reduction, myself included, have used up way too much time and energy trying to distinguish ourselves either as “users” or “non-users,” abstinence versus harm reduction—time and energy that I believe we need to be spending on communicating to one another our differing opinions and working together to come up with creative and innovative ways to help minimize the damage that harm reduction workers encounter on a daily basis. If we are willing to communicate with one another, I believe that future drug-related deaths among harm reduction workers can be greatly reduced.

I therefore encourage everyone to critically examine and reflect upon how your own philosophies about harm reduction, drug use, and drug treatment are interconnected and what impact they have on your personal lives as well as on the health and well-being of individuals you serve. In addition, I encourage you to share more of your experiences with one another so that we can break down walls of silence that prevent us from achieving our full potential. How can we as a movement help prevent our own brothers and sisters from dying? How can we help prevent future deaths among harm reduction workers?

We can begin by not allowing the lives of people we deeply care about to be minimized by simply dismissing their deaths as “occupational hazards” of injection drug use. We all know that people have used drugs since the beginning of time, and that people will continue to use drugs long after we are gone. However, this does not mean that we should sit idly by and chalk one up to bad luck. We need to work together to make people who choose not to use drugs be more respectful and understanding of people who choose to use drugs, and vice versa. In addition, we can work together to refute the belief that people who choose to use drugs are somehow incapable of taking care of themselves, that they need the knowledge and the values of people in recovery imposed upon them to make their lives better. If there is anything that I’ve learned over the years, it is that I am a student of life and not an expert. I cannot save lives.

Furthermore, we can work together to help one another remember that all of us are trying to reduce harm and that no one person or philosophy within the harm reduction movement is absolute. Like the experiential model of learning, we must start with an idea, implement it at a given time, learn from our mistakes, and continue to change the parts that are not working. Finally, we can work together to help one another remember that preventing the spread of disease is our main focus, not whether people choose to use drugs or choose not to use drugs.

Reducing drug-related harm among individuals who provide services, as well as among people who receive them, will require us to take a critical look at our own philosophies of harm reduction, drug use, and drug treatment, and to communicate with one another. This process will not be easy and it will make many of us uncomfortable. However, we are all too familiar with the alternative: SILENCE = DEATH.

Ken Vail is the Founding Director of The Xchange Point, a harm reduction and HIV prevention program in Cleveland, OH.
Even though we try to avoid it, it’s human nature to develop closer bonds with some clients than with others. James, a wiry, bespectacled, grandfatherly figure, was one of those memorable clients for me. Personable and intelligent, he had my respect, admiration, and camaraderie as he struggled to put his life back in order after experiencing a decades-long drug habit, homelessness, and then AIDS.

Things were starting to click again for James. He was having more contact with his estranged wife, he had visits with his grandchildren, his health was good, and he was sober. Then, a brief bout with pneumonia put him into the hospital for a week.

James weathered that storm, but a few days after his discharge came word that he was caught up in a buyers sweep near a busy crack corner. Upon hearing this news, my heart dropped into my boots, and I felt, well, as if I’d just lost a good friend. I felt the same brand of pain as I might have had James died.

Just as black lung disease afflicts coal miners and repetitive stress injuries plague those working in meat packing plants, grief and loss are occupational hazards of the harm reduction field. The specters of relapse, overdose, and AIDS travel about with those of us who reach out to drug users.

Anyone who’s worked in harm reduction for more than a few months is all too aware of these on-the-job hazards. Who in the field hasn’t experienced grief as a client or co-worker succumbed to AIDS or slips back into destructive habits that inhibit a full and passionate life? But recognizing these feelings, and dealing with them in a healthy fashion, are two entirely different matters. Regardless of what caused the grief, if it lingers unresolved, it can have a profoundly negative effect on a worker’s well-being and relationship to others.

While we tend to associate bereavement and grief with death and dying, the feelings are not limited to the passing of another human being. Grief is a normal and natural reaction to any loss. We can mourn the loss of a job or grieve over the relocation of a close friend; grief can be the dominant emotion when a cherished co-worker finds employment somewhere. Indeed, the American Heritage Dictionary’s first definition of the verb ‘bereave’ is “to deprive of (something valued).” And in the world of drug users, if a personality shift occurs because someone has become sober or returned to drug use, or if we are witness to decidedly self-destructive acts, these can produce grief and a deep sense of loss—feelings that require mourning.

Margery Allingham writes in her book The Tiger in the Smoke that “mourning is not forgetting... It is an undoing. Every minute tie has to be untied and something permanent and valuable recovered and assimilated from the knot. The end is gain, of course. Blessed are they that mourn, for they shall be made strong, in fact. But the process is like all other human births, painful and long and dangerous.”

Many bereavement experts agree that the most significant loss experienced by survivors is the elimination of spiritual centering. (In the case of James and other clients, it’s possible that their well-being can become too closely linked with our own stability, which is a whole other area requiring constant self-monitoring.) A death or some other traumatic event can totally disrupt one’s life. Inner faith can help one maintain some sense of equilibrium until a new order is created, and those who find that the spiritual centering eludes them can seek guidance from bereavement counselors, social workers, and clergy. Interestingly, it is believed by many practitioners who work with the bereaved that families—be they birth, choice, or professional—are unlikely milieu for gaining either the elusive inner faith or equanimity in the grieving process. This presumption is based on the understanding that beliefs, world views, and values are so personal that they can only be found within individuals. In short, individuals grieve, families don’t.

One false assumption families can make during a grieving process is that since everyone lost the same individual, the grief process should be identical for each member. Or some family members may feel the sense of loss they are experiencing is greater than that of others, and that their suffering is more intense because of the relationship they had with the deceased. The example of James can be used to illustrate this point: I was very likely the only member of the “family” who was so affected by his relapse.

Another possible scenario is that some family members will believe that
5th Annual Women and HIV Conference  
San Francisco, CA  
January 30 & 31, 1997  
Contact: Lisa Higgins at (415) 554-8448

8th International Conference  
on the Reduction of Drug-Related Harm  
Maison de la Mutualite, Paris  
March 23-27, 1997  
Contact: 44 (0)151 227 4423

HIV/AIDS on the Frontline Conference  
Orange County, CA  
March 31 & April 1, 1997  
Contact: Orange County Health Care Agency at (714) 834-8020

American Methadone Treatment Association  
Methadone Conference  
Sheraton Chicago Hotel & Towers, Chicago, IL  
April 13-16, 1997  
Contact: (609) 845-5010

North American Syringe Exchange Convention VII  
Holiday Inn on the Bay, San Diego, CA  
April 24-26, 1997  
Contact: NASEN at (206) 272-4857

19th National Lesbian & Gay Health Conference/  
15th National AIDS/HIV Forum  
Radisson Hotel Atlanta, July 26-30, 1997  
Contact: P.O. Box 33022, Washington, DC 20033  
Fax: (202) 234-1467

Audiotapes of all the plenary and break-out sessions of HRC's  
First National Harm Reduction Conference that took place  
from September 18-21, 1996 in Oakland are available individually  
or as a complete set. Please call Conference Recording  
Service at (510) 527-3600 for a price and title listing.
the loss was less significant for themselves and they may be uneasy about expectations that they should act in certain ways to oblige other family members. Because family members may need to socially confirm the reality of the loss and what it’s done to their perceived world, they may also project greater similarity in values and beliefs onto the family than what in truth exists.

When a couple experiences a mutual loss, it is believed that they are the least likely to be able to help one another. Their relationship with the deceased, and with one another, along with two unique sets of “baggage,” generally blocks common grief resolution.

Regardless of where one’s feelings about a loss happen to land on the spectrum, they should not be avoided. We all know that if strong feelings are not expressed directly, they are certain to come out indirectly. Therefore, one of the most important things for all of us to remember as we try to follow our very individual paths in

**Grief is a normal and natural reaction to any loss.**

the ongoing grieving process is to be an active and supportive listener. But first we need to give to our family members and to ourselves permission to grieve in our unique styles and to our distinctive needs.

James, by the way, eventually viewed his arrest as a wake-up call and is now back spending time with his family and taking care of his health.

The *Addiction Letter* recommends two booklets for the bereaved and bereavement caregivers, both by Alan Wolfelt: *How to Reach Out for Help When You are Grieving* (33 pages) and *How to Start and Lead a Bereavement Support Group* (44 pages, oversized). The cost is $3. Contact Batesville Management Service: (800) 622-8373 in the U.S. or (800) 446-2504 ext. 7788 in Canada.

*Stephen Arrendell lives in New York City.*

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**HARM REDUCTION AND THE TWELVE STEPS**

Many of the first harm reduction activists in the United States were people in 12-step recovery programs. In conjunction with the First National Harm Reduction Conference, a group of people in 12-step programs (ACOA, AA, NA, OA, and others) who also work in harm reduction met to discuss some of the complex issues that arise at the intersection of these two philosophies. The following statement was one of the results of their efforts.

— R.S.

The following statement is not the opinion of any 12-step fellowship but rather a set of recommendations from individuals who are involved in both harm reduction and in 12-step recovery. We are members of anonymous fellowships and as such do not endorse and are not affiliated with any drug treatment facility or modality. We want to share with you our needs and wants as people involved in 12-step recovery and at the same time make it clear that we realize that there are many different definitions of recovery, all of which are equally valid.

First, we cannot afford to minimize the various issues that arise among people in 12-step recovery who are conducting harm reduction work. We need to support each other in the management of these issues. We also need to realize and acknowledge the fact that both individual and organizational responsibility are necessary to support people who choose 12-step recovery.

Second, we must acknowledge the stigmatization surrounding drug use, and work together to dispel the myth that harm reduction and abstinence are incompatible. This will require that we build bridges of unity while at the same time respecting each others’ boundaries. There are some ways in which this has already started to occur. In Los Angeles, there’s a 12-step meeting where people who use are invited to participate in the sharing portion of the meeting. Treatment centers in Hawaii invite pregnant mothers on methadone to join their program.

Third, we need to continue to utilize the harm reduction movement as a vehicle for educating users and non-users. As 12-step members who work in the field of harm reduction, we can educate members of these fellowships through example and provide them with information to help them become more open-minded. It is not our job to judge. We need to view difference in a constructive way, and strive to find our common bonds. By communicating with one another a variety of information and by addressing conflict between people who choose to use drugs and people who choose not to use drugs, we can create a truly inclusive movement.

We would like to close by saying that this conference has marked an historic event for those of us in recovery. For the first time ever, we have discussed and shared our needs and wants. We want to invite your feedback. We want to hear any concerns or suggestions you may have. This is the beginning of an ongoing dialogue and a giant step toward inclusion rather than exclusion.
Supporting Users on the Job

by Erica Berman

When I was asked to talk about supporting drug users in the workplace, I have to say it was quite a process to think about what to say. I thought, “Isn’t it obvious? Don’t all people have a fundamental right to support in the workplace?” That’s where I got stuck. I couldn’t go beyond the obvious. So I’m going to break it down and talk about what support means to me.

Support means honesty. When I say honesty, I mean an encouragement of honesty at all levels of the workplace. I mean the program directors need to be honest about themselves, the accountants need to be honest about themselves, board members need to be honest about themselves, the executive directors need to be honest about themselves, and through that process the peer educators or whatever frontline workers we’re talking about can begin to feel as if they, too, can be honest about themselves. Through the encouragement of honesty without the fear of backlash, people begin to put their shit on the table and start problem-solving about whatever harm may be happening in their lives. And through the skills we learn from that, we can begin to problem solve with our clients. Or say, for instance, people’s drug use isn’t causing harm. Cannot that be talked about honestly, too? What else do we need as support? We need compassion and acceptance. We need people to realize that we all have different lives and different reasons, and that those are all beautiful things to be cherished and understood so that we can continue to believe in our differences and realize just how much we have to learn and teach each other because of them.

And what we need is allies — people who believe that we have the power to control our own lives and people who will remind us of that. And we need expectations from our peers, from our co-workers, from our supervisors. We need people to expect us to be accountable, and to do a damn good job at what we do, to expect that we will come in on time and that we will use responsibly, and that we will challenge the idea of us as chaotic users who flail around and get nothing done. Support also means a good health plan, a plan that involves primary care, mental health, a dental plan, and most importantly holistic healing. We want accessibility to acupuncture, massage, herbs, all the stuff we can do at home and a chance to learn what that all means. Can you image a health plan for drug users? Can you imagine a physician that would prescribe methadone? We also need humane alternative plans for each individual on an as-need basis. If a person can’t come in enough, perhaps he or she could become a consultant. Or perhaps she could be on an advisory committee or on the board of directors. But those things need to be implemented in the most respectful way possible, with the realization of how important the person’s ideas and input really are.

I’d like you to look forward to the day when, along with gay men and lesbians, drug users are a protected clause in the hiring process.

Erica Berman is a 22-year-old girl who has been doing research for the past three or four years. Before that it was outreach, and throughout she has been working at a needle exchange program. Erica is an on-off-on heroin user, and is dedicated to drug users’ — but most importantly poor drug users’ — rights.

Through the encouragement of honesty without the fear of backlash, people begin to put their shit on the table and start problem-solving.
I would like to introduce this discussion about occupational health with a little story that takes us back to the Middle Ages, to one of the big European cities where a new cathedral is being built. And as you might know, the stones used to build the cathedrals were cut at the building site. Big rocks were brought in and then stones were cut from the rocks. Now, imagine yourself walking there and that you go up to one of the stonecutters and ask him, “What are you doing?” The stonecutter responds, “Can’t you see that I’m cutting stones?” You walk up to a second stonecutter and you also ask him “What are you doing?” and he looks up at you and says, “I have a big family, 12 kids, and they need to be fed, clothed, and sheltered, so I need to earn some money and that’s why I’m cutting stones. That’s what I’m doing here — earning money.” Finally, you walk up to a third stonecutter and ask him, “What are you doing here?” And he looks up with a big smile and says, “I’m building a cathedral.”

HARM REDUCTION WORK: DAILY PRACTICE

A simple model of what’s needed to perform a job in the field of harm reduction can be illustrated by an upside-down triangle, and at the three points are knowledge, skills, and professional attitude. I think that in our training, there’s often too much emphasis on knowledge and skills and too little on the professional attitude. Too little attention is given to the person of the worker. (When I say “worker” I mean paid staff as well as volunteers.) The motivations, needs, values, belief systems, qualities, and limitations of the worker are all instrumental in this work. Knowledge and skills will only be effective in our work if they are embedded in a professional attitude that has integrated these things. A starting worker will of course be different in this respect from someone who’s been working in the field for five years already, so this process needs continuous attention.

When asked how he wrote all of his songs, how he got them out of his head, the British pop musician Elvis Costello replied, “When you’re a clumsy guitar player, technically speaking, you happen to find just the right notes.” And that’s what it’s all about. The worker is in a constant process of discovering what is the story of the person he or she’s working with. The worker needs to be clumsy and to have an open attitude. The worker is not the expert, but more like a guide. It is the worker’s job to get out of the way rather than impose what he or she thinks on the one who’s sitting in front of them. The worker needs courage to stand up against racism and stigmatization. It’s hard to create space for the people we work for in this society, so the worker needs empathy to be able to hear the participant’s story, and a sense of solidarity with the participant. The worker needs involvement — a heart — in order to do this job. But the worker also needs resoluteness and the will to go on and on despite adversity. People will relapse, and they will go to jail after you’ve spent a lot of time with them.

The worker needs boundaries to protect him- or herself against ever-increasing demands. Harm reduction work comes with an enormous amount of stress, and the live-or-die context of this work, especially here in the United States, creates a pain that workers are faced with every day. As harm reduction workers, we talk about meeting the people we work with where they’re at, but that’s easier said than done. It means you have to accept and endure a lot of pain. We need to have respect for our participants, for their communities, for their coping mechanisms, and for their solutions. Workers especially need to be conscious in their job. As a worker, one needs to be prepared to go fully into the relationship with a participant on the one hand, and be fully conscious of what one brings into the relationship on the other. Does it help or does it hinder? Workers need to differ-
entiate between their own needs and the needs of the participants.

And then there are security issues. For a lot of people who work in harm reduction, it’s their first “legitimate” job. It means a lot of exposure, getting used to the structure of a work rhythm, and managing their drug use. For workers who have stopped using, it means finding a way to work with people who still use — possible confrontation with an old life that can kick up a lot of stuff. Many workers are also HIV-infected, so they’ll be constantly confronted with that issue. A lot of people start doing this work with a lot of heart, with a lot of involvement, and they ask a great deal of themselves, but sometimes they make unrealistic demands on themselves and become disillusioned and burned out.

There is no precise methodology for doing harm reduction work. One learns by doing it, by failing, and by standing up again. There’s only scattered training, and controlling mechanisms is disproportionate to the small budgets most harm reduction programs have. There’s often no ongoing team support, organized in a structural way, and the sociopolitical context in which we work the police arrests, the fact that communities don’t understand what we’re doing — all create insecurity for staff and volunteers.

So people have to survive in this job, and what I realized at a certain point is that there are basically two survival mechanisms that people employ. I call them the head-helper and the heart-helpers. The head-helper build a wall of professionalism, and hide behind their professional role, for protection. They can’t show any empathy, they don’t have authenticity, they deny their feelings, create too much distance, and become cold and cynical. They’re not effective workers. That’s one extreme. On the other side — and we see a lot of them in the harm reduction field — are the heart-helpers. These are the love types, ready to take a lot of risks, be adventurous, and say no to professionalism. They fuse with the subjects they work with, don’t want protection, are very empathetic, their solidarity with their participants is very high, their feelings are right there, present, and there’s little distance. But heart-helpers are easily hurt and manipulated, and often they’re not effective either. What is important is not that we can recognize these types, but that we see that characteristics from both are needed. We need the heart and the involvement in this work, and we need the head to protect ourselves, and to keep on doing the work. And it’s important in the career of a worker in this field to find the right balance between the two.

Another way of looking at that balance is the worker zip(pered)—on one side workload, and on the other side bearing capacity. Workers must learn to integrate the two in a creative way where their needs match the needs of the work. But again, this is a continuous process.

**Burnout and Burnthrough**

People in the harm reduction field are on fire. The spirit, the heart, the involvement is high, and it’s important to realize this as managers, supervisors, and colleagues. So it takes quite a person to be able to survive in the field of harm reduction. In my experience as a staff supervisor, people don’t have all the qualities they need in a balanced way when they apply for a job. Especially in harm reduction programs where we work mostly with peers, often this is their first job after years of living on the other side. In a constant process of trial-and-error, they learn gradually what they need to know and develop a personal style that needs to be balanced over and over again, as any professional should in fact do. There will be frequent mistakes and unpredictable situations from which the worker can learn if he or she is helped.

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Constant attention is needed to guide inexperienced workers through their first stage of disillusionment. If they’re left alone with this, they will experience a crisis and the crisis will become more severe and eventually lead to burnout. The best way to describe burnout from years of working with it and treating it, is swallowed anger. It’s a lot of frustration that is swallowed, stays inside, and leads to the self-isolation of the worker. On an organizational level, individual burnout shows in staff absenteeism, high sickness level and staff turnover, low level of job satisfaction, lots of conflicts, and in the end, the ineffective delivery of services and damage to the clients.

For all the reasons I’ve mentioned, I think it’s clear that in this work we can be sure that burnout crises will happen among workers. I prefer to use the term “burnthrough” rather than “burnout” because of the negative connotations associated with “burnout.” I also don’t talk about a burnout syndrome but about a burnthrough phenomenon. Burnthrough is not an illness but rather a phenomenon of working life, and by using the term burnthrough, one can refer to the analogy of the rocket in which a no-longer functioning stage is done away with during the course of a mission that can then be continued with less mass. So it’s about a worker who learns that there are some things in her professional attitude that aren’t effective, and when you help her, she can lose that part that isn’t helpful and move on in her career. When a supervisor doesn’t help the worker on the individual level, it will often result in burnout and the whole rocket will crash.

Burnthrough is also not just simply a question of individual failure. It’s better seen as an ecological malfunction. The organization, the individual and everything surrounding them are all part of a related and dynamic process and the individual worker is part of that process. So individual staff burnout is also a sign that there is something wrong within the organization.

**CONCLUSION**

It’s okay to burn out. The trick is not to make an ash of yourself. The model that I developed and worked with in The Netherlands and later this past year at St. Ann’s is one that features ongoing staff support. The central idea is that I work in the team: I do the outreach with them, I do needle exchange with them, I go out in the street with them, I sit in meetings with them, I’m one of their colleagues, and on the other hand, I am also their supervisor. I have individual supervision meetings every two or three weeks, working especially on the personal processes that I’ve been talking about but also the next step, where an individual staff member is going and what do they need to get there. I also do team supervisions every two weeks. Team-building is crucial. It is important that when two outreach workers are standing on the sidewalk doing their work that people who meet them feel that there’s a family behind them. Conflicts, cooperation, and the relationship between target groups, the whole community, and the team—all of these things are talked about. Ongoing training is another very important part of this model. Finally, recruitment of new members is not just about the job requirements, but also looks at what the team needs in terms of gender, race, and personality type. Integration of new team members and volunteers is a crucial task that is often neglected because of lack of time. Evaluation and feedback are very important. Tell your workers what they’ve been doing. Supervisors know how many people the organization has reached and other such data because they have to write these reports every month, reports that rarely find their way into the hands of the individuals who actually do the work. In my experience I have found that sharing this information is very motivating and helpful in directing resources.

So, is it possible to avoid burnout and maintain spirit? I think it is if we invest in ourselves, in our teams, and in our workers. We must not have a throw-away policy but adopt a caring approach to our workers and our colleagues. I think also that it’s economic. Eighty percent of our budgets are salaries, so to create quality in this work, we need to invest in workers, and so it’s also an effective thing because it will help the people who we work for to create a better life. Harm reduction management is really human resources management—something that’s very important to realize when we start or run an agency.

**The worker is not the expert, but more like a guide.**

Bart Majoor is a psychologist who worked in the field of drug care and harm reduction in The Netherlands for 17 years, including six years as the head of the Department of Methodology and Training of the Netherlands Institute on Alcohol and Drugs (NIAD). Since the fall of 1995, he has been the Deputy Director at St. Ann’s Corner of
Methadone is one of the best harm reduction tools there is for narcotic addiction, and the delivery system and the people who are in methadone treatment need to work together to make it a positive experience. Heroin addiction is a medical condition. Methadone treatment must cease operating on a negative reinforcement model of behavior control but rather be considered a legitimate medical treatment that is delivered with dignity and respect.

Methadone is not a substitute; rather, it is a replacement therapy for a deranged opiate receptor-ligand system. Methadone is not addictive. The conditions for a drug to be classified as addictive are behavioral as developed by the American Medical Association.

Recipients of methadone treatment shall be called ‘patients.’ It is denigrating for a methadone patient to be called a ‘client.’ We are patients just like everyone else who goes to a doctor. And since methadone is health care, terms like ‘termination’ need to be omitted from the vocabulary used to talk about the methadone delivery system.

DEMANDS

• In no instance shall a patient’s dose be used as a punitive tool to make a person comply with administrative policies (e.g., a missed appointment, inability to give a urine, or missed payments).
• No patient shall be denied methadone because of inability to pay. Treatment shall be affordable to all.
• Methadone doses shall be medically determined for the individual patient without maximum cap. Patients have the right to always be aware of and informed about their dose. No blind dosing shall occur unless requested by the patient. A patient’s does shall not be raised or lowered without the patient’s consent. In the event that the medical director of the clinic determines that an adjustment in dose is necessary, it must be in consultation with the patient as the patient has the right to know the medical reasons why they may need a dose adjustment. However, the final decision to increase or decrease dose shall rest with the patient.
• Methadone shall not be used as a behavioral tool (e.g., “go take a urine and then get medicated”; “see your counselor and then get medicated”).
• Federal, state, and local regulations and clinic policy must be available for patients to view at all times.
• In compliance with federal guidelines, clinic policy regarding cause for discharge shall be posted in an accessible place for all patients to view.
• Hours for medication shall be scheduled for the convenience of the patients and not the staff.
• State and/or local authorities shall ensure that all patients receive due process prior to discharge.
• No patient shall be subjected to supervised urines. However, this coalition does support unsupervised random urines in accordance with federal guidelines.
• In accordance with federal guidelines, no significant treatment decisions shall be based solely on one urine report. No patient may be discharged for displaying symptoms of their disease, for example, heroin use and/or ongoing positive urines.
• As there is no treatment for cocaine use, no patient shall be discharged for positive cocaine urines.
• As this coalition sees the use of marijuana as causing far less harm than discharging a heroin addict to the streets; and as urine toxicology testing for marijuana is so costly; no program shall test for marijuana use as clinic policy nor shall patients be discharged for marijuana use.
• Patients and staff shall designate an ombudsman to help resolve grievances. Programs should empower patients to establish pro-active initiatives such as advisory boards, patient advocates, committees, groups, etc.
• All staff shall receive sensitivity training and training in using a harm reduction approach.
• Methadone programs must have at least one methadone patient on clinical staff.
• Patients should be able to access a counselor of their choice who shall serve primarily as a case manager to help patients access community services, as needed.
• Methadone programs shall have a designated vocational rehabilitation counselor with appropriate credentials and education regarding methadone.

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• Primary care physicians should be able to prescribe methadone for addiction. At the very least, physicians should be able to prescribe methadone to any narcotic addict who has HIV/AIDS, hepatitis-C, or other infectious disease.
• Iatrogenic patients should not be forced into methadone programs for narcotic addiction. Instead, should they need methadone for chronic pain, they shall be treated by their physician.
• All methadone programs shall make provisions for patients who may have missed clinic, such as the late clinic that once existed at Beth Israel Medical Center in New York City.
• Programs shall replace lost or spilled medication on an individual basis.
• When courtesy dosing, patients shall not be coerced into double payment—regular payment at the home clinic and payment at the visiting clinic.
• All states shall make methadone available to their residents who require treatment for narcotic addiction.
• Narcotics Anonymous (NA) and other 12-step programs shall consider methadone a legitimate, prescribed medication. Methadone patients shall be able to participate in all areas of NA. Methadone is recovery and methadone shall be considered drug-free.
• Methadone treatment programs may not force patients to stop taking medications prescribed for mental health conditions.
• The Drug Enforcement Agency (DEA) and the Food and Drug Administration (FDA) shall not be involved in regulating the clinical aspects of methadone treatment except for basic regulatory policies as they are applied to all other medical treatments.

CRIMINAL JUSTICE ISSUES
• With regard to the criminal justice system, incarcerated narcotic addicts and methadone patients shall be given methadone for withdrawal and/or maintenance in a compassionate and medically appropriate manner while incarcerated. The New York Riker’s Island KEEP Program is recommended as a nationwide model. No jailhouse detox!
• Probation and parole authorities shall consider methadone a legitimate medical treatment, and no methadone patient shall be considered in violation of probation or parole based on their entry into or participation in methadone treatment.
• Drug treatment modalities should not be specified as a condition of parole or probation.

NUESTRAS VOCES
La Primera Conferencia Nacional de Reducir el Daño tomo lugar en Oakland, California los días 18-21 de septiembre. Aunque no existieron talleres en español la representación latina fue notable. Siendo la única latina y puertorriqueña empleada por la Coalición de Reducir el Daño (Harm Reduction Coalition), siento orgullo de representar mi pueblo, mi gente. Quiziera por este medio urgir a los latinos a someter articulos en español para el periodico Communication. Me comprometo a revisar sus articulos. Nuestra sección se titula “NUESTRAS VOCES.” Latina/os: haz tus voces presenten Communication y somten tus articulos hoy. Gracias.

—Paula Santiago
New Yorkers Face Assault Under “Welfare Reform”  

by Corrine Carey

By sending a proposal to the New York State Assembly which will require drug testing of the state’s welfare recipients, New York Governor George Pataki on November 14, 1996 became the first state leader to act on the federal welfare reform passed by the Senate and signed by the President this past summer. Section 902 of Title 9 of the Personal Responsibility and Work Opportunities Act of 1996 -- what everyone now calls the Welfare Reform Act -- authorizes the states to start drug testing and sanctioning welfare recipients. Section 902 says that states shall not be prohibited by the Federal Government from testing welfare recipients for use of controlled substances nor from sanctioning welfare recipients who test positive for use of controlled substances.

One sentence contained in this mammoth (300 pages long) and historic Act provides the states with a powerful weapon in their “war on drugs.”

New York State is different from other states that have to implement federal welfare reform changes because it is one of only two states whose constitution contains a provision mandating that the state provide some level of assistance to the poor. Article 17 of the New York State Constitution reads: “The aid, care and support of the needy are public concerns and shall be provided for by the state.” Although many people have suggested that New York State should amend its constitution and delete the guarantee of aid to the poor, it is likely that Article 17 will prevent some of the more egregious and draconian welfare reform measures from taking effect. But while some have predicted that “New York State will remain more generous than other states” in its implementation of federally-mandated changes, concern about how much money welfare costs will continue to drive the effort to cut welfare recipients from the rolls, and because drug users are a relatively unsympathetic class of recipients, plans to deny them cash benefits will be the easiest for voters to swallow.

Sent to the New York State Assembly on November 14, Pataki’s plan would begin a process whereby anyone applying for cash assistance will be told that he or she will be drug tested as a requirement for getting benefits. If an applicant refuses to submit to a drug test, his or her case will not be processed, although if the applicant has children, the children would still be eligible for non-cash benefits such as rent vouchers, food, and clothing. If the applicant tests negative at the time of the application, the application is processed as usual (processing generally takes 30 days). If the applicant tests positive, the application is processed as usual, but the applicant is informed that he or she will receive no cash benefits as long as he or she tests positive. Upon approval of the application, the applicant is re-tested, and if the test result is again positive, the applicant is denied cash assistance (but not other types of non-cash assistance). Current recipients of cash assistance will be tested periodically, usually at re-certification, and if the test is positive, the same sanctions that apply to new applicants will be imposed — cash benefits are discontinued.

Drug treatment provisions will be the same as they are now — a social service official (caseworker) may, if he or she thinks that an applicant or recipient is seeking cash assistance because of a drug or alcohol problem, refer that individual to treatment and require compliance with the treatment plan as a condition for future receipt of welfare. The new plan creates no entitlement to treatment. In other words, if there is no treatment available, an applicant or recipient of public assistance will be denied cash benefits but not offered treatment.

New York’s plan may be used as a model as other states assemble their plans to meet the federal welfare reform requirements. Random, suspicionless drug testing of a class of poor people such as Governor Pataki’s plan requires may violate the Fourth Amendment’s proscription of unreasonable searches and seizures, the Due Process clause of the Fifth Amendment, and the Fourteenth Amendment’s guarantee of Equal Protection of the laws. But a constitutional challenge to the Pataki plan can only happen after significant numbers of people have been affected by it — by an assault on individual rights of privacy and common decency, or by cutting cash assistance to New York’s most desperately poor.

The New York State Assembly will begin debating the Pataki proposal soon. If you live in New York and you disagree with Pataki’s plan to drug test welfare recipients and applicants, you should contact your local representative and voice your concerns, organize letter writing campaigns and lobbying, and meet with others who share your views to talk about what you can do. If you don’t live in New York and are concerned about these issues, you should pay close attention to the welfare reform efforts in your own state. New York Assembly members and legislators everywhere need to know that they can’t solve the “drug problem” (addiction, crime, and poverty) by taking away the benefits that help drug users survive, and that forcing people into treatment is an ineffective way of ending addiction. Assaulting people’s civil liberties only demeans the dignity of the testers, the tested, and the protections of the Constitution.

Corrine Carey is a student at the University at Buffalo School of Law and is active in the harm reduction movement.

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2. Personal Responsibility and Work Opportunities Reconciliation Act of 1996 (PRA), passed by the House by a vote of 256 to 170 along party lines and passed.

continued on page 21
THE SPECTRUM OF HARM REDUCTION

by Edith Springer, A.C.S.W.

HIV-Related Interventions
- syringe exchange
- bleaching injection equipment
- promotion of safer sex
- referrals to HIV-antibody testing
- referrals to HIV-related medical care
- referrals to/provision of HIV
- psychosocial care and case management

Ancillary Interventions
- referrals to/provision of wide spectrum of care
- entitlements
- housing
- alternative and holistic therapeutics (e.g., massage, acupuncture, nutritional counseling)
- psychotherapy
- support groups
- healing centers (e.g., yoga, meditation, wellness work)

More Compassionate Drug Treatment
- Abstinence-Oriented Programs
  - use of harm reduction strategies to attain abstinence for those who desire it; goal of abstinence must be freely chosen by consumer; moderation goals accepted;
  - consumer treated with dignity and respect
  - Prochaska-DiClemente's stages of change
  - Motivational interviewing
  - acupuncture detox
  - slow reduction course detox
  - medicate withdrawal symptoms during detox
  - consumer sets time-frame for change: client-centered care

Chemotherapeutic Options
- non-controlling; consumer has autonomy
- methadone maintenance
- LAAM
- antabuse or naltrexone freely chosen
- anti-depressants for cocaine and crack users

Additional/Improved Drug Treatment Options
- drug substitution therapies (e.g., buprenorphine)
- medical maintenance on drug of choice (e.g., heroin maintenance)
- methadone prescribed by primary care physicians
- federal and state methadone regulations changed to eliminate over-control, infantilization, loss of freedom, and stigma, and to allow consumers to be normalized in society
- new combinations of interventions (e.g., residential methadone maintenance, inpatient acupuncture detox)
- research into experimental treatments (e.g., ibogaine)

Drug Use Management Interventions
- for those who want to continue using drugs
  - teach safer drug use (e.g., proper injection techniques;
  - abscess management; vein care;
  - advice regarding drug combinations;
  - changing route of administration;
  - safer coping;
  - substitution of less harmful drugs; (overdose prevention and management)
  - encourage more responsible drug use (e.g., more control over when, how often, where, how, and with whom one uses; taking care of business first: maintaining entitlements and housing, keep medical appointments, respecting the rules of agencies regarding drug use on the premises, buy the Pampers first!)
  - changing drug use (e.g., controlling dosage, cutting down)
  - Make related behaviors safer (e.g., prostitution; less violence)

Advocating for Changes in Drug Policy
- treatment versus incarceration; more and better drug courts
- changes in drug paraphernalia laws
- reduction in penalties for drug-related offenses
- rehabilitation and vocational training in prison

Edith Springer is a harm reduction trainer and Clinical Director of the New York Peer AIDS Education Coalition (NYPaec)
**IS IT HARM REDUCTION?**

Who sets the goals of the intervention?
How is the power between worker and consumer balanced? Is it balanced?
What is the array of choices offered the consumer?
Who decides that it is necessary for a consumer to change her drug-using behavior?
Who sets the time-frame for change?
Is consumer feedback sought? If so, is it used?
Who makes the rules and sets the structure, whether for an entire agency or in a one-on-one clinical relationship?
Who in the worker-consumer relationship is seen as competent?
Who in the organization provides services and interventions?
Who sits on an agency's governing board?
Who designed the intervention?
How is drug use viewed?
Are the intervention and the workers providing it non-judgmental?
How are consumer complaints addressed?
Who from the agency presents at conferences?
Meets with funders?
Is the intervention user-friendly?
Are the workers and consumers seen as equals?
How are consumers treated? (Harm reduction treats them lovely)

**WHAT DISTINGUISHES US AS HARM REDUCTIONISTS?**

How do we treat each other?
How does an agency treat its workers?
How does an agency treat other agencies?
Do we work in a spirit of coalition-building or a spirit of competition, greed, and jealousy?
How do we deal with workers who use drugs?
Do we enforce a tyranny of political correctness? (Judgment, bias, superiority, smugness?)
Are we able to admit to mistakes, apologize, and be open to feedback?
Are we honest or are we shady?
Do we work in a spirit of love or one of ego?
Do we have compassion for ourselves?

**SOME OF THE GOALS OF HARM REDUCTION**

Save lives
Safer drug use
Reducing drug use
Getting off drugs
Improved emotional state
Improved health and better nutrition
Better living situation
More stable income
Better social relationships
Reducing social isolation
Increasing normalization
Reducing risky behaviors
More intact, better functioning family units
Reducing violence and aggression
Greater ability to love and be loved
Higher self-esteem
Reducing stigma

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... by the Senate in a vote of 78 to 21 - with all 53 Republicans voting for it - on
August 1, 1996.
3 PRA, Title IX, Section 902.
4 "...welfare reform bill [will] reverse six decades of social policy, eliminating the Federal
guarantee of cash assistance for the nation's poorest children." The New York
5 Provisions in the PRA which would forbid the states from providing any aid whatsoever
to illegal aliens and impose heavy restrictions on aid to legal immigrants are

those most likely to be in conflict with Section 17. Recently struck down as per
Section 17 was a law that, by imposing a six-month waiting period,
effectively denied benefits to a class of primarily single adults who move to
New York from other states. Ben Dobbs, "Law restricting Home Relief aid
7 Telephone interview with Ed Colfer, Principal Budget Examiner, New York State
Division of the Budget (December 3, 1996).
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