Welcoming Address: First National Harm Reduction Conference

by Allan Clear

Harm reduction is a relatively new approach to working with drug users. We, the people at this conference, are the people defining what harm reduction is. It’s not something set in stone. It’s something that is growing, forming. Harm reduction is our perpetual revolution as we keep on adapting and changing and working through our individual needs and the needs of the people in front of us. Harm reduction doesn’t come from the top down. It comes from the person, from within us in a sense. When talking about drug-related harm, it comes out of the specific needs of the drug user. By necessity, we have to re-conceptualize harm reduction with every new situation. Of course, there’s a set of parameters or guidelines we can work with, but we have to be flexible, and we have to be totally prepared to reproduce the revolution at any particular time.

Do Unto Others: The Huwomaniy of Harm Reduction

by Dave Purchase

It’s so good to see so many of us in the same room. Make health not war.

I’m not an expert on harm reduction like Edith Springer or Allan Clear or many of the other people that we’ll have a chance to meet here. But I have been involved in some versions of it for a while and I’d like to share with you what experience has taught me are innate qualities of the harm reduction effort.
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This issue of Harm Reduction Communication commemorates the First National Harm Reduction Conference, organized and hosted by the Harm Reduction Coalition (HRC) from September 18 to 21, 1996 in Oakland, CA. The conference was truly a defining event for harm reduction in the United States. While harm reduction has been slowly gaining ground as a legitimate approach for working with illicit drug users in cities and counties across the U.S., the conference was the first time those of us who have been doing this work came together as a national force, the first opportunity we had to really look at ourselves en masse and realize that the sum total of our frequently isolated and difficult struggles to implement harm reduction had actually coalesced into a social and political movement with the potential to be a powerful catalyst for social change. This gathering was the source of a new consciousness that did not previously exist about what we’ve been doing and where we need to go as proponents of harm reduction – and what our existence means to the culture. While our past experience almost certainly guarantees that our continued fight to provide for and ensure the health needs and dignity of illicit drug users and their communities will be an uphill battle, the conference enabled many of us to believe for the first time that in fact we are quite well-equipped for the struggle. When we think back just seven or eight years ago to the ragtag bunch of us in New York City and San Francisco who established illegal needle exchange programs in our spare time and against everyone’s better advice, and to our counterparts in Tacoma and Santa Cruz and Chicago and Los Angeles and Fairbanks who were doing the same, it was impossible to stand in the Oakland Convention Center in the midst of all the progress, strength, and yes, even unity, that were palpable at the First National Harm Reduction Conference and not think that a revolution had somehow quietly transpired.

The American harm reduction movement has recently been criticized by harm reduction practitioners and organizers from abroad as “too political.” The organizers of the annual International Conference on the Reduction of Drug-Related Harm have assiduously avoided sitting one of their conferences in the United States for eight years now despite the fact that the U.S. exerts tremendous economic and political pressure on the world community to comply with its War on Drugs strategy, and despite the fact that against incredible odds and some of the most inhospitable conditions in the world, the United States today boasts some of the most advanced and creative harm reduction programs anywhere. Yet our work still goes largely unrecognized, if not outright ignored, by the international community. There seems to be a perception that because we do not have experimental heroin maintenance trials like those in Switzerland or shooting rooms like those in Bremen, Germany, that harm reduction is not happening in the U.S. The First National Harm Reduction Conference was a triumph in that it explored harm reduction in the uniquely difficult and complicated context of American life, and illustrated how harm reduction can be implemented under even the most adverse environments. As a British harm reduction practitioner we know who worked for several years in New York City before moving back to England said, “You haven’t done harm reduction until you’ve done harm reduction in the United States.”

Because harm reduction in America is necessarily political – needle exchange, for example, is still simultaneously a form of service provision and civil disobedience in most parts of the country – any harm reduction movement in the U.S. is going to also be a political movement. Because it questions some of the most basic ways our culture tells us to live, think, and interact with one another; and because it inherently challenges oppressive social and economic structures that serve to perpetuate and promote poverty, racism, violence, trauma, political powerlessness, sexism, and heterosexism; harm reduction in the United States cannot be thought of as simply a public health-based “drug policy alternative” or some other novel but equally neutral approach to a long-standing social continued on page 24
I'm here to represent all of us who believe in abstinence. That's where I come from: abstinence. Years ago, when I would come into a room and hear somebody say 'harm reduction,' I said, "You must be crazy." When Edith Springer told me, "We want to treat people with compassion," I said, "Compassion for what?" When she said, "We want to teach people how to use safely," I said, "There is no safe use. How you gonna do that?" So I left Edith, because I had bigger fish to fry.

When I did my social work internship at Kings County Hospital in Brooklyn and worked in the methadone maintenance clinic there, it started to hit me, come up on me a little bit saying, "You ain't doin' nothing, really." Every time I saw a patient, I was supposed to be giving him expert counseling and therapeutic advice, but I found myself saying the same thing over and over again: "You need to get clean." The guys and girls were just looking at me like, "You told me this last week. Give me some solutions. Give me some answers." And, quite frankly, that's how I came to harm reduction. I came to harm reduction kicking and screaming.

Most of us came to harm reduction through HIV. 'Cause if wasn't for HIV-disease, you wouldn't have told me nothin' about no harm reduction. See, I'm from Bedford-Stuyvesant in Brooklyn where drugs is everywhere and can't nobody tell me that you can solve this problem other than by removing it. So I came to understand as time went on that my job was really about healing and not about curing, not about changing, and not about determining what other people's paths should be. Now, this is really hard because I went to social work school and substance abuse counseling school and they didn't tell us that! They said, "The patient comes in. The patient is helpless. You sit the patient down and you teach the patient how to stop using by any means necessary."

Speaking of Malcolm X, and as a person who has followed the teachings of Malcolm X, one of the things I've learned is that it's okay to be wrong. I was one of those domatic counselors, you know: "I came up the hard way and so can you." I was from the Clarence Thomas school of substance abuse counseling. But the arrival of HIV-disease turned me around. HIV-disease made me confront myself and ask, "What is more important? That people stay alive or that people not use drugs?" And then I heard Dave Purchase say, "Dead junkies can't get clean." Dave and Edith taught me about bleaching needles and so forth, and these were the culprits who got me involved in harm reduction.

My whole thought pattern at that time was, "If I could just fix this. If I could just fix this." There was no way to analyze or even conceptualize a solution to the drug problem or a solution to drug availability. Wonderful, we keep people alive and we begin to look at substance abuse as a public health issue, but really for the whole society of users and communities of users, we're still pretty much at a loss. What I had to do was really start looking at me and start examining how I was thinking about stuff.

Now, I believed that abstinence was the only way to work with people who use drugs. I thought that users couldn't hear me. Users can't hear me! Users can't do anything while they're using drugs! I started to feel dishonest about the fact that I was really doing nothing about the consequences of heroin use for my patients in the methadone clinic. In fact, I could sit and talk to a patient for 30 minutes and listen to all their stories about how they got the most recent abscess and how their partner just overdosed, and how so-and-so did this, and all I could do was sit there and say, "If only you would stop using drugs, all that would change." Which I found out later was a lie. I had no information about how to help people use safely. None, except the bleach concept; no information on how to help people to have a better life.

I was also one of those people who, despite my own experiences, was hooked on the media, and the media will lie to you. You know how the media makes you think about...
drug users: like this little, singular, pernicious snake in society, just waiting around for you to leave your pocketbook on the chair. There is no use for drug users in society because all they want to do is use. And after we use, all we want to do is chill. That's all we do: use and chill. But I began to see some pretty productive people coming in to talk to me, and the main topic that people wanted to talk about was the differences in society. Poverty was a main concern for a lot of people: "I don't have the money. I don't have the opportunity." I know some people say, "You got the money to buy drugs." That's a whole separate issue, believe me. Or, "people use welfare money to buy drugs." I don't know how many of you have been on welfare, but they ain't really tryin' to give you money to be reformin'. It ain't that much money!

Drug use solved a lot of people's problems in society, particularly around poverty. It helped people feel better about the fact that their family was deteriorating. It helped people feel grandiose instead of in despair. It helped people have social networks and recognition and so forth, and be respected in their society. I also saw, because of the illegality of drugs, a lot of frustration. I was talking to a brother the other day who has been to jail every year for the past eighteen years. It doesn't make any sense — every year for eighteen years! Get a clue! That kind of frustration leads to aggression. Folks start picking up guns and drinkin' forty ounce.

As a counselor, I had a very low success rate. And you know how in in-patient treatment they tell you, "Out of you ten people, only one of you is gonna make it." And you talk about don't set up envy and jealousy! You tryin' to kill the other nine people! So, what I really had to come to terms with was the fact that, sobriety ain't for everybody. How could that be? As a public health worker, as a person who provides and cares for the public health of society, I had to ask myself the simple question: "What about the other 90 percent? What about the 90 percent for whom abstinence didn't work?"

So for me, harm reduction was just a trip to looking at different ways of doing things, multiple strategies, and little by little I have learned more about harm reduction and I accept more about harm reduction. But it has been a slow process with me, and I am thankful to people for being so patient with me, because I believed in the dry cleaning drug treatment system, and I still do. Drug treatment, I always say, is like dry cleaning: you take your clothes in, and they tell you if there's any stains on anything — that's the assessment part. You get your clothes cleaned, you go pick them up, and that's what drug treatment is like. You go down there and you do your intake, you come out, and you're supposed to be fixed. It has always behooved me to ask why anyone who was using would not rush right on in, drug treatment being such a simple process and one that is so readily accessible to most people.

So, I began to think about things, and I sat down with other people in HRC's Harm Reduction Working Group and we asked, "How about teaching people how to manage their drug use?" That was a big one for me. Because the old me would have said, "Buy the Pampers first? Why would I want to do that? See, 'cause if I spend my food stamp money on these Pampers, I will get money when I sell these Pampers on the street." That's what my mind said. Impossible. Until I actually began to try it and use it and think about it, and find out that people not only can do it, but want to do it, and feel better about themselves when they do it. I was amazed. I didn't come to

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harm reduction saying "Yippee!" I was like, "Uh-uh, that ain't gonna work." But I'm telling you, I tried these different things and tried to develop my own things in different cases and it worked.

I began to think about drug users in a different way. Drug users have families. Drug users are employers. Drug users have jobs. Drug users want to stay healthy, and the access

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My Journey
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to services we offer should not be regulated by whether or not you're using. That was something that even way back, I couldn't agree with. For a lot of services, users can't even get in. Drug users pay taxes, and therefore drug users should have the same quality of services as everyone else.

Harm reduction is a form of social justice. That's all it is. It really ain't that complex. It's a form of social justice that talks about the quality of life for each and every individual, period. It's just that simple. And when we look at how we're doing business now, with the current drug policy, social control, the fact that people are saying that needle exchange is going to increase use — which is dumb. Now that don't make no sense, like some people are gonna see a needle exchange and decide they wanna be a heroin addict or shoot some cocaine. Harm reduction, on the other hand, has so many benefits that even on your worst day, even on your best abstinence day, even on your 20th AA anniversary, you can't beat harm reduction.

Now, you know I'm gonna talk about black people and Spanish people. Let's be realistic. It's a whole, complex different ballgame when we're talking about black folks and Latin folks. Because the effects in the community are different. Arrest rates are different. There is going to be discussion this week that in our community, we see drugs as a barrier. It keeps us away from all that good stuff like family life, ambition, achievement and so on. Now, for you white people, I must tell you: y'all use most of the drugs. Y'all just don't go to jail. Y'all live in nice neighborhoods, you have social acceptability and employment, and financial status — and some of us black folks be livin' there too. Y'all come from that, but we come from this. It's no wonder that most of the jails are filled with African-American men.

When you go into the black community and talk about harm reduction, you got a whole other ball of wax to deal with. All people can tell you is, "Reduce this. Reduce these police taking me to jail. Reduce my brothers and sisters doin' time for a hit."

What is it with police and black people? They live in our neighborhoods. That's all they want to do is come see us all the time. So, we're the one's who end up going to jail. When you go into the black community and talk about harm reduction, you got a whole other ball of wax to deal with. All people can tell you is, "Reduce this. Reduce these police taking me to jail. Reduce my brothers and sisters doin' time for a hit."

I hope one day we'll have harm reduction centers all over the country. I have my feelings about harm reduction and abstinence being in the same building. That's a whole other issue, but I do hope that someday harm reduction will be the norm and I think through the work of the Harm Reduction Coalition and people like you, and those of us who get mad at each other and cuss each other out and all that kind of stuff, we're gonna have all that in harm reduction. Everybody thinks that they're in charge. Everybody thinks they're right, including me! With all that, you know it's gonna be a mess. But if we don't do it, nobody's gonna do it. Somebody's got to make the change.

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Competency, "Compliance," & Contracting:

Using Harm Reduction to Engage HIV+ Drug Users in Medical Services

by Catherine Lyons

I work at San Francisco General Hospital in the AIDS clinic, and some of us have actually been doing harm reduction for a long time but only recently have developed the language to articulate that and integrate it into our practice. I’m going to talk about some of the issues and challenges involved in using harm reduction in an out-patient medical setting, and I’d like to start by describing something that’s been going on for the last nine months or so in HIV care. We have all these new drugs—protease inhibitors. We have a new way to monitor patients called the viral load test, and as a clinician this has been exciting. In clinical practice, we like to have clear algorithms; we want to have objective criteria to guide our treatment decisions. Looking at viral load and T-cells is crucial, but it’s only a piece of the picture.

There are a lot of drugs that shouldn’t be taken with protease inhibitors. The protease inhibitor ritonavir (Norvir®), in particular, has a lot of drug interactions, as do both saquinavir (Invirase®) and indinavir (Crixivan®). Ritonavir interacts with a lot of psychiatric medicines. It interacts with a lot of narcotics. Of course, we have no idea what the interaction is with street drugs. And anyone who works with people on methadone will tell you that methadone doses have to be adjusted when a person starts taking ritonavir.

The other thing that people are probably familiar with is that indinavir, for example, has to be taken every eight hours on an empty stomach, and you’re talking about people who are already taking a lot of other medicines. Personally, I would find such a regimen extremely difficult. So, we’re asking people whose lives are maybe disorganized and chaotic already to add this new stress into their lives, and that has to be part of the algorithm.

Another thing is that ritonavir has to be refrigerated, so you need to make sure that the person has a refrigerator if you’re going to prescribe this medicine for them. The focus must be on the whole person, not just their virus. A lot of the people that we work with who are actively using drugs may also be mentally ill or have other concomitant issues, be it homelessness, be it chaotic social situations. There are behaviors that people have — like not keeping appointments, coming late, not following through with procedures that are recommended — that cause them to be defined as “non-compliant” patients. And there are some people out there in the medical field who have said, “We cannot give any of these people protease inhibitors.” There’s a whole blanket population of people who may be being ruled out in terms of certain treatments for HIV disease.

A lot of people hear harm reduction and what they think you’re talking about is giving people what they want. They don’t see it as meeting people where they’re at and working with them. What we do in terms of trying to integrate harm reduction into our medical practice is making it happen on an individual level, in terms of specific tools that we can utilize in managing patients in the clinic. Hopefully, someday it will also happen administratively, and it is happening a little bit, but there are lots of challenges there.

Harm reduction is the kind of thing that providers need to hear. It seems very basic, but I think we all know that health care providers don’t always treat people with dignity. We don’t necessarily believe that everybody has the right, equally, to comprehensive medical and social ser-

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We need to remind ourselves of the fact that the outcomes are in the hands of the patient. We are not dealing with children. We are dealing with competent adults.

One of the hardest things to get at is the realization that at the heart of harm reduction is the patient/provider relationship. This is where you cannot use algorithms. You cannot say, “This is what harm reduction is and this is how you use it in your setting.” Some of it is retraining and changing people’s thought processes, and it works because you have a relationship with the individual. It doesn’t work if you don’t have a relationship with the individual. As has been repeated over and over again at this conference, historically, drug users who refuse to come into the system do so because they have been treated really, really badly. They come in expecting to be treated badly, and more often than not, their expectations are met. It is therefore incumbent upon us as providers to work with that individual and say, “You know, it doesn’t have to be that way.” However, I feel like I need to prove this to the patient.

There are things you want to talk about early in the relationship. You want to be clear about the boundaries of the relationship, meaning how and when they can reach you, how the clinic works. You just need to be very clear about how and when a patient can expect to get care. You also want to find out who the other people in the community are — other providers or outreach workers, maybe — with whom your patient works and who they trust. That’s an important link in working with individuals who, at first, may really mistrust you.

Another important piece is to establish goals together. When somebody walks into my clinic and they know they’re HIV+, they may or may not know what their t-cell count is. I’m not going to sit there and say, “Okay, this is your t-cell count, and now I’m going to tell you what to do.” I’m going to sit down and talk to them and say, “What is it that you want here today?” And it may be that they want a letter of diagnosis so that they can access social services. They may be totally disinterested in antiretrovirals at that point in time, but if I work with that person in terms of what their goals are today, then ultimately, they may choose to engage in treatment.

So again, I think a lot of this is basic for people who are involved in harm reduction. However, people are as uncomfortable talking about drug use as they are talking about sexuality. A lot of it is our own personal ignorance. I am not an intravenous drug user, so if somebody comes and tells me something and I don’t understand what it is they’re doing, I ask them. I’m not embarrassed. It’s not something to be ashamed of. In fact, people appreciate that. I think that we also need to appreciate people’s honesty and forthrightness, and understand that it is ridiculous to expect complete honesty from the get-go; people have been punished for telling the truth, and it’s going to take them a long time to decide whether or not they are going to choose to trust you. I think there are ways, however, of asking questions in an open, non-judgmental manner that will encourage someone to divulge at least a certain amount of information that you need, and you need a lot of information to provide good medical care.

Many people will tell you that they know what is going to come out of somebody’s mouth based on what their body language is. Body language is important. Some drug users are used to being treated like “junkies”: people don’t want to touch them. Verbal language is also very important. This is something I have really struggled with with my colleagues. Words like ‘compliant’ and ‘non-compliant,’ words like ‘drug-seeking’ carry a lot of judgmental weight — even when said behind a person’s back. We have to be very careful how we use words. Being a harm reductionist is to be patient-centered.

Finally, I’m going to share a couple specific harm reduction strategies that we have used in our clinic. One of them is something that we euphemistically call “co-management.” I don’t know if that’s the right word, but basically it refers to a
multi-disciplinary approach. In a medical setting, the doctor is historically the focal person, but what our approach tries to do is spread that out, and to acknowledge that a person’s medical situation is not, first and foremost, their most pressing concern, and that a social worker, outreach worker, drug counselor, or friend may be integral in terms of dealing with that person. We have a form that identifies who all these people are, and that sets up goals in writing.

There has been a lot of talk about pain management, and this is something that we need to educate our fellow nurses and doctors about: number one, it is really important to diffuse this issue from the get-go, and one way you diffuse it is to assure people that they’re going to be comfortable, and to make sure that they understand that you believe what they’re saying about pain. It’s important to get a little bit of a sense about what a patient’s belief system about pain is. Occasionally what they say and what you observe may not completely match, and then it’s better to bring that out into the open instead of walking out of the room and saying, “This person is just trying to get drugs out of me, just trying to con me.”

Other really important information that providers don’t know is that people who are on medication often aren’t getting adequate pain medication. I use drug contracts a lot, and a drug contract is a document signed by both the patient and their provider. It states that the patient agrees to get her medicines only in the manner, frequency, and amount pre-agreed upon. It’s a partnership: the agreement can be modified as needed via a discussion between the patient and her provider. There is a sense of predictability. The person knows that every week or two weeks, or every month, they can come in and get their medicine. This prevents us from having to focus on the person’s anxiety at every single visit — “Am I going to get enough pain medicine?” — and allows us to focus on other medical issues. The details of the frequency and the quantity of pain medication that’s been agreed upon with the primary provider are documented on the chart.

Administratively, people with disorganized, chaotic lives need drop-in, urgent care seven days-a-week, integrated social services on-site so that they don’t have to run somewhere else to see the social worker or whatever, and outreach and satellite clinics. And last but not least, there must be an administrative policy that says that abstinence is not a criterion for receiving care: you focus on people’s behavior when they come to a clinic, and not on whether or not they’re sober.

Catherine Lyons is a nurse practitioner in the AIDS Clinic at San Francisco General Hospital. She has worked as an NP with people with HIV since 1985, and with drug and alcohol users since 1976.

First National Harm Reduction Conference
Audiotapes Available

Audiotapes of all plenary and breakout sessions of HRC’s First National Harm Reduction Conference are available individually or as a complete set from the Conference Recording Service.

Call them at (510) 527-3600 for a price and title listing.
On the Death of Nelly Velasco

by Anonymous

I picked up the last edition of the Harm Reduction Coalition’s newsletter from my mailbox on my way to work on a Wednesday night, sort of excited because a friend had written an article in it. Silly, but I wanted to see it in print. I saw articles written by others that I knew in the movement, including one by Nelly Velasco, but I went back to those later. The last time I had seen some of these people was in September at the First National Harm Reduction Conference in Oakland. When I paged back to Nelly’s article to read it, what first caught my eye was the box of type below it in italics. Nelly had died of an overdose shortly after the Oakland conference.

I sat there at work shocked and stunned. This wasn’t the first time. And there hasn’t been any typical way to get the information. Over the phone, email, now the newsletter. Why didn’t I hear before? And how could this happen to another one of us? And then, that question that comes after each one of these deaths: who’s next?

I thought about all of the letters in my head that I wanted to write after each death. Angry letters about the harm caused by the illegality and social stigma attached to heroin use—and the dangers of shooting alone caused by such stigma. My argument has been time and time again that if more people knew and cared (and not in some sick “tough love” kind of way, but really cared, “watched her back”) he or she wouldn’t have had to die. I’ve argued with countless people that, ‘No, it wasn’t a suicide. Sure, you can get depressed as a heroin addict, but she didn’t kill herself.’ ‘How do you know?’ they often ask. ‘There were three bags left on the table,’ I’ve said. ‘If she wanted to kill herself, she’d’ve shot all of them, not saved some for later.’ But this time, maybe in part because of my own struggles with heroin in the past year (but not because of any feelings I have about Nelly’s own use—I don’t want anyone to misunderstand me) I am thinking more about me, my use, and the way we all use the drug.

The harm that comes from illegality, the social stigma—all of that I still believe in. But I also think that we all need to start understanding what fucking role harm reduction plays in our own very valuable lives. I don’t want to see another one of my friends or colleagues in this movement die. This statement is trite, I know, but I think all of us feel this way. But I also don’t want to see another one of us so fucked up that we can’t even keep our eyes open for a few minutes. So fucked up that we can’t talk to one another. So fucked up that we start neglecting important health care concerns. I feel that whenever I get high, I have a responsibility to try as hard as I can not to fucking OD.

Now, I know that most supposed “ODs” are not ODs at all. The deaths can be caused by poison in the cut or some other adverse reaction. And I know that overdose deaths are often caused by the fact that the user didn’t know the strength of the dope he or she was shooting. But sometimes, sometimes, the deaths are because we just use too fucking much.

I know because I have been there with friends who have done just that. And thank the goddess that I was there or they would have been gone. Lost to me. I saw them shoot too much, nod out, and start to fade. I’ve done the ice tricks and the slapping, pulling the person to their feet and threatening, ‘I’m calling 911, motherfucker! Wake up or I will call 911! Talk to me, say something, say I am over-reacting and ruining your high or I will call 911!’ And once I did call 911. But I was there, you see, and they’re still here with us.

But Nelly isn’t. And neither are some other very important activists and thinkers and people we cared very much about. Now I’m on my soapbox, recognizable to the friends who’ve heard me admonish them before:

➤ Try not to use alone. (I know, I do too. Heroin is sometimes an “alone” kind of drug.)
➤ Please moderate what you shoot. You don’t have to get so high that you can’t even feel it. (I know you want to sometimes.)
➤ Test the bag. We tell our exchangers to do that, don’t we? It just takes a little patience.
➤ If you’re shooting 10 to 15 bags a day (East Coast lingo—sorry, take a break. You know, the high is better when you start using again, anyhow.
➤ If you start to get in over your head, if you need a break or whatever, call one of us. We’ve started this whole damn network, haven’t we? I envision that as being a place of refuge, an ear at the end of the phone, a couch to crash on.
➤ And if you want to stop for good or for now, traditional treatment is not your only option. There are people you can access who know about alternative therapies and herbal remedies and harm reduction techniques. These methods don’t work for everybody, but hey, neither does 12-step.

Chances are I don’t know you and I haven’t gotten high with you, but chances are that I have. Either way, it would break my heart to read about your death from an overdose next month or next year. And we can’t afford to lose you.

The author is an East Coast professional who, owing to the political and social climate currently surrounding illicit drugs, is regrettably unable to reveal his/her identity.
This is a historic meeting. I believe this is the biggest gathering of harm reductionists ever, and that’s really exciting. A thousand people will pass through here to share their experiences in the next few days. The people at this gathering are a testimony to the diversity of this movement. We have policymakers, we have academics, and we have law enforcement people here. We have researchers. We have people who work in drug treatment. We have drug users and activists. We have front-line workers. We have to strive to keep that diversity and keep that strength and remember that we are all the experts. No matter where we come from, no matter where we study – whether it’s the streets or the university – we have become the experts about our own lives.

Yesterday, I had the opportunity to hear Mayor Harris, Oakland’s Mayor. It’s a shame that he’s unable to be here today. His remarks were courageous and bold. He was clear and direct about the need for harm reduction in the community and the need for us to nurture each other, and he understood that harm reduction is a life-giving and life-affirming thing. That kind of leadership gives me hope that we can recover from our losses of the last few years.

The Harm Reduction Coalition (HRC) came out of a vision of people working in harm reduction that there was an alternative to the current set of norms. HRC was formed to turn that vision into reality, and I think quite simply that the goal of HRC is to effect change so that harm reduction becomes the national approach to drug use and drug users in the United States. The way that HRC wants to do this is through three main programs, or avenues. First, we concentrate on the development of resources for service providers and drug users. There’s very little support, very little information — or very little reliable information — about drug use and about how to reduce the harm related to drug use, and about what some of the solutions are to some of the problems related to drug use. We’re also creating a training institute so that we can help support people as they go through the change of implementing harm reduction within their agencies and within their communities and within their lives. That feeds into the third avenue which is community organizing, and let me make it clear that we don’t believe change comes from the top. I think we’ve seen through the political process that we are not going to get anything given to us. We cannot even get equal access, democratic access, to HIV prevention materials for all people in this country. So, we’re not going to get it given to us, and what we have to do is work from the ground, from the grass-roots, and the training institute is a way of augmenting that — to effect change within service provision so that basically the laws become untenable because we’re doing this work, and it becomes clear that what’s current policy just does not make sense. Over the next year, after this conference is over, HRC is going to spend time building upon what comes out of this conference — the networking, the community organizing, the ideas — so that we can translate a person’s ideas from Kansas so that a person in California can use those ideas. And we are going to try to facilitate a process whereby we don’t all work in isolation. I think that’s partly what’s important about this conference. In some instances there’s only one or two people representing a whole state. A lot of what we do is not validated because we work in isolation, and people think that because we do what we do we’re kind of whacked, and that’s not true. We’re just a little bit ahead of our time. So this coming together and recognizing what we have in common, recognizing the humanity we feel within our work, and realizing that the work we do is important is crucial to our being able to continue to do it.

HRC’s other main function, as far as I’m concerned, is to facilitate the voice of drug users. We believe that you cannot have a dialogue, that we cannot provide solutions or move forward unless all voices are at the table, and all the people are at the table.
And drug users have been excluded totally from the dialogue and HRC wants to facilitate that voice. Our communities can no longer tolerate in silence the decli-
mation that has gone on - the unnecessary deaths, the disease, the jailings, the withholding of services, the withholding of pain medication, the break-up of families: it's like family values don't exist when it comes to us. The whole lack of treatment opportunities and the stigma that goes through everything we do. We can no longer tolerate or accept that as the norm. When we, as a community, agitate for access, or we develop our own education, when we take control of our own services and our own lives, we do so as a form of self-defense.

I think the tone for this conference was set yesterday with the drug user town meeting; the first ever national meeting of drug users who came together to talk about how to organize and work together for their own self-defense. That 40 or 50 people showed up to the meeting was a triumph. That was a great gift to the movement. There was also a methadone consumers meeting. People on methadone are stuck right in the middle: they're stuck with the stigma of drug use, they're not accepted as people in recovery, and they're not treated with the respect that people in 12-step programs get as individuals who have courageously taken on the issue of drugs in their own lives. We talk about deregulation, and how we're trying to get the government out of our lives — which I actually see as an abdication of responsibility on the part of the government — but if we're going to take that premise, then we need to recognize that methadone is the most overregulated drug there is. We would not tolerate what goes down with methadone if it was Prozac. You don't go on a waiting list for a year to receive Prozac, and I don't see why we should accept that when it comes to drug treatment. And then there was the town meeting that was put together and held for those people who have had a history of drug use and no longer use drugs, because historically, within the harm reduction movement, people in recovery and people in 12-step programs have been in the forefront. And there are many issues that surround that in terms of a lifestyle choice and the occupational experience of people who live a life of abstinence, and their issues came up in that meeting. For me, I think what is important is that these three groups of people have so much in common, and as we grow as a movement, we have to look at how to bring all this together. These different groups are like tributaries of a large river, and we need to realize that we're not going to be a majority in this community. We are activists for a minority position in many ways, but we also need to realize that the minority can have a lot of power. But for us to develop and hold on to power, we need to bring all the streams together. And although I just focused on the users, and the people on methadone, and the people with a history of drug use, the researchers, and academics, law enforcement people, and service providers are kind of like the oil in the machine. We have to translate the ideas into action. We have to take it back to our agencies. We have to take it back to law enforce-

ment. I think whenever we hear someone like Nick Pastore talk about what he's done in New Haven with community policing, not only is it courageous, but, in the way he talks about it, it's been smart on crime. And I think we need to reconceptualize our language so we can take this back and enact all of our ideas and put them into practice. This conference is about how we can all work together, how we can look at what's common in our experiences and not at what our differences are. What do we have in common and what can we achieve?

One of the things we desperately need is for the researchers out there to develop outcome measures for harm reduction. Researchers: think about that over the next four days. We need that desperately.

We're in California, and as I said before, the City of Oakland is really supportive of what's going on at this conference, but generally, the people of California don't live in a supportive environment. Take the experience of Santa Clara this year when Dan Lundgren came and shut down their needle exchange program; and look at how wrong and malevolent Pete Wilson is that he should turn around and take away what communities have decided they want! And then there's the cannabis buyers club bust in Los Angeles two days ago, built upon the cannabis buyers club bust in San Francisco earlier this month. The fact that Donna Shalala and Barry McCaffrey and Bill Clinton
think it's threatening enough to
come and campaign in California
is an even better reason to support
the medical marijuana campaign
and California should vote "yes"
for medical marijuana.

I hope the people who have
worked so hard on the medical
marijuana campaign here in
California take that momentum
and turn it toward creating addi-
tional access to AIDS care for
people with AIDS and people
with chronic illnesses. I think we need
to look at how we address access
to care for people who use drugs
around medications for HIV-dis-
ease. We need to agitate further for
proper pain medication for people
who use drugs. We need to agitate
for access to protease inhibitors
and other AIDS therapies for peo-
ple who use drugs. We need to
agitate for clinical trials that
include illicit drug users. So I hope
that the effort and energy that's
being put into the medical mari-
juana campaign will be used to
further some of these other activi-
ties.

As we go through the next four
days, let's look at the little tri-
umphs, let's look at the happiness
and the productivity. We are the
people who are providing the
solutions. We are not the people
who have just thrown up our
hands and said, "just say no." We
are the people who have taken a
step forward in saying there's a
basis in our communities, there's a
basis out there, and there are ways
to deal with it. We are the people
with the solutions in our hands,
and over the next four days let's
look at that. Let's look at the tri-
umphs. Let's look at the way we
can really change things. Let's
look at each other. Let's be proud
of who we are and let's be proud
of each other.

Allan Clear is the Executive
Director of the Harm Reduction
Coalition.

Beyond the Disease Model:
Clinical Psychology
and Substance Use
Management

by Patt Denning, Ph.D.

I'm going to talk about some
comparisons between traditional
chemical dependency treatment ideas
and practice, mental health ideas and
practice, and harm
reduction, and how
these all interact.
When I was in school
— and probably when
most of you were in
school — I didn't
learn anything about
chemical dependency.
Nobody taught it to
me. I was a clinical
psychologist. I didn't
work with those peo-
ple, so there was noth-
ing for me to learn,
supposedly, about
chemical dependency.
Then, once schools
started putting chemi-

cal dependency cours-
es into the curriculum,
what a lot of my colleagues
learned was the disease model.
I really think
there is a conspiracy in the education-
al system to keep people from being
aware that there are a number of
other models of addiction that have
been around in this country even
prior to harm reduction, models
that can collectively be called 'adaptive
models.' They include psychoan-
alytic, psychodynamic, cognitive behav-
ioral, and moderation management
approaches — all of these different
kinds of treatment interventions.
Since nobody told us about them in
school, I'm going to talk a little about
those distinctions here.

The disease model and
its attendant treatment
modality —
AA and other
12-step programs
— has become the
dogmatic basis
for public policy,
professional intervention,
and societal understanding.

We as clinicians have been abandon-
ing our patients and our principles to
the disease model. Because of very
real, historical failures to adequately
consider substance abuse in our
work, we are now being told that we
have no place in the treatment of
these problems unless we adhere to
the principles of the disease model.
As a result, we abandon our patients
to a program of rigid beliefs and
hunches about the nature of addic-
tion and the nature of recovery. We
further abandon our patients and our
principles by using heavy confronta-
tion of denial at the beginning of
continued on next page
Psychology
continued from previous page

poverty. These are the people who
really suffer the most.

Now, the interesting thing about
this being a biological disease is that
for supposedly about ten percent of
the population of America, there will
be a lifetime prevalence. That is, ten
percent of the population will de-
velop alcoholism over the course of their
lives. Of course, the alcohol industry
loves this, and the liquor industry is
one of the primary supporters of the
disease model. Why? Because, if
only ten percent of us in this room
are going to get the disease of alco-
holism, then most of us can use their
products as much as we want and as
often as we want. Only ten percent of
us are going to get it. Furthermore,
because it has nothing to do with race
or class, the liquor industry can do a
service for the poor, ethnic neighbor-
hoods by loading the corner stores
with high potency beers, malt
liquors, and fortified wines, because
these people are poor and can’t afford
the more expensive stuff. “We ought
to help ’em out by making this stuff
cheap, strong, and affordable
and only ten percent are gonna get
addicted.” This is what happens
with the economics of the disease
model in our society.

The adaptive models, which
again include psychodynamic, psy-
choanalytic, and cognitive behavioral
models, start with the idea that drugs
are used for many purposes and with
many consequences. They un-
derstand that there is such a thing as
recreational use, and such a thing as
self-medication, and that the out-
comes of drug use may be good.
People may get real positive benefits
from using drugs or alcohol. Outcomes may also just be
benign, maybe neutral. They may also be dis-

astrous. There is a range of possibili-
ties. Another belief is that drugs usu-
ally solve a problem rather than cre-
ate one: that drugs work. A hundred
thousand heroin addicts can’t be
wrong. Drugs work for whatever the
person is trying to find a solution to,
and most people do search. They
engage in an active search for the
drug of their choice. Economics and
self-medication cause people to
become poly-abusers. But, for the
most part, folks have something that
works for them.

Later on, of course, it comes back
and bites you in the butt. People who
develop severe drug problems do so
by an accident of pharmacology. The
truth is that if I, my dog, or any of
you use enough of a substance over a
long enough period of time, we’re all
going to get addicted. That is not
interesting to me. That is an accident
of pharmacology, and there’s not
much more to say about that. What is
interesting is, “Why might I use a huge
amount of a certain drug over a long
period of time?” That’s what’s inter-
esting. Why would anyone do that?

Many people recover with little
or no help from us. Another

important thing
in clinical models, adaptive
models, is that people who use
and people who don’t use or abuse drugs,
or people who are addicts, are all
understandable by the same concepts
that we use to treat other people.
There is no difference between
people who use and people who don’t
except for the behavior. The psycho-
logical principles do not need to be
special in order to understand people
who get into problems with drugs.

One of the things that has hap-
pended with the disease model, due
in part to an antipathy toward profes-
sionals, is that there has developed
what Stanton Peele calls “the cult of
the addict as expert” in which profes-
sionals have been pushed aside and
the addict is recognized as the only
person who can understand. I think
what happens with a lot of adaptive
models is turf wars: first the psychologists and then the social workers try to muscle their way back in and say, "No we're the experts." So we have an active fight between who's the expert, the addict, or the mental health professional. Harm reduction manages very nicely to heal that division.

The other thing that is very important especially for psychoanalytic and psychodynamic thinkers is that substance abuse is very often seen as a symptom, and I'm a psychodynamic person so I believe that too — that there are underlying, root causes to people's problems with drugs. However, it is not true that the pharmacology of the drug is not important, and it's not true that we mental health professionals don't need to know specific information about pharmacology in order to be helpful. For one thing, once a person becomes persistently addicted, not just casually addicted, that addiction develops what's called 'functional autonomy.' It becomes unmoored from any psychodynamic or emotional underpinnings and develops a life of its own. Before you get into that much trouble, there are triggers for substance use. Once you develop functional autonomy, there aren't any triggers anymore: life is a trigger.

If I am an alcoholic, and I am persistently addicted, maybe I used to drink after a fight with my girlfriend, maybe I used to drink after a hard day at work, but now I drink when I feel good. I drink when I feel bad. I drink when I want to have a drink and I drink when I don't especially want to have a drink. It's become unmoored, and if we're going to treat people who have that functional autonomy in their addiction, we have to realize that there are certain harm reduction techniques that are more useful with some drugs than with others. This is usually a function of the pharmacology of the drug more so than the person who is using. For example, the technique of reducing the amount of the drug used at any one time is very helpful for longer-acting drugs like alcohol, heroin, and sometimes amphetamine. Crack cocaine, however, like nicotine, is a rapid-onset, short-acting drug. The abrupt rise and fall of levels of the drug in the brain cause intense feelings of euphoria followed within about 30 minutes by equally intense feelings of depression. The abrupt mood changes are very compelling and very reinforcing to the user. It is extremely difficult for them to limit the amount they are using given this experience. What works better is to help them reduce the frequency of using crack, rather than the amount, at any one time. Using drug holidays or drug substitution several days a week is more likely to work for the person to reduce the harm done by crack over time.

Harm reduction reminds me of the Hippocratic Oath which states — and physicians take this oath — "Do no harm." That is the first principle in medicine, and embedded in the rest of that oath is the agreement that you will actively help. So, do no harm and actively help: that's precisely what harm reduction does. Harm reduction has very little opinion on whether the use of a drug is pathological, and focuses instead on the negative consequences of use to the person, their family, and society. Harm reduction also manages to very neatly avoid the "nature/nurture" controversy. It matters not whether this is a biological disease, or the result of faulty learning, or the result of a trauma. What matters is that damage is being done to the person.

Harm reduction has a focus on the rights of individual users to make choices and along with that, their right to sensitive, appropriate assistance with drug-related problems on their own terms. Harm reduction is organically based on cultural, racial, ethnic, and gender differences. It is amazing. It is unlike any other public health movement in this country: from the beginning, intimately interwoven from the grassroots up; it is diversity. We are truly the tribes of the United States here. We are truly the United Nations. Harm reduction also gets rid of the split between the importance that the user brings to educating the treatment person, and the expertise that the treatment person brings to inform the addict about what might be going on. Harm reduction encourages and celebrates the expertise of users and workers.

Finally, harm reduction is based on an awareness that the user may have other, more pressing needs than drug abuse. They may have housing needs. They may have funding needs, or child care needs. The user may have all sorts of other things that they need and want to talk about. This is the basis of consumer-driven services: that we as workers, we have the responsibility of developing a needs hierarchy for the people under our care that is based on their assessment of their needs more often than our assessment of their needs.

Patt Denning, Ph.D. is a psychologist in San Francisco and Oakland. For 16 years, she was the director of several psychiatric clinics in San Francisco and is now in private practice. Patt has developed an alternative approach to the treatment of substance use disorders called Addiction Treatment Alternatives, which is based on harm reduction principles and uses traditional types of psychotherapy. Patt also teaches at the San Francisco School of Psychology and is involved in post-doctoral training of psychologists in her model of addiction treatment. The author of the monograph Triple Diagnosis: Patients with Co-occurring HIV, Substance Use, and Psychiatric Disorders, Patt is working on a book about her approach to addiction treatment.
In response to evaluations from the First National Harm Reduction Conference and to numerous requests for intensive training in areas of harm reduction practice, the Second National Harm Reduction Conference will offer more interactive sessions aimed at helping participants build practical skills, while leaving adequate time and space for discussion.

In addition to the main plenary and break-out sessions, the following events will also be held in conjunction with the Second National Harm Reduction Conference:

Pre-conference Training Intensives: October 6, 1998 — Intended to provide participants with in-depth training and skills building on a variety of harm reduction topics. Will require pre-registration, as space is limited.

Pre-conference Meetings: October 6, 1998 — These caucus meetings will enable members of specific communities or those interested in particular issues to meet and organize for a full day.

Evening Forums and Cauluses — Meeting space will also be available each evening of the conference for community organizing, networking, and caucus meetings.

Cleveland was selected for its central location and proximity to other major Mid-west cities including Chicago, Milwaukee and Pittsburgh. Look for a registration booklet during the summer of 1997.
Program Development
- designing and implementing harm reduction programs
- incorporating a harm reduction approach into existing direct services
- designing interventions for specific populations of drug users and those affected by drug-related harm
- presenting the complex issues faced by harm reduction workers and programs, including working with and supporting staff members who use illicit drugs, managing stress, and addressing bereavement

Practical Harm Reduction
- implementing substance use management and safer drug use strategies
- developing overdose prevention and response plans
- providing practical medical information for drug users

Clinical Issues
- developing effective therapeutic relationships with individuals who use drugs; defining harm reduction-based standards of care in clinical practice
- using a harm reduction approach in counseling, case management, and social work models
- incorporating information and feedback from consumers in the design of direct services and policy

Policy Design
- creating harm reduction-based policy, from the development of operating and personnel guidelines for direct service programs to implementing community-wide public health and social policy

Harm Reduction Theory
- exploring the relationships, consistencies, and differences between abstinence-based and harm reduction-based models for working with drug users
- identifying the goals of and measures of success for harm reduction-based interventions
- meshing traditional drug treatment and harm reduction approaches
- exploring issues of spirituality involved in harm reduction

Community Organizing
- facilitating and supporting the self-organization of current drug users, former drug users and methadone consumers to impact public policy, reduce social isolation, and build a supportive community
- providing opportunities for social service providers to meet, collaborate and form information and support networks
- catalyzing effective advocacy networks

Art and Culture
- looking at representations of drug users in the mass media
- using cultural interventions to reduce drug-related harm
Bisexual Crystal Injectors in Seattle

by Chilly Clay

The drug variously known as "crystal," "crank," "meth," or "speed" is a powerful, illicitly manufactured stimulant. Crystal meth has been used on the West Coast for at least 30 years by populations ranging from housewives to biker gangs, from adolescent ravers to truck drivers, from factory and restaurant shift workers to urban gay men. Like other stimulants, crystal meth is a "get-up-and-go, can-do" kind of drug. It elevates the heart rate, increases blood pressure, and gives users a sense of energy and euphoria.

Note my mention of certain occupational groups who use methamphetamine. Unlike opiates, sedatives, or alcohol, stimulant drugs, whether legal or illegal, are often used for their performance-enhancing role in the American workplace (another example, of course, is coffee). While there is broad condemnation of stimulant abuse in the media, Americans also tend to value the very characteristics in its working citizens that stimulant drugs can produce in users — qualities like productivity, sociability, alertness, energy, and focus. For workers who use licit and illicit stimulants, the work ethic itself is part of the cultural logic that shapes and informs use patterns.

But for other populations of speed users, other reasons for using and other kinds of cultural logic come into play. Gay and bisexual speed users are one such group. I began working with gay and bisexual meth injectors because of concerns around the very high HIV rates in men who reported having sex with other men who injected methamphetamine. A comparative seroprevalence sketch for Seattle illustrates this point:

About four to five percent of heterosexual drug injectors are HIV-positive. About 19 percent of gay men who do not shoot drugs are HIV-positive. About 40 percent of men who have sex with men and shoot crystal meth are HIV-positive. This last figure astonished and confounded epidemiologists and HIV prevention staff. While the data suggested that gay and bisexual speed injectors had the highest seroprevalence rate in Washington State, no one understood the real-world contexts in which HIV transmission was occurring.

As a result of these very high HIV rates, the health department asked me to hang out with, talk to, and gather stories of experiences and behaviors from gay and bisexual meth injectors. With the ultimate goal of understanding how and why HIV was passed among them, I spoke with 28 men: four were African-American, one Chinese-American, one Filipino-Native American, and 22 were white. Most of the men had an average education of high school. Most were poor. Several had been kicked out of their homes as adolescents because they were gay, and several had engaged in survival sex. Fifteen of the 29 men knew they were HIV+.

Crystal could be a tool for overcoming sexual fears, a way of being sexually connected, or a means of crossing the psychological and social borders around same-sex desire — a means of exploring taboo zones of physical pleasure on forbidden objects of desire.

We wanted to know how methamphetamine contributed to these high HIV rates. Why do relatively large cohorts of gay men use this drug? What does it do for them? What does it do to them? How are a person's motivations for using intertwined with broader social and cultural dynamics? How will gaining this knowledge help us interpret HIV seroprevalence patterns and design appropriate HIV interventions?

The Physical Effects of Crystal Meth
Before I try to address some of these questions, I should probably say a bit more about the physical effects of methamphetamine. Meth easily crosses the blood-brain barrier and floods the central nervous system with feel-good neurotransmitters like dopamine and serotonin. Our nervous system interprets these chemicals as the essence of pleasure, satisfaction, and well-being. A typical crystal high might last 12 to 18 hours depending on its quality. Among some of its other effects, crystal meth can temporarily deaden physical and emotional pain, create a sense of euphoria, and enhance sensual pleasure and sexual contact. While neuro-chemical...

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Psychotherapy with Actively Using Adults
Workshop by Helga Grunberg, Debra Rothschild, and Andrew Tatnisky
June 13, 1997,
Albert Ellis Institute, 45 East 65th Street, New York, NY
Contact: New York State Psychological Association Division on Addictions, 6 Executive Park Drive, Albany, NY 12203.
Fee: $25, registration required.

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

The United States Conference on AIDS
September 18-21, 1997,
Fontainebleau Hilton Resort & Towers, Miami Beach, FL
Contact: The United States Conference on AIDS, 1931 13th Street, NW, Washington, DC 20009-4432.

Rocky Mountain Regional Conference on Drugs and HIV
October 1997,
Denver, CO
HRC Contact: Paula Santiago, National Community Organizer, New York: (212) 213-6376.
Regional Contact: Paul Z. Simons, Executive Director, PEERS (People Engaged in Education and Reduction Strategies), Denver: (303) 455-2472.
Sponsors: Harm Reduction Coalition (New York and Oakland), PEERS (Denver), Colorado Department of Public Health and Environment (Denver), Centers for Disease Control and Prevention (Atlanta), Boulder County Health Department, Coloradans Working Together: Preventing HIV/AIDS (Denver), Regional Users’ Group (Denver), American Foundation for AIDS Research (New York), University of Colorado Health & Behavioral Science Department (Denver), North American Syringe Exchange Network (Tacoma), and North American Users’ Union (NAUU).

Watch for exact conference dates and location!

Harm Reduction:
What Does It Mean for Women?
October 17, 1997,
Mt. Sinai Medical Center, New York, NY
Contact: Paula Santiago, Coordinator, Women & Harm Reduction Working Group, New York: (212) 213-6376.

Increasing Effective Clinical Interventions for Drug Use and Other Risky Behaviors: Harm Reduction and Psychotherapy
October 24, 1997,
John Jay College of Criminal Justice, New York, NY
HRC Contact: Allan Clear, Executive Director, New York: (212) 213-6373
Sponsors: Mental Health Professionals in Harm Reduction (New York), Harm Reduction Coalition.

National AIDS Treatment Advocates Forum
November 9-12, 1997,
The Handlery Hotel & Resort, San Diego, CA
Contact: (202) 483-6622; e-mail: nmacx@aol.com
processes contribute to these effects, biological explanations leave unanswered questions about why methamphetamine takes hold in certain populations, how it functions, and what people’s drug use means to them.

So, what do men say about the drug? Well, for one, methamphetamine’s reputation for sexual enhancement is not without foundation. Indeed, the stories confirmed what many of us knew from living in gay communities—that crystal meth can be an extremely powerful sexual facilitator. For some subgroups of gay and bisexual men, crystal was injected both as a prelude and interlude to sexual activity. Many described it as sexually liberating and commonly reported having sex (or sexual fantasies) for 8 to 12 hours. In this context, crystal could be a tool for overcoming sexual fears, a way of being sexually connected, or a means of crossing the psychological and social borders around same-sex desire—a means of exploring taboo zones of physical pleasure on forbidden objects of desire. In the highly homophobic context of this society (and most others, for that matter), if one man wants to gaze into another man’s eyes, kiss his mouth, caress his nipples, or touch his penis, he transgresses social, moral, and, in some states, legal rules. And it is in this sexual context that HIV is primarily transmitted. Perhaps this is one reason why in Seattle—where syringes can be rather easily purchased or exchanged—24 of 28 men reported that unprotected anal sex was a much more likely mode of HIV transmission for themselves and the men they knew than was sharing injection equipment. But there are other reasons for using crystal (and I use the word “reason” tentatively because it implies that our motives are rational and consciously constructed. It implies no place for unconscious motives.) Crystal can also be an escape from both acute and chronic pain. In particular, many men used it to medicate the debilitating and devitalizing effects of HIV and AIDS. For some men with HIV-related fatigue, crystal can bring a temporary restoration of energy, functioning, and vitality. It allows houses to be cleaned, permits some disabled to temporarily walk, and can restore the memory and feeling of a sexuality that HIV had gradually escorted away. Methamphetamine allows some light to escape depression’s black hole (at least until a very ugly crash brings the depression back with a vengeance). In effect, crystal offers a dependable way to change the quality and features of the everyday world—a world otherwise mediated by chronic pain. In a manner analogous to what a fix can mean to heroin users, crystal can be both a means of getting high and a means of “getting well.”

In a manner analogous to what a fix can mean to heroin users, crystal can be both a means of getting high and a means of “getting well.”

But the effects of homophobia are paradoxical. While homophobia is an incredibly destructive force to gay, lesbian and transgendered people, it continues to foster new social formations and new social identities as queer resistance asserts itself. Analogously, how homophobia shapes drug use among gay men is paradoxical and double-edged. If we bracket off judgment of drug use
itself, we can see how a drug like crystal meth could be used as a ritual facilitator in sexual awakening and celebration. Crystal eases men over turbulent sexual borders. It helps them face and then defy social, cultural, and legal proscriptions on homo-desire and sex. Unfortunately, crystal's ability to facilitate, medicate, and alleviate is matched and often exceeded by its harms. For some men, sex without crystal meth becomes impossible to imagine. Many report equating the two in the expression “meth is sex and sex is meth.” Long-term, frequent, high-dose usage can bring a spectrum of problems ranging from skin disorders to paranoia and psychosis. It is critical to understand the destructive potentials and effects of methamphetamine use but I have chosen not to focus on them here. Others aplenty will talk about them. Typically, anti-drug discourse only examines the pathology of drug (ab)use and drug (ab)users without reference to social, cultural, and material conditions that contribute to ill consequences. If we examine only the pathologies and dysfunctional aspects of illicit drug use, we achieve a shallow and incomplete understanding. We lose sight of the drug’s functional power and meaning for specific men in specific settings.

One last point. Gay and bisexual meth users compound the deviancy of being gay through the deviancy of injecting. Shooting drugs, clearly a personal choice in a way that being gay is not, violates dominant community standards of acceptable behavior. Injecting, in fact, not only transgresses dominant heterosexual standards but the standards of the broader gay and lesbian community within which most gay injectors live. A recurrent theme among men I interviewed was a feeling of separation from the larger gay community because they were injectors. They reported feeling put down not only by the queer community that did not use crystal, but also from the gay men who used crystal but considered themselves better because they only snorted the drug.

Such community standards are vital because they place constraints on behaviors that are harmful to social integrity. But they, too, are double-edged. Deviant behaviors are arbitrarily drawn in relation to a socially- and culturally-defined “normal” range. But not all deviant behaviors bring harm to others. And the flip-side of these powerful social norms is that people who cannot or will not live within them are dis-owned and forced to the margins. The fact that these social “sinners” primarily hurt themselves — not other people — is mitigative but only slightly. Clearly, segments of the gay and lesbian community can be just as moralistic, harsh, and judgmental as any other community when it comes to drugs and needle use.

It is all too easy for those standing at the sidelines of the HIV/AIDS epidemic to merely place blame on individuals for getting or transmitting HIV, for being pathological drug addicts, for being “irresponsible.” The war on drugs has further fostered the use of language in which drug users are described in terms of their supposed weak character, their moral failings, their genetic predispositions or diseases, and their criminality. All of these vocabularies focus on the pathology of the individuals and overlook the critical effects of social context in shaping drug use patterns and the transmission of HIV. They overlook the processes by which individuals, for better or worse, internalize and transform cultural messages and deal with the effects of oppression. The vocabularies of pathology prejudice our perceptions. They preclude an ability to listen to drug users with more open ears. They preclude an ability to recognize the capacities drug users possess to become creative partners in addressing social problems. I believe harm reduction is an antidote to the toxic effects of judgment and moralism that frames our thinking and actions on the issues of drugs and drug users. I think harm reduction is a countering force in our “refusal to imagine one another with empathy and compassion,” to our tendency to “cultivate human sympathies unequally and narrowly.”

Chilly Clay is a Health Educator and Ethnographer with the Seattle-King County Department of Public Health. He currently coordinates the health department’s programming for NEON—an HIV/STD prevention program for gay and bisexual men who inject methamphetamine. NEON, which is rooted in harm reduction, is a collaboration between the health department, Stonewall Recovery Services, Street Outreach Services, and gay and bisexual meth injectors.

1. While there are large populations of gay and bisexual meth users in all major cities in the Western United States, my comments apply primarily or only to Seattle. Use patterns, primary routes of administration, and drug terms vary from region to region.

2. I have noticed that the mention of gay white men often invokes stereotypes of class privilege. Most of the gay men in this ethnography come from working class backgrounds and, at the time of the interviews, were struggling to get by.

Do unto others

continued from page 1

There will be qualities of harm reduction which, at this conference and in the future, we will together define as we apply it to various situations. However, there are some characteristics of harm reduction which my experience has convinced me are innate to its nature. We are sometimes criticized, and at times rightly, for being unable to succinctly state in a few simple sentences what harm reduction is and is not. This is understandable. Harm reduction is an attitude. It is built from within, not from without. It is more difficult to explain an attitude than it is to recite rules. Dogma and truth are rarely found in the same pasture.

Harm reduction is not the chic political fad du jour. Nor are we the front for any political agenda, regardless of whether most of us approve of that agenda or disapprove of it. Though it may have significant and serious political consequences, harm reduction is not a political effort. It is a movement within and about humanity.

Harm reduction is not a new idea. It is, in fact, a very old notion contemporarily applied to a particular field. Mo Tse, hundreds of years before the Carpenter, said, “Do not do to other people what you do not want them to do to you.” Lao Tse, before that, said, “It is a sane person who sees themselves in the eyes of others.” Everybody knows what the Carpenter said. Whatever else the golden rule may be, it is astute insight into the nature of human behavior.

Harm reduction is a current manifestation of the age-old struggle for the universal recognition of the inherent dignity in all life. This struggle is between those who see the infinite dignity in themselves and others, and those who, being unable to see it in themselves, suffer from an intense sense of inadequacy and must degrade, dehumanize, and enslave others in order to elevate themselves. This struggle will go on long after we are gone.

Harm reduction is against harm, neutral on the use of drugs per se, and in favor of any positive change, as defined by the person making the change. That’s any positive change. We all set our own rate of change and we all set the same rate. We change at the pace that is possible for each of us. As a result, we are all changing at the same speed. The race is always a tie and we are all the winners.

As proponents of harm reduction, we must be certain to practice it among ourselves, to courteously allow our differences without harsh judgment. We must support and watch out for each other. We must be kind to each other. Not just because it’s important as an example, but because we need it ourselves and it works.

Finally, harm reduction — being logical, practical, right, and effective — is more enjoyable than following a path that leads nowhere and supporting “laws” of behavior that do not work. Harm reduction is fun, and fun is what I suggest you do here. Be kind, take care of yourselves as you see fit, and have a great time in Oakland.

Dave Purchase is the Director of Point Defiance AIDS Projects in Tacoma, WA and Founder and Director of the North American Syringe Exchange Network (NASEN).
Ask Mother Dog will appear as a regular column in Harm Reduction Communication.

Welcome to the premiere of a new Harm Reduction Communication column: Harm Reduction for Parents. Each edition of this column will explore one of the various issues and aspects of parenting within the context of user lifestyles. Not only will we report on relevant current events and information, but I hope that you will accept my invitation to make this a truly interactive forum by sending me your thoughts, ideas, and questions.

As a single mother of two, parenting is a subject of great importance to me. In addition to being a parent, I work with several harm reduction agencies, including our local needle exchange. I also have a history as a user and, yes, at times, abuser of illicit drugs and alcohol. I was born heroin-addicted, but my drug of choice for the last 15 years has been speed by injection – but more on that in future columns.

Back to being a mom. My twelve-year-old has good attendance and makes high grades in junior high. Most who meet him would find him well-mannered, street-smart, intelligent, mature, and creative. All of this under abject poverty. There are very few resources available to me as a mother in my situation and particularly as a mother who uses drugs – other than the many times drug dealers in the neighborhood anonymously delivered clothing, food, and medical supplies to my doorstep. I decided to start this column so that other parents in similar situations can come together and share ideas and information, discuss triumphs and challenges, and empower one another in our parenting and in our lives.

Parenting at the edge of the new millennium poses an overwhelming array of choices and decisions. When brought within the context of an ‘alternative’ user lifestyle, one finds oneself not unlike a prisoner of old – forging new trails in a hostile realm, alone. There are few if any positive role models and little or no resources for information, advice, or support. Even when there exists some information or resources, access may or may not be feasible. Sadly, the parent usually faces a multitude of risks, even when asking user-related questions out of parental love and concern.

The hurdles and pitfalls a parent who uses faces are seemingly endless and ever-increasing. Near the head of the list is the stigmatization and negative labeling. Often we users buy into these devastating stereotypes to some degree or another. But this is where harm reduction comes in – by openly and honestly exploring the myths and dogmas about illicit drugs, together we can discover what is real for us and what to discard.

For instance, the myth that “You can’t be a good parent and be on drugs,” or, even more popular, “If you’re using, you’re a downright failure as a parent,” are just two of the many examples of damaging stereotypes users face. Even if one were a “lousy parent,” it is unlikely that one would be a 100 percent failure in every aspect and to the same degree at any given time. We’ve got to put harm reduction into practice and focus on what works for us as parents and try to reduce the degree of harm in the areas that don’t work as well.

There are also a lot of legal ramifications for parents who use drugs. Child Protective Services (CPS) not being the least of that which often prevents us from accessing much-needed services and support, and which keeps us looking over our shoulder – and nothing spoils family dinner hour like having your kids snatched by the government. No divorce is as devastating to a family as the fear of arrest and the threat of incarceration.

This column will explore these issues and more, as well as grapple with such topics as: what to tell your child when they ask about your lifestyle (“Mommy, how come all your friends come over at 3:00 am?”); how to present the concept of drug use versus drug abuse to your children; how to deal with a child that is using or has begun to ask questions; money management issues for parents who use drugs. This column will try to dispel the lies, myths, and stereotypes about parents who use drugs and develop a consciousness that is prepared to deal with the negative messages and dogmas about illicit drugs without falling victim to them.

—Mother Dog

We want to hear what you have to say! Please send responses and questions to Mother Dog, Harm Reduction Coalition, 3223 Lakeshore Avenue, Oakland, CA 94610. I’d also like to recommend a booklet put out by The National Council on Crime and Delinquency (NCCD) called, “Kids, Drugs, and Drug Education: A Harm Reduction Approach.” To order a copy, write to NCCD, 685 Market Street, Suite 620, San Francisco, CA 94105; phone: (415) 896-6223; fax: (415) 896-5109.
problem. Harm reduction in the United States is about nothing less than creating a new social contract. Coming together at the conference helped us see the huge implications of our undertaking. We hope this issue of *Harm Reduction Communication* will help clarify for those from abroad why harm reduction in the United States must be as much about political organizing as it is about public health.

While the formal conference program itself was exceptionally diverse and informative, some of the most important work that happened over those four days in September were community organizing efforts that occurred in addition to or in conjunction with the conference itself. The day before the conference began, a users' "town hall" meeting attended by more than 50 drug users took place: users got together to define their own harm reduction agenda, discuss issues that were important to them, and simply be with one another for a few hours in an environment where they didn't feel freakish or felt they had to hide or deny a central aspect of their lives. (The fact that more than a few people with track marks felt comfortable wearing short sleeves throughout the conference spoke volumes about the atmosphere of the event.) At the same time, a meeting of methadone consumers and of people in recovery who work in harm reduction also took place to the same ends. HRC's goal of facilitating and supporting the self-advocacy efforts of those most affected by drug-related harm and of ensuring the genuine participation of these same folks at all levels of the conference was not just lip-service: users were not relegated to the famous "users' perspective panel" typically featured at drug policy reform conferences – always in a tiny, airless, over-crowded room no one can find, the last panel of the last day of the conference when everyone is too exhausted to care about attending yet another session. A caucus of people of color got together one evening; the California Syringe Exchange Network (CASEN) met; an evening gathering to discuss the provision of medical treatment for drug injectors with HIV-disease was convened and drew close to 75 participants; and a meeting about medical marijuana was equally well-attended. Numerous other gatherings and organizing meetings were held throughout the days of the conference. People came to work!

While there is obviously not room in this single issue of *Harm Reduction Communication* to present even a fraction of the presentations and discussions that were part of the First National Harm Reduction Conference, we've done our best to present some of the plenary and break-out sessions that we felt conveyed a sense of the new political consciousness born at the conference; sessions that were particularly helpful in contributing to our understanding of what harm reduction is; or those which discuss a specific aspect of harm reduction theory in practice. The welcoming remarks of Harm Reduction Coalition Executive Director Allan Clear reflect on some of the successes gained and challenges faced by the harm reduction movement in 1996, and encourage us to see the importance of coming together to validate each others' work. Dave Purchase, Director of the North American Syringe Exchange Network (NASEN), does for us in his opening address what he says harm reductionists have been criticized for not doing in the past: offering a succinct, straightforward definition of harm reduction. In his famous, no-nonsense way, Dave lays out beautifully what harm reduction, at its core, is really all about. Allan's and Dave's remarks provide an inspiring introduction to this issue of *Harm Reduction Communication*.

Also in this issue, Imani Woods describes how she came – reluctantly at first — to integrate an acceptance of harm reduction with her belief structure about drugs that is strongly abstinence-based. Imani's courage in being able to ask very tough questions about the efficacy of her own approach to and beliefs about drug-related harm, to look at and think about alternative ways of doing things, and to listen to other viewpoints, will hopefully encourage all of us to be more open-minded toward each other. Her journey will hopefully help open the eyes of those who are dogmatically wedded to only one way of approaching drug-related harm.

Several pieces in this edition of the newsletter very effectively describe how to translate harm reduction ideas into programs and interventions – what harm reduction means when you really get down to it and it's just you and your client sitting around a desk in a counseling room or clinic office. Catherine Lyons of San Francisco General Hospital's outpatient AIDS clinic describes some of the harm reduction approaches she uses to build effective clinical relationships with her drug-using patients, many of whom have been mistreated by health care providers in the past and are therefore mistrustful of social service systems claiming to offer help; and Chilly Clay discusses his work with a successful community-based harm reduction intervention for gay and bisexual male crystal meth users in the Seattle area. Both of these important presentations provide concrete examples of the power of harm reduction to effectively
impact populations frequently thought of as “recalcitrant, “hard-to-reach,” “non-compliant,” or worse, and illuminate how traditional helping systems and approaches themselves — and not the folks who use them — are responsible for actively alienating illicit drug users.

Next, Oakland-based psychologist Patt Denning reveals for us how the cultural hegemony of the disease model of addiction has for so long prevented mental health professionals from being able to effectively assist their drug-using clients, and presents other models — including harm reduction — for understanding and dealing with drug-related harm. Patt reminds us that developing harm reduction theory is critical to our enterprise of intervening in drug-related harm. James Cancienne, Jennifer Kaplan, and Karyn Kaplan of Gay Men’s Health Crisis in New York City also address a theoretical issue in harm reduction: how to design outcome measures for assessing the efficacy of harm reduction interventions. Those of us who work in harm reduction or use it in our own lives witness or experience every day the beneficial impact this approach has on reducing drug-related harm. Critics, funders, and others, however, often demand data that “prove” that harm reduction “works,” and James’, Jennifer’s, and Karyn’s article brings us closer to an understanding of what we should be looking for in harm reduction program evaluation and how to find it.

This issue of Harm Reduction Communication also includes a couple of items not related to the conference. We’re very proud to present the first installment of Ask Mother Dog, a regular column that will be devoted to issues involving drug use and parenting — a topic that is difficult for even some harm reductionists to grapple with given the incredible sensationalism, stereotyping, and stigmatization attached to being a parent who uses drugs. As we have in the past, HRC hopes to break new ground by demystifying this issue and daring to simply talk honestly and openly about it. And finally, as part of HRC’s ongoing commitment to dealing with issues of how we as harm reductionists look after ourselves and each other and safely integrate the use of drugs into our lives if we so choose, we present the response of a reader who learned of the death of newsletter contributor Nelly Velasco, reported in the last issue of Harm Reduction Communication.

We hope this issue of Harm Reduction Communication once again challenges you to expand your thinking about harm reduction, and prompts you to contribute to one of our next issues — whether in the form of an article, a letter to the editor, or some other response to something you’ve seen here or have been thinking about. As always, we would love to hear from you! Thank you for your ongoing commitment to harm reduction. It is making a difference.

— Rod Sorge with Sara Kershner

P.S. HRC’s Second National Harm Reduction Conference will take place in Cleveland from October 7 to 10, 1998. Incorporating many of the evaluation responses and suggestions from 1996 attendees, the Second National Conference will feature a primarily interactive format that allows ample time for discussions, debates, and community organizing. You’ll receive preliminary announcement materials about the event soon, followed by official call for abstract and registration booklets. For additional information, contact the Conference Coordinator, Second National Harm Reduction Conference, 3223 Lakeshore Avenue, Oakland, CA 94610.
Successful Harm Reduction Forum Held in Austin, Texas

by Pat Garrett

New and current Harm Reduction Working Group members met in Austin, TX this past December for its twice-yearly meeting. The Working Group, in conjunction with the Texas AIDS Network, sponsored a community forum on harm reduction. Austin-based Working Group member Pat Garrett co-moderated the event, and the following HRWG members and HRC staff made presentations about different aspects of harm reduction: HRC's Executive Director Allan Clear and Director of Education & Training Sara Kershmar presented an overview of harm reduction principles and how harm reduction is successful in fighting HIV and other communicable diseases; Stuart Fisk (Pittsburgh) talked about how needle exchange and harm reduction can reduce disease associated with blood-borne pathogens; Sena Gates (Honolulu) and Scott Stokes (Milwaukee) spoke about legislation and public policy changes taken to accommodate harm reduction activities in their locales; George Kenney (Boston) explained how he helped his community understand harm reduction and needle exchange; and Ron McMillian (Kansas City) discussed how harm reduction principles can be applied to work with persons living and earning their money on the streets. The community forum was attended by approximately 45 individuals representing social services, criminal justice, law enforcement, and drug treatment.

Austin harm reduction organizations are poised to introduce to the 75th Texas Legislature a proposed exemption to the existing Texas paraphernalia law to allow needle exchange programs to operate legally. With the assistance and expertise of Harm Reduction Working Group members, a broader perspective of harm reduction and its potential impact on public health was presented to the Austin community.

Pat Garrett is the Executive Director of the CARE Program in Austin and a member of HRC's Harm Reduction Working Group.

WE WANT YOU FOR HRC MEMBERSHIP

Becoming a member of the Harm Reduction Coalition is one of the most significant ways you can support our organization’s work and mission. As a coalition of harm reduction practitioners, providers, and consumers, HRC draws its strength, diversity, and expertise from the nationwide network—people and organizations like you—who are HRC members.

As a member, you will receive regular reports about HRC activities and events; a one-year subscription to Harm Reduction Communication; and discounts on HRC conferences, trainings, publications, and merchandise. So demonstrate your support of harm reduction and the Harm Reduction Coalition by becoming a member today.

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Send all membership subscriptions to:
Membership, Harm Reduction Coalition, 22 West 27th Street, 5th Floor, New York, NY 10001
phone: (212) 213-6376; fax: (212) 213-5882; e-mail: hrc@harmreduction.org

Harm Reduction Working Group Seeks New Members

HRC's Harm Reduction Working Group (HRWG) is currently seeking new members. A program of the Harm Reduction Coalition, HRWG is a working advisory board of 22 harm reduction providers, activists, and consumers from around the country that meets twice a year to help direct the programmatic and community organizing work of the Harm Reduction Coalition. HRWG members are required, at minimum, to attend two meetings a year and significantly contribute to the work of at least one committee for the duration of their two-year term. New members nominated from this current application round will be expected to attend their first HRWG meeting in December. HRC covers expenses for members to attend meetings.

HRWG members are chosen based on their experience in the field of end/or life experience with harm reduction, and every attempt is made to ensure that HRWG remains diverse in terms of race, sex, sexual identity, drug use history, class, profession/discipline, HIV/AIDS status, and geography. If interested, please call HRC's National Community Organizer Paula Santiago at (212) 213-6376 ext. 15 for an application.
What are we looking for?

Our challenge as researchers is to design a way to measure the processes that occur in the counseling groups, including feelings as expressed by participants; relationships between the counselor and the participants; and relationships between the participants themselves.

by James Cancienne, Jennifer Kaplan, and Karyn Kaplan

James Cancienne, Jennifer Kaplan, and Karyn Kaplan work in the Department of Evaluation and Research at Gay Men’s Health Crisis (GMHC) in New York City where they perform both process and outcome evaluations on various programs and interventions provided by the agency. On a panel at HRC’s First National Harm Reduction Conference, James, Jennifer, and Karyn discussed the challenges of designing an evaluation that would capture outcome measures for GMHC’s Substance Use Counseling & Education (SUCE) program, an HIV prevention, harm reduction group counseling intervention for gay men concerned about their drug use and sexual risk-taking behaviors developed by GMHC’s Director of Prevention, Richard Elovich.

— R.S.

Gay Men’s Health Crisis (GMHC) is a large, non-profit AIDS service organization located in New York City. The Substance Use Counseling & Education (SUCE) program, an initiative of GMHC’s HIV prevention department, is a counseling intervention that incorporates harm reduction principles and is targeted at gay, drug-using men. While SUCE’s ultimate goal is HIV prevention, the processes that lead to that goal are not clear cut. HIV prevention is not as simple as we’d like to believe. People have risky sex for a variety of reasons, and the SUCE program grew out of this realization and the recognition that HIV prevention is a very complicated endeavor.

SUCE offers short-term counseling groups for HIV-positive and HIV-negative gay men; individual counseling sessions; and acupuncture services. The main component of the program – the counseling groups – assists participants in assessing their drug use and sexual risk-taking behaviors, and encourages them to talk about the underlying psychological factors that affect each of these behaviors. The program’s curriculum incorporates a patchwork of behavioral change theories modified to fit within a harm reduction methodology. One central goal of the program is to increase participants’ understanding of the relationship between their illicit drug use and their feelings or emotional state when using these substances, with the ultimate goal of reducing their likelihood of engaging in sexual behaviors which may put them at risk for HIV.

Most of the men who respond to the SUCE ads probably know that GMHC is an AIDS service agency whose mission includes HIV prevention. It would therefore be easy for us to measure changes in safer sex practices over time. This would be a legitimate outcome study, and we could call it a day. But as applied to counseling, harm reduction is a relatively new paradigm. Earlier in the epidemic, it was widely believed that education or knowledge about safer sex equaled HIV prevention, so programs educated people about HIV and how to protect themselves from infection. Later, we realized that people...

continued on next page
Because traditional evaluation methods are inadequate but because funders often demand tangible data that indicate behavior change, our task is to identify outcome measures using a hybrid of traditional research methods that will provide us with a combination of both detailed and generalizable results.

Because people actually needed more multiple skills-building type workshops. Now, we understand that HIV prevention has a lot to do with an individual’s internal thoughts, feelings, self-image, interpersonal style, and the stigma and cultural differences they experience, and so counseling-type groups are now becoming more popular as a result of this realization.

SUCE takes this last idea and makes the assumption that drug use and sexual risk-taking are related in some way, and that underlying behaviors or emotional issues relating to self-esteem, depression, and loneliness play a significant role in this relationship. Further, if clients are able to address these underlying psychological issues, the hope is that they will use drugs more safely and thus decrease their risky sexual behaviors. In harm reduction counseling services, there’s no obvious technology like the needle and syringe in a needle exchange program to measure outcomes against. Our challenge as researchers, then, is to design a way to measure the processes that occur in the counseling groups, including feelings as expressed by participants; relationships between the counselor and the participants; and relationships between the participants themselves. The difficulty in this is not only that there are multiple factors that contribute to HIV risk-taking behaviors, but also that in keeping with a harm reduction philosophy, the SUCE program shifts to meet the needs of the clients.

For example, if a client is not in a place where he’s able or ready to practice safer sex, it’s not appropriate for a counselor to explicitly promote a reduction in unsafe sex because the program won’t be meeting this individual’s particular needs. When identifying outcome variables, we do have a variety of standard research options to choose from. Some researchers typically conflate many complicated variables into fewer, more manageable ones, often according to common themes. This is often reductive, however, and provides results that are too general to really mean much. And outcomes typically measured by traditional pre- and post-test designs are inappropriate for measuring incremental changes brought about by counseling. If we created measures that took into account all of the different stages at which people enter the program and all the possible needs they present, the net of the responses would be enormous and unmanageable. Finally, if we designed an individual case-by-case study – following each client to find out what his needs were and whether they were met over time – it would be very time-consuming and expensive, and would probably not even capture the full nature of the program in that it’s detail would not be generalizable to other programs. Because these traditional methods are inadequate but because funders often demand tangible data that indicate behavior change, our task is to identify outcome measures using a hybrid of traditional research methods that will provide us with a combination of both detailed and generalizable results. If we fail to measure catalysts of behavior change, we’ll be missing the key to SUCE’s programmatic intervention and what the harm reduction philosophy demands that we measure: the presenting needs of each SUCE client.

**Program Philosophy and Operating Principles**

Based on an analysis of self-administered intake and assessment forms and in-depth interviews that the SUCE program conducted with clients, we found that most of SUCE’s clients were white, Manhattan-based gay men in their 20s and 30s, so this is not a generalizable sample. In any case, the analyzed data show that these individuals were coming to the program because of the negative

impact they felt their illicit drug use was having on their lives. They reported contacting SUCE because their drug use was ruining their health, their relationships, and/or their ability to work, and because they had a general sense of having lost control over their lives. This actually came up quite a lot: “I’m out of control.” “I’m feeling like I’ve lost control of my life.” What people hoped to get from the program, according to our analysis, was an alternative support mechanism, a new type of help that they were not specifically identifying.

So what does SUCE offer these men who, according to their intake forms, couldn’t specify what that alternative helping mechanism that they expressed a desperate need to find might look like? Prochaska’s stages of change model informs the SUCE program in two ways: it gives the counselor an instrument for assessing the individual client as well as a way to help the client see himself and his drug use or compulsive sexual behavior as part of a continuum of change. It’s not a linear model but a spiral model that takes into account ongoing drug use and relapse from the client’s identified goals. SUCE’s program director, who also facilitated counseling groups, often said that simply showing up to a group was an example of a client taking some action.

Another program concept is the toleration of ambivalence. Clients are encouraged to explore their ambivalent feelings about everything from having unprotected anal sex to showing up for the groups and participating in the program at all. One individual in the program spoke about his shame at having kept his HIV-positive serostatus to himself for over seven years, and his conflicted feelings around disclosure were legitimized by the group. Another thing that the program likes to do with its clients is a cost-benefit analysis of their drug use or sexual behavior, which allows the individual to acknowledge what he’s getting from his drug use or sexual behavior as well as the detrimental effects it may be having on his life. For example, a client might say that he likes to go into a bar, get totally coked up, meet a guy, go home, and get fucked, but that the downside includes the fact that he’s spent all his money, he feels like shit, or he’s nervous or anxious about HIV risk. The program helps the participants clarify the context in which these behaviors are taking place and the consequences of their actions; this is where looking at antecedent behavior facilitates the client’s further understanding of the possible patterns and consequence of their behaviors as well as the feelings underlying these behaviors. So, for example, the guy who goes into the bar, does a lot of coke, and gets fucked will perhaps be asked about what he’s feeling when he walks into the bar, what’s going on with his feelings before the action actually takes place, and why he likes to do the coke. It might come out that he’s feeling insecure or ugly or shy and doing coke makes him feel sexy and hot. So antecedent behavior is revealing to explore in a group.

Often group members are encouraged to model difficult conversations that they want to have, for example, coming out to their family members or having a difficult conversation around safer sex with a sexual partner. For some of the HIV-positive men in the groups, coming out as HIV-positive often coincided with coming out as gay. Modeling such a conversation could decrease the anxiety around having that conversation. Active listening, mirroring, positive reinforcement, and witnessing are other techniques used by the program to facilitate the group process. SUCE’s program director frequently talked about witnessing as something akin to having one’s parent watch one jump off a diving board and having an observer to imbue the action with meaning. Gay men — at least those in the population that the program targets — are often both physically and emotionally distant from their families and they have few social resources. Using the group to recognize and affirm one’s actions and thoughts seems to be valuable to a lot of the men.

According to the program’s philosophy, as a client identifies and clarifies his feelings — especially in relation to his drug use and sexual behavior — he no longer thinks about his drug use in the same way he did when he entered the program, and this cognitive transformation occurs through these types of processes as well as by maintaining a gay-friendly environment, a non-judgmental counselor attitude, a safe space. Each client is with a group of HIV-positive or HIV-negative gay men (the groups are divided by serostatus) and individuals can develop their communication skills, develop alternative coping mechanisms, and actually use the group to have therapeutic relationships. Once the client has been exposed to the program for 10, 20 or 30 weeks (the groups run in 10 week durations), what ideally happens is that the conversations take on a different tenor. The client is more able to identify the underlying feelings behind his drug use or sexual behavior and becomes aware that the drug use may in fact be a coping mechanism for some other stressor — AIDS anxiety, internalized homophobia, societal homophobia, stress, depression, or hopelessness, to name a few. For example, one group participant described the pain of having his father, who was a German death camp survivor, declare that hearing.
about his son’s homosexuality was the worst thing that ever happened to him.

Through the program, the client hopefully discovers a relationship between what he considers his out-of-control behavior and his feelings. According to the program’s assumptions, once a client makes this link, he will be better able to implement alternative coping mechanisms, avail himself of the support system provided by the group and program, and achieve clarity and self-awareness that will help him continue moving down the road to whatever self-directed behavior change he may want to make.

Thinking Evaluation:
Envisioning Outcome Measures

We’ve been funded to do a process evaluation of the SUCE program which will then turn into an outcome evaluation, so we have the luxury of a year to sort of look into the program, interview the counselors and the clients, and really find out what’s going on with the intervention and try to come up with viable outcome measures that truly respect the harm reduction philosophy, that is, measures that don’t dwindle down to the meaningless variables that we typically think of in large research studies.

The two ways we proceed into looking at this program and the issues that come up as we do so involve the meanings that these young men associate with their risk-taking behavior (whether it be drug use or sexual risk-taking); and the processes by which they go about engaging in risk-taking behaviors. The meaning and the process—and there are many of them. For example, an individual might say he has unprotected anal sex because he feels very emotionally cut-off, he can’t articulate his feelings to someone else, and he feels very isolated and removed to the extent that the only way he can feel connected to another individual on an interpersonal level is to get fucked without a condom. This is very valuable and very real, and it’s also obviously very complicated and difficult to work with. Other men report that they have realistically assessed their situation and feel that they are unwilling to give up certain sexual acts. For them, their lives are not worth living unless it includes a particular kind of sexual act. So these are kinds of the meanings that are associated with risk-taking behaviors that we have to take seriously and understand in order to see how over time things can change so that we can at least try to reduce the risk in these individuals’ lives.

There are also different processes by which people go about engaging in unsafe behaviors. We often hear clients who say, “Well, it’s stupid to have unsafe sex, I wouldn’t have unsafe sex, but then I fell in love. I met this guy who’s the greatest guy in the world and I let him penetrate me without a condom because it felt so right.” On the other hand, you might get a client who is so-called “straight” during the week but on the weekend takes a couple bongs of crystal meth, goes to a sex party, and gets sucked six or seven times in a weekend and feels very good about that. So again, there are these sort of distinct processes by which people take risks in their lives, processes that can’t simply be narrowed down. Our challenge as evaluators, then, is to try to get as much data as we can but in the most economical and reasonable manner as possible, and so we’ve tried to come up with some common themes.

One such theme that we’ve found to be particularly pertinent is a sense of hopelessness that many of the clients have—a hopelessness about the future. Some guys do not have a sense of themselves past their next trick, or past Friday or Saturday night when they’re going to do their coke and go out and have sex. They have no sense of what it would be like to be 45 years old or 50 years old and what their life would look like. They have no hope, really, for the future. I was listening to the radio yesterday and heard Jonathan Mann talk about urban African-American men, and how if you go and ask them how hopeful they are about their future, listen to that answer, and then say to them “wear a condom every time,” just how ridiculous that message is. That’s one piece of what we’re trying to grasp in our outcome measures: how much do these people really care about reducing the risk in their lives?

A second theme that is a very strong factor involves interpersonal issues. Many of SUCE’s clients feel terribly isolated, terribly lonely, terribly depressed, and drugs and sex are one venue by which they can
feel connected to the world. This interpersonal issue also has to do with gay identity – how comfortable they are with being gay, and how comfortable they feel associating with the gay community. So we’ve got interpersonal issues and then also the issue of comfort around one’s sexual identity that are factors that mediate risk-taking behaviors.

The last theme we’d like to mention here and which we find to be the most important is the issue of dissociation. We believe that while these men are having unprotected anal sex that they cannot be thinking about AIDS. They cannot be thinking about death. They cannot be thinking about the potential of becoming HIV-infected. They really have to forget in that moment about these obviously very striking issues. So, over the 10-week, 20-week, or 30-week session, most of the efforts made by the participants are about integrating self-esteem and self-image issues, issues related to feeling good about oneself, and issues related to why they may feel like they may not want to protect themselves. We feel that if people talk about that, if they talk about their fantasies around having unsafe sex, their issues around isolation, that these things will then become more integrated, made more conscious over time, so that when the opportunity arises to have risky sex, there will be more of a consciousness about how one feels about oneself and about the risk one is taking.

So we are looking into measures – there’s actually very good measures on dissociation right now – and we’re also wanting to look at it from a gay developmental/historical perspective. We’ve found that gay men are particularly good at dissociating or forgetting things because they’ve been trained and practiced all their lives at hiding, many of them, their sexuality. So they really have the cognitive propensity, just as someone who’s been sexually abused has the propensity, to really be able to forget.

There are of course, problems that we’ve run into in measuring these outcomes. The fact that all the members of the counseling groups are gay and the counselors are gay — and obviously GMHC itself is a very gay-friendly place — helps the clients feel more comfortable communicating and creates a trusting environment, but we’re unclear about exactly which factors are more important. For example, if simply being around other gay men is the important factor, that really tells us a lot because we can do a lot more economical interventions if we don’t need to hire professional staff who are also gay. So while we’re looking at what outcome measures to use, we also want to look at what’s more effectively correlated with a successful outcome so that we can make sure that in our next round of interventions, we place an emphasis on those particular variables.

Finally, I just want to mention that while we’re doing this research we need to constantly keep in mind that what we’re taking about is risk reduction. We’re not talking about outcome as abstinence versus non-abstinence or use. For example, the guy who I spoke about earlier who says he goes out on the weekends and gets fucked all weekend on crystal meth, at the end of 30 weeks he may have an instance of unsafe sex, but it may be with one partner, it may be with someone he cares about, and it may be something that he at that point in his life feels he needs and wants to do, and we need to respect that. If we did a traditional outcome measure and found that, “Well, this guy’s still having unsafe sex,” that measure would show up in the data but the reality is that he’s cutting back on his drug use as it relates to sexual risk-taking and he’s not having the multitude of sexual partners he once had. He has one partner, which is still risky, but as compared to having seven partners in a week, he’s certainly practicing risk reduction. And so all of our measures over time need to take into account the risk reduction factor, and not be focused on the end-all, no-risk, or wear-a-condom-every-time message that we’re constantly inundated with.

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