Prison or Treatment: A Real Choice?
Interview with Bonnie Veysey

BY ELLEN MILLER-MACK,
PHOTOS BY MICHAEL JACOBSON-HARDY

SEPTEMBER 24, 1999

E: Observation about residential drug treatment and incarceration: both strip people of their identities.

B: Incarceration is based on a logic of security first, and the easiest way to improve security is to have equal standards of behavior—procedures and protocols—for everyone. To keep a secure institution, you apply the same requirements to everyone: reducing individuality is a goal regardless of whether you are male or female. Residential drug treatment for women is making some progress, although it varies quite a bit. There is a growing acknowledgment that women are different from men, and that a woman’s individuality and creativity can be engaged.

E: Observation: Neither residential drug treatment or incarceration prepares people for life in the real world.

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This issue is dedicated to the memory of Dana Beard (aka Sheila O’Shea). Dana, we miss you!

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

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

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

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


Cover photo: (HRC)
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n February 4, 1999, the NYPD gave Amadou Diallo the right to remain silent. And they did it without even saying a word. Firing 41 bullets in 8 seconds, the police killed an unarmed, innocent man. Also wounded that night was the constitutional right of every American to due process of law—ACLU ad that appeared in the NY Times shortly after the four officers charged with his killing were acquitted on all counts.

When Amadou Diallo’s killers got off scot free last February there was a protest in his old Bronx neighborhood. A few arrests were made; one of the arrested protesters was a 23-year-old man by the name of Malcolm Ferguson. On March 1, less than one week after the verdict, Malcolm was shot and killed in a struggle with a NYC undercover cop. Malcolm was fleeing cops who were checking out a known drug spot, and he was unarmed. Shortly after the killing, police were saying that heroin had been found on his body. Within days, the NYPD was branding Malcolm a heroin addict and dealer. Only days later another New Yorker was shot and killed by police, this time because he objected to an undercover cop’s attempts to buy pot from him. Although Patrick Dorismond did not have any pot on him when he was killed, and was actually a security guard, the Mayor let us know he had a prior marijuana arrest—enough to earn him the designation “drug user.” Go back almost another year, to when Gideon Busch was killed by six cops. You could ask Gideon, if he was still alive, how he managed to scare 6 cops badly enough that they had to shoot him dead. Since he can’t answer, the Mayor and the NYPD answered for him: besides being “mentally unstable,” he had been smoking pot—the implication being that he was in a pot induced craze! The common thread in all three cases: authorities used the drug use of the victims as a subtle justification for their deaths at the hands of cops.

This past February Time Magazine published a story in their Law section called “A Get Tough Policy That Failed.” Among other things, this article was a catalog of the failures of the Drug War. Included were photos of Derrick Smith, a 19-year old New Yorker convicted of selling crack, who committed suicide rather than serve a long sentence, and Jedonna Young, recently released after serving 20 years for heroin possession. Search the internet under police brutality and the drug war. It took a police raid into the home of a middle class Cuban American family to wake up white America to the new face of law enforcement. African-American residents of our inner cities, who have been dealing with a virtual state of siege for the last thirty years, responded with a collective “Tell me something I don’t already know!”

Yes, the Drug War has been in the news a lot lately, generating “celebrated” cases, incidents so shocking they offend even the middleclass, the ones supposedly being protected from “criminals” like Patrick, Malcolm, Gideon...the list is endless. There are plenty of stories that don’t make the news: Joey, who was hopelessly strung out on pills and heroin. In and out of rehab, on and off of methadone and dope, he had to sell to support his habit. Caught one last time, he killed himself rather than serve the stiff sentence he knew he was going to get. Or my friend, who shall remain nameless, recipient of a 1 year suspended sentence for the residue found in a syringe. (We won’t even talk about the illegal stop and search that led to the syringe’s discovery: we gave up those rights years ago!) Having failed to live up to her probation requirements, she now faces the threat of discovery and jail every day.

Yet Patrick, Malcolm and the rest are not so different than you and I. Unfortunately, they happened to get in the way of the drug war juggernaut, and became its victims. Then the military (in this case domestic law enforcement) did what armies always do when civilians are killed: justified its actions by demonizing the victims while telling us that in war there’s always “collateral” damage. As we enter a new phase of this war—when it becomes so important to win, to avoid another loss like Vietnam—in New York City we are also given a hint of what it will look like should we lose: rising crime rates and falling arrest rates, supposedly fallout from the reining in of NYPD’s elite street crime unit in the Diallo killing’s aftermath.

For a few days after the Elian debacle, when people realized that no one is immune to state-sanctioned violence, it looked like maybe things would change. Maybe people would see the ugly underside of the beast’s belly, and just say NO. Enough! But now I don’t think so. After further reflection most of us will come to believe this isn’t our problem. (Besides, the Elian raid was yesterday’s news: now we have the price of our Microsoft stock to worry about. And there’s those rising crime rates...) Call me a pessimist, but I think it’s only going to get worse, before it eventually does get better. Things always get better. It may take ten years, but change will come. Sadly, twenty years from now we’ll be putting up our own memorial wall. All those needless deaths. For what?

—PAUL CHERASHORE
Prison or Treatment: A Real Choice? cont. from cover

B: Absolutely, both of those situations are total environments, total communities. While inside, there are very few decisions that women are allowed to make regarding their day to day lives. There are few opportunities to try out new interpersonal or drug resistance strategies: strategies that deal with how to relate to family, work and all the pressures that a woman experiences upon her release.

E: How are we different from men?

B: From a corrections point of view the most important difference is how women and men organize in groups. Men tend to organize hierarchically around power, and women tend to organize in flat structures around “who you know” (relationships). Increasingly, residential treatment programs for women are responding to women’s needs to connect with other people who have important roles in their lives, as mothers and as friends and as partners. In a therapeutic environment, you get men to disclose and acknowledge responsibility. But with women, that’s never a problem. Women are always willing to accept responsibility for their behavior and anything else that they can possibly claim responsibility for. And they’re willing to disclose a lot more readily in therapy than men. You have to treat a woman in a more holistic fashion.

E: Both residential drug treatment and incarceration, in most cases, rip mothers from their children.

B: That’s true. A couple of prisons have infant programs, but the kids can only remain for a few months. Residential treatment usually excludes children, but more and more they’re being brought in with the moms. But that’s an issue that we need to consider carefully. Talking to women themselves, sometimes they’re really looking for a break from their social responsibilities so they can take care of themselves instead of always taking care of someone else.

E: Observation: Drug treatment expects the nearly impossible. I.e. it expects people to be able to figure out how to remain clean and sober for the rest of their days. The consequences of relapse, both in the residential drug treatment and within the criminal justice system, seem to have equally horrific consequences for women, with failure resulting in incarceration.

B: Assuming that drug treatment is part of a correctional program, or some sort of diversion, yes, I think it is nearly impossible. We know that relapse is predictable. We hope to extend the periods of relapse, from point of failure to point of failure, so that over the course of a woman’s life she will come to a point where she can remain clean and sober. Certainly, one would not expect that early in her recovery career. But there are very few places where you can fail without being incarcerated again. If a woman in a residential drug treatment program goes out and gets high, and she comes back and they discover this, they throw her back in jail. And certainly if she commits any crimes she goes back to jail. Yes, I think both actions have the same result, depending again on the residential treatment program, and their policy toward use during the program. If it breaks their policy of total abstinence and it’s linked to a correctional program (which is fairly common), then the woman goes directly back to jail.

There are very few places where you can fail without being incarcerated again.

Collected by Ellen Miller-Mack

The following 2 letters were written by women who are, in effect, political prisoners. They express their feelings and observations about the drug war, particularly how incarceration and coerced treatment have impacted their lives. Lisa ran away from home for the first time at age 5. She was in and out of foster care throughout her childhood, and took up drug use at an early age. She was a patient of mine while in jail. Dianna’s parents were writers who also taught at a number of colleges around the world. She was exposed to heroin as a teenager, while living in Australia. She was a patient of mine while in jail. Dianna’s parents were writers who also taught at a number of colleges around the world. She was exposed to heroin as a teenager, while living in Australia. She continued on with her own education and has a postgraduate degree. At the time Dianna wrote this letter, she was incarcerated for violating probation, and was negotiating with her probation officer. Dianna was eventually released to her mother’s custody.

Nurse practitioners provide medical/primary care, very
E: Residential drug treatment and correctional facilities are similar in their emphasis on security and control. The rules are very arbitrary, and women are treated like children. This is where the link between treatment and incarceration is most oppressive.

B: In mental health treatment, correctional facilities and drug treatment, one of the foundations of intervention is creating doable behavior contracts. Involving women in creating very specific behavioral plans can give them a sense of safety. I.e.: this is what you can do. If you don’t do this or you do this, this is what will happen. Really laying out the consequences of unwanted behavior. The difference is in creating a contract with women instead of creating rules without their understanding why or how it might benefit them. There is a nothing to gain from infantilizing people. And there is no gain from excluding women from their own recovery process. But I do think that contracts for minute behaviors can create a sense of safety for women.

E: Some women’s sexuality is devastated. It’s very difficult for me to imagine how a woman can come into her powers in either the setting of incarceration, or residential drug treatment.

B: Many women will be returning to the community and returning to relationships with male partners. In single sex places, it’s very difficult for women to reclaim their sexuality, or begin to understand their sexuality and sensuality.

E: And when some women finally have an opportunity to develop emotional and sexual relationships with other women, it is not allowed.

B: That is correct. One fact we know is that women who are addicted to drugs and alcohol also have higher rates of childhood physical and sexual abuse. There are a lot of problems and issues around sexuality, and healing needs to be accomplished. In the therapeutic communities that have mixed populations, the sexual politics and the sexual exchange can be really problematic: not healing to women but rather continuing patterns that have hurt them in the past and continue to hurt them. And in American society we don’t allow women to be their own sexual persons, to derive pleasure safely, on their own terms, from their sexual activities. We don’t have a trauma recovery that is body-based, only the kind that’s thinking-based.

E: Let’s think about sexuality in the broad context of self expression, sexuality as part of just being a living, breathing woman. Let me give an example of what happened to a woman that I know, in a mixed residential program. She got sent back to jail for flirting with a man in the kitchen. She was expressing herself. And she may have been doing something that was intuitively part of her healing. Yet unconditionally that is perceived as something negative, detrimental, something to be punished for.

B: What can I say? It’s not an individual issue, it’s a systems issue. It’s a program issue. Female inmates also get punished for trading sex for cigarettes or favors from correctional officers. That makes no sense to me. In situations where there are power differentials it makes no sense to me to punish the person who has a lower power position for trying to improve their situation. It happens all the time. Judging women for their behavior by a standard that is different from the males is endemic in our culture. I assume that the male recipient was pleased with the attentions, and if this person was not similarly punished, that’s really problematic. But how do you address something that is so inherent in a culture? I don’t find it surprising. It’s quite predictable. The rules are explicit: no fraternizing with the opposite sex. It flies in the face of a woman’s self expression as a full human being.

E: Observation: Conditions of probation link drug treatment and incarceration, unmercifully. The contracts are very explicit, including, oftentimes, completely disrupting a relationship that they may have with someone who also happens to have been using drugs or who also happens to have a record, along with the random urine tests or the daily urines. The absolute abstinence includes abstaining from people women have relationships with.

B: Women often use drugs in association with somebody. So what’s the easiest way to improve the probability that a woman will be able to stay clean and sober? Disrupt their relationships with drug users and associates. That’s research based. Corrections/probation are very interested in research based outcomes. So they will use what comes out of the research community and say, “okay, well let’s improve our probation success rate, and this is the way we’re going to do it.” It’s goes back again to the idea of probation.

What is probation? If the purpose is to reintegrate the individual into a community, you’re more likely to put into place intermediate sanctions, progressive sanctions, change supervision levels for someone who is at risk of relapse. But if you believe probation is risk management and that anyone using drugs becomes an increased risk to the community, then if the woman fails her drug treatment, she will be re-incarcerated. much the way doctors do. In most states, we can write prescriptions for all kinds of medications; we diagnose and treat.

In some settings, we are able to spend more time with folks than doctors. My focus is on helping each woman achieve her own health goals. I am a partner, listener, facilitator, advocate and clinician. The women at the jail entrust me with the stories of their lives, and are open to discovering how to feel better. I’ve been listening to these women very carefully, and a whole world of brazen injustice has opened up to me. Of course I can’t speak for anyone but myself, but I take what they’ve taught me and speak. And I encourage them to write. What can they really use from the various institutions that have intruded on their lives? What will relieve their pain, bring them back to their kids, begin their healing? What would meaningful, effective, healing drug treatment look like? What is safety, and have you ever known it?

My gratitude to these women is huge. They give me clarity of purpose.—ELLEN MILLER-MACK

April 15, 1998

Dear Ms. Jensen,

Hello from Rikers. I hope you are doing well. This is Dianna Kastanakis, one of your people on probation. I am ok, feeling much healthier and mentally much clearer. I’ll be seeing you on the 21st in court.

First and foremost I would like to apologize for not having heeded your recommendation of going to court, but I unfortunately was focused on my using at the time. I realize that you were only trying to look out for my well-being and trying to keep me out of more trouble. I wasn’t being responsible back then—and I’m doing my time for it. I know my parents have kept in close contact with you and the police department, and that they have expressed their opinion on, and concerns for, my future. Although their residence is probably the safest environment for me (and what I often refer to as my home), I am 28 years-old and should be judged as an individual. And there are other places that are safe and drug free where I could temporarily reside. I do understand and respect, however, all the concern my parents have, and I regret all the suffering I have inadvertently caused them through my substance use.

I would like it to be known that I am not interested in completing a treatment program. Here in jail my movement might be restricted but I at least have freedom of thought, something I would not have in the programs. I know that to succeed in treatment one must have a desire within to be drug free. However, I also feel that some programs are actually detrimental, and neither suited to my personal needs nor to my philosophy of recovery.

If I use once I am told that I have “relapsed” when I’d rather think of such an incident as “research.” I am told that I have a disease, which I do not accept. I am told to always use the word “addict” after my name. Why not identify as a daughter, as an anthropologist, as a human being? I am told to focus on self-defeating behavior rather than self-empowering behavior. I am told that as a prostitute I was selling myself; this is a moral judgement that is very dangerous (as if people were or could be commodities)! I was my own boss, selling a service, never degrading myself because of my occupation. On the contrary, I empowered myself, while growing and learning immensely about myself and other people. This even though sex work is illegal (but
The idea of risk management is built on male offenders, and probation department policies are based on male offenders. The unrecognized cost of returning a woman to incarceration has not been considered by most probation departments.

Love and sexuality are part of human existence. It’s very hard for me to accept that something good and healthy—involving love in a relationship—is not permitted, as a condition of probation.

B: No, it is because they are considered poor fits. There are exclusionary criteria based on diagnostic category. If you have any kind of a psychotic disorder you will be excluded out of hand. For women, this is problematic. Number one, it needs to be person based. If a woman who is diagnosed with schizophrenia has the ability to sit through groups, and to benefit from residential treatment, I believe that she should be allowed to. Secondly, because diagnoses are not hard and fast, and a woman’s diagnosis will shift over time, those exclusionary criteria are very damaging. If you link drug treatment and correctional outcomes (i.e. treatment brings diversion from jail into probation), and there is an exclusionary criteria for a woman who has a mental health condition, then you are treating women differently and it’s having an impact on their constitutional rights.

Although we don’t have the prevalence estimates in general for women that exist for men, there are two female-based studies available for mental disorders, one of jails and one of prisons. There is nothing about probation. We don’t know a whole lot about the intersection of criminal behavior, substance use and mental health symptoms, and we know less about it in terms of women. We don’t know the impact of the violence that women sustain over the course of their lives, especially on their substance abuse.

who are drug users, it is more complex. Often times people can keep those relationships pretty secret, depending on what the probation department’s standard is for supervision. I think women are real smart about this. If they’ve had enough time to think about their recovery and reflect on their pathways into addiction, they make their own choices. And they will continue to make choices, knowing that there are consequences for those choices.

Do you think that it would be a good and healthy thing, if the range of choices for women includes continued use of an illegal substance? B: In this current culture, I don’t see that happening. But let’s push the envelope a little bit and go over to alcohol. Or prescribed drugs. Because women can abuse alcohol or prescribed drugs without criminal sanction.

Concerns do you have regarding women with mental illness? B: The sad state of affairs is that most women who have significant mental health problems are excluded from drug treatment, period.

Because they are not allowed to take medication?

We don’t know the impact of the violence that women sustain over the course of their lives, especially on their substance abuse.

that is another issue altogether).

In jail I can avoid contact with certain people. In a program I am encouraged to interact with, and confide in, people with whom I’d rather not share my vulnerabilities: many people react hatefully and meanly when threatened or jealous of an individual. In a program I am also told to not interact with men, and overall I feel that women are encouraged to “act like ladies”—in other words, to be dainty and submissive rather than assertive and “real.” My success in the program depended on active participation in AA and NA meetings, and I was doomed to failure for having an interest in Rational Recovery and Buddhist spirituality.

At least in jail I can choose the books I read without fear of criticism, choose who I associate with and to what extent, and decide whether I want to go to AA or NA meetings—which, incidentally, I am on the waiting list for. Here I can go to the gym, read, write, have a prison job, go to art class and go to church, and I don’t feel anybody is trying to transform my way of thinking to fit someone else’s mold. There is more than one path to self-improvement, and here I feel the path I prefer is more accessible.

My point is I’d rather complete my time in Rikers rather than in a program. I honestly find it more beneficial for my situation, considering that my parents don’t seem anxious to have me at their house upon my release, I would rather wrap up my case, since probation until April (or extended probation) would be more rope to hang myself with, and prevent me from going to my native country, Greece.

My mother did mention to me that she would be willing to take me into her home if I was in a methadone program. I consider this to be a reasonable option, since I have had trouble staying off heroin for the past six years. Although I would still be dependent on a substance, my life would have some structure and stability, and could be normal and crime-free. However, I must say that right now I feel reluctant to be released into a methadone program. I’d rather wrap up my time with perhaps 30 more days in Rikers. Then, upon release, deal with my addiction and consider seriously whether methadone is what I need. (I would prefer heroin-distribution programs to methadone as heroin is much less harmful. I won’t get into the reasons why we don’t have this choice, other than to say that it’s a politically motivated decision that’s related to the enormous amount of revenue this drug’s continued illegality generates in the black market.)

I hope this letter finds you in good health and spirits, and I hope you take my feelings and opinions into consideration. I believe we can come to an agreeable compromise. I did complete almost four months of treatment, and gave only one dirty urine for marijuana. Although sufficient reason for discharge—which I can respect, but feel is a little severe—it was not heroin or cocaine. I did trespass, but I hope you don’t feel that this merits too severe a punishment. In any case, I know and have faith that you have the utmost concern for my well being. I thank you for your time and patience, and I am looking forward to seeing you on Thursday the 21st.

Sincerely,

Diana Kastanakis
adulthood, if not starting very, very young—has direct and known mental health consequences. So the women that we’re seeing in corrections have pretty significant emotional problems. As long as that goes unacknowledged and untreated, we set women up for this continuing cycle of violence, of substance use, of incarceration.

Our conditions of confinement, particularly for women who are victims of violence, are inhumane. They directly mimic what has happened to them as children. We need to start thinking about those conditions of confinement. Privacy, supervision, how we manage women in crises. Whether we have men in uniform throwing a woman to the ground or whether we have talk down strategies. How we restrain women for psychiatric purposes. All of those things need to be reconsidered, as they are being reconsidered in the psychiatric community. I would like to see the number of women incarcerated, particularly for drug related offenses, reduced.

I don’t think any woman who is convicted of a non-violent crime needs to be behind bars; I think its social cost is too high.

**E:** What if you were designing a diversion program for women with mental health issues?

**B:** First and foremost is meeting basic needs, like housing that allows women to have children with them. If you have that, you can then find ways of giving women meaningful roles—whether that is involvement in educational activities, job readiness or employment. So that women can normalize their lives, have something that is meaningful for them to do. Then you set up a structure in which women can start their recovery emotionally and from substances. The clinical services that are required on top of that are fairly minimal. I don’t think it’s necessary for all women to have psychotherapists. I do believe it is important for women to have friends and relationships, and opportunities to talk to each other. Women need a full array of services that they themselves choose to receive.

Many women do want professional assistance more than medication. Many women find medication to work quite well, some women don’t. Some women really like to have a professional to talk to for lots of different reasons. A typical request may be “I don’t want to burden my friend with this, but I really need to talk about this.” It may be a safety issue, like “I’m afraid that I can’t control myself and I need to talk to a professional where I feel safe to fall apart.”

**E:** So then really, these are all elements that need to be used in residential drug treatment, assuming that the majority of women who are in those programs have mental health issues? And would they be beneficial for women with very serious diagnoses, such as bipolar disorders, or schizophrenia?

**B:** Sure, those are the fundamental requirements. You’ve got to take care of basic needs first, and roles are very important for women. And then the clinical pieces are important, but if you can’t take care of the basic needs first, nothing else really matters.

**E:** Will it ever be possible to infuse traditional drug treatment with harm reduction strategies if the criminal justice system is paying the bill?

**B:** I think so. If you can get the corrections side to understand recovery, then I think you have a chance of pushing harm reduction strategies. That’s really, really difficult stuff. But hypothetically it is possible. We’ve been pretty effective in getting harm reduction strategies out to the general public. If you can gain the acceptance of drug treatment, and have them saying harm reduction is safe and therapeutically sound and efficacious, then the department of corrections will probably come too.

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Bonita M. Veysey, Ph.D, has written several articles on the specific needs of women with substance abuse and mental disorders in the criminal justice system and has consulted with correctional facilities regarding the need for services for women in trouble with the law. She worked as a researcher in mental health services and corrections policies for 15 years prior to joining the faculty of Rutgers University.

Michael Jacobson-Hardy is the author of Behind the Razor Wire: Portrait of a Contemporary American Prison System and The Changing Landscape of Labor: American Workers and Workplaces. His photographs have been exhibited widely and are included in many public and private collections, including the Smithsonian Institution, the Henry Ford Museum, the Yale University Art Gallery and the Rose Art Museum at Brandeis University.

Lisa writes from jail

In my 23 years of existence I have seen a lot. A lot of drug abuse, a lot of crime, a lot of incarcerations and much drug treatment. From my experiences I have formed some opinions of my own about how drug addicts should be helped.

I definitely don’t believe that locking people away from society is the answer. Something like over 80% of people incarcerated in county jails are there for drug-related charges. These charges usually consist of minor offenses such as violations of probation, dirty urine, simple possession and small-scale larceny. Recidivism is very high for addicts, meaning they go out and do the same kind of crimes—most of which don’t endanger anyone directly—and end up back in jail. I am aware that drugs are illegal and I won’t go into whether I think they should be or not; I just don’t believe that someone who is in jail for giving a dirty urine should get the same sentence as someone who commits “real” crimes.

Jails don’t offer much to help addicts recover. There are some short term groups which basically educate people about addiction and suggest ways to stay away from drugs. They tell you to change just about every aspect of your life: avoid “people, places and things.” I really don’t think all of that matters as much as what’s in your head. I know no matter where I am, no matter who I’m with, if I get the thought in my mind that I am going to get high, I do it. It’s really hard to give up everything you know and a lot of people can’t.

As far as programs like halfway houses go, I have mixed feelings. I’ve been to six different programs and a couple of them twice. All of them had their own philosophies and rules. Some were very strict and had a lot of structure: lots of groups all day and limited or no freedom to do what you want. I didn’t last long in those programs. The longest I made it was about 2 weeks before I either get thrown out or left on my own. They may work for some people but I found the more rules there were the more reasons I had to rebel. I didn’t like having to be forced to talk about my feelings, or past; if you aren’t ready to deal with all of that, it actually causes more harm than good. There wasn’t really anything to prepare people for the dealing with the “real world” upon release, where there isn’t that type of structure, or people to make your decisions.

There are programs that go to the extreme opposite and have very little structure and a lot of freedom to do whatever you’d like. Instead of paid staff to tell you what to do, a “social model” runs it; meaning you are supposed to go to other residents for help and support. It’s important to learn how to ask for help. But again, if you’re not ready for a lot of freedom, which can be dangerous, then it’s not good. Out of all the programs, this is the only one I graduated.

Then there are the programs that fall somewhere in between. I find those to be the best to help you not only stay away from drugs and alcohol, but to transition into society, too. I think it’s important to have a middle ground with structure and freedom.

I’m not sure if jails or programs can make any difference to people who aren’t ready to change. I guess it really depends on how desperate a person is.
The parole system had its root in the moral ideas of the Quakers. The Quakers held that an individual should, after some time in prison reflecting and rehabilitating, be released into the community at the earliest possible time. “It’s purpose is to help individuals reintegrate into society as constructive individuals as soon as they are able...” said the United States Supreme Court in *Morrissey v Brewer*, a 1972 case which formalized parole law. In order to help the parolee make the transition back into the community, the parole system mandates that they obey a series of stringent conditions designed to prevent behavior that’s seen as dangerous or destructive, and that they report regularly to a parole officer. That officer was historically cast in a combination role as a cop and social worker, and the workings of parole were more informal and collaborative than the adversarial set-up of criminal trials. The Parole Officer was to counsel the parolee; refer them to counseling, treatment and job training as appropriate and generally offer support and a sympathetic ear to individuals attempting to adjust to life in the “free world.” At the same time, if the P.O. believes that her supervisee isn’t adjusting properly, her responsibility is to impose new conditions of parole or, as a last resort, charge them with violating the conditions of their parole and re-incarcerate them.

As rehabilitative (change) oriented theories of incarceration have been replaced by an ideology of punishment, the parole officer has become more and more a law enforcement officer and the system of parole more about repression than reintegration. Parole officers are under substantial pressure to re-incarcerate their parolees at the earliest opportunity rather than to work with them over the rough spots.

Whether the parole system ever lived up to its humane-sounding ideals is open to question. There’s no doubt, though, that parole officers are feeling pressure: recently, the N.Y. State Parole Officer’s Association circulated a petition opposing the N.Y. Police Department’s use of parole officers in law enforcement operations like “Operation Gunslinger.” The N.Y.P.D. are taking advantage of the fact that while police need a warrant or consent to enter an individual’s home, parolees must let their parole officers come in and search their homes, as part of the conditions of parole. “Gunslinger” and other recent campaigns have teamed P.O.’s with N.Y.P.D. officers, who get a free pass past your constitutional rights and into your home as a result.

The reality of parole can be harsh. If you are granted parole, your “discharge plan” to parole may very well instruct you to report to a homeless shelter as your “approved residence,” even if you have a history of serious mental or physical health issues. (In those instances, you may very well be released without sufficient medication or, more likely, with none at all, and directions to go to a hospital emergency room the day after your release for assessment. You will be expected to travel at your own expense to meet with your parole officer, apply for public assistance and attend drug treatment programs and job-training. If you fail to keep any of these appointments, you may very well be charged with violating your parole and sent back to prison.

One of the standard conditions of parole is that all drug use is prohibited. The parole system will most likely require any individual with a substantial drug history to submit regularly to urine tests by their P.O., and to participate in some sort of drug treatment. Though P.O.’s will look askance at continuing positive urinalyses, their significance may be outweighed by the individual’s continued participation in treatment. Of course, those of us who defend accused parole violators too often see situations in
which parolees are violated before any attempt is made by the P.O. to refer them for any type of supportive programs.

Tips for Agencies
If you interact with parolees as a service provider there are a variety of ways you can support these clients. If your client has the misfortune to be charged with a parole violation (or even if the P.O. and their supervisor are considering it) your intervention may prove to be vital:

First and foremost: if you report a client’s failure to regularly attend a program, or failure to participate appropriately, they may very well be sent back to prison. Try to balance your contractual and professional responsibilities with the understanding that parole is a “zero tolerance” system. If you have to report a client’s non-participation try to include in your report a recommendation that they return to your program after they are again released from jail, if that is appropriate.

Parolees are far too often charged with parole violations because of inaccurate information provided to their P.O.s by drug treatment and other programs. If you are asked whether or not an individual is still making use of your services, make sure you give the right information. Trying to retract incorrect information after your client is incarcerated for a parole violation is difficult, and they will still spend days if not months in jail waiting for it all to get sorted out. If you have the opportunity to make a positive assessment of a parolee’s participation in your program activities put it in writing and send a copy to both the parole officer and to the individual.

If You Are On Parole
You probably already understand that the system is more interested in your submission to their authority than they are in what you're really thinking or doing. If you are on parole and are using drugs or have a substantial drug history, the best course of action is to find a drug treatment program you can live with, and build whatever relationship you can with your counselor there. Showing that you are attending consistently may prove to be more important than a dirty urine.

If you are referred to a drug program that you don’t find helpful, feel free to locate another one for yourself—but make sure that your P.O. knows what you’re doing, and don’t stop your attendance at the first program till your acceptance into the second one is firmly up.

There are conditions of parole that prohibit being involved in criminal activity, and that require you to report every instance of police contact to your parole officer as soon as you can. An arrest will not necessarily result in a violation of your parole, but failing to tell your P.O. about it most likely will.

If you are arrested or even questioned on the street by a police officer make sure that your parole officer is informed as soon as possible. If you are incarcerated and are having trouble making telephone calls, get someone else to do it: your attorney at your arraignment, a social services worker in the jail, a chaplain or a relative. If the parole officer is difficult to get in touch with, have that person request to speak to a supervisor and write down their name and the date and time of the call. Your parole officer will automatically get an “arrest notice” informing them of your arrest a day or two after it happens, so you’re not saving yourself by failing to notify them.

You have probably had experience with a lot of attorneys, some not so competent. If you are arrested on a new criminal charge or charged with violating your parole, try to let your attorney know the truth about what happened. They can’t talk anyone without your prior approval, and it’s better if they hear it from you than from the prosecutor.

Eve S. Rosahn is an attorney with the Parole Revocation Defense Unit of The Legal Aid Society. If you are on parole, or if you are a service provider who works with parolees, and you need some information, please call her at 718-260-4749, or send an e-mail to her at erosahn@legal-aid.org.

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**PRISON FACTS**

- There are about 70,000 prisoners in NY state prisons, and another 20,000 being held at Riker’s Island alone on NYC sentences or awaiting trial or parole revocation hearings.

- One-third of the people who went to jail in 1996 were parole violators, often as a result of drug use.

- 23% of all state prisoners and 60% of all federal prisoners are incarcerated for drug crimes, and we don’t know how many for drug-related crimes.

- The chances of getting a prison sentence after being arrested for a drug crime rose 447% from 1980 to 1992.

- In 1997 only 9.7% of prisoners nationally were receiving drug treatment, down from 24.5% in 1991—despite the fact that treatment is often a requirement for parole release.

- There are profound racist disparities in who goes to prison for drug use. African-Americans represent 13% of the nation’s monthly drug users, 35% of those arrested for drug possession, and 74% of those who go to prison for drug possession.

- Number of prisoners in all US corrections facilities: 2,000,000

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1 The figures in this section were obtained from The Sentencing Project, a non-profit organization studying the rates and nature of incarceration in the U.S. Try their web site at www.Sentencing project.org, or write to them at The Sentencing Project, 514 10th Street, NW, Suite 1000, Washington, DC 20004.

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What do we mean when we talk about harm reduction? This term is used and abused so often. Agencies are named, trainings are given, jeremiads are hurled, conferences are convened, all in the name of harm reduction. I was sure I knew. There might be shades of difference between my ideas and those of the people who sat around me at the plenary of HRC’s 2nd National Harm Reduction Conference, but all of us would probably agree on most of the basic issues.

Secure as I was in my grasp of harm reduction, I was dispatched to bring the gospel to Moscow. On the plane on the way over, I sat next to an information systems engineer from Indiana who had a suitcase full of religious tracts. Both of us were on a mission: he to save souls, me to save lives. Both of us were self-righteous in the way that all true believers are.
I spent twelve days in Moscow in May (1999-2000), and now I am left wondering what harm reduction is all about. My ideas about harm reduction have been informed largely by my work at the Lower East Side Harm Reduction Center, and my knowledge of similar programs. I see harm reduction as a set of strategies for working with people who use drugs so that services can be delivered in a meaningful and appropriate way. I see harm reduction also as the basis of a critique of many aspects of American society, from the war on drugs to the inequities of the healthcare system and on and on. By nature I am suspicious of all orthodoxies. My approach is wholly pragmatic, and I’ve always liked the fact that so many aspects of harm reduction were self-evident and common sense approaches. Smug as I was in my belief in my pragmatic outlook, I hoped that there was much good that my agency could do through this partnership: no vague hocus-pocus, just concrete, replicable programs and strategies. Injection drug use is exploding in Moscow. During the Soviet era, all pharmaceuticals came in liquid form, cheaper than pills or capsules. At the same time, there was no pot or crack to smoke, and very little cocaine or heroin to snort, so if you were a drug user, you were shooting up. The end of the Soviet era left an entire country in a vacuum of values and assurances. There were no longer any guarantees. Since 1991, tanks have rolled through the streets of the capital, banks have vanished, the health care system has collapsed, people work for months without receiving a paycheck. Many young people have started using drugs. Twenty percent of the students at Moscow State University are shooting up. Rates of HIV are just a step behind. In 1995 there were 500 known AIDS cases in Russia. As of December, 1998, there were 20,000. Ninety percent of these are related to syringe sharing among injection drug users. Over the winter (of 1998-99, ed), I put in a proposal to partner with a Russian non-governmental social services agency to provide technical assistance in developing a program to prevent the spread of HIV among injection drug users. Here in New York City, syringe sharing is driven by the scarcity of sterile syringes. Provide access to sterile syringes and you bring HIV transmission to a standstill. Further, you provide a gateway to services and healthcare to people who wouldn’t otherwise have that access. All so obvious. Because syringe exchange has been so successful in reducing the spread of HIV in communities where injection drug use is prevalent in New York City, surely the same benefits would be seen in Moscow. Our proposal was enthusiastically funded. We were partnered with an agency called NAN, an acronym for Nyet Alkogolizmu y Narcomanii, or “No to Alcoholism and Drug

People come in to be tested because they are sick, and they want to find out if HIV is the cause of their illness.
Here in the U.S., the way we connect with drug users is by offering syringe access.

Use.” (The name alone made me suspicious.) NAN began their work providing services to children who were made homeless by their parents’ drug and alcohol use. They set up a shelter for these children in 1987. Gradually, they began to provide services, such as drug detox and counseling, to the drug using parents. In Russia, all of these ideas were completely new. NAN was the first to break this ground. The president of the organization has been named a special advisor on youth and drug use to the Russian government. NAN enjoys a sterling reputation in Russia, and provides trainings to service providers throughout the Confederation of Independent States (CIS). The purpose of the May trip was to meet the folks from NAN and develop a workplan to guide our efforts over the next two years.

Moscow is an intensely political city. The Russian President, Boris Yeltsin, was the former Moscow party boss. The current mayor of Moscow, Yuri Lushkov, will probably be the next president. People who work in City government want to work in the regional government. People who work in the regional government want to work for the Federal government. The way not to advance is to be associated with anything controversial.

Mayor Lushkov has put billions of foreign aid dollars into beautifying Moscow. Everything has a fresh coat of paint. The city is the cleanest I’ve ever seen. Russia is also a largely militarized society as a result of the decades of the Cold War. There are three police forces and their duties and responsibilities overlap. But basically, being a police officer is Moscow is all about using the threat of arrest to extort money. Police tend to only stop BMWs and Mercedes for traffic violations. If commercial sex workers or drug users have a few hundred dollars on them, they avoid arrest. The police are everywhere. There’s one on every corner, as stone faced Socialist-Realist era heroic statues. They don’t even say hello back.

NAN is committed to doing needle exchange. They have managed to get a letter of acknowledgment from the local government office in the southwest corner of Moscow where they operate, as well as the local police precincts. They will begin by developing literature, then starting street outreach, recruiting peer outreach workers, developing contacts and gaining the trust of users. Next August, they start distributing syringes.

After working for five straight days to develop a workplan down to the slightest detail to accomplish this, I am frankly at a loss to claim definitively that this will be a harm reduction program. It will provide access to clean needles, street outreach and supportive services, but it will be unlike any one of the dozens of organizations I’ve seen that do that in the U.S. For one thing, the drug users are different. They’re all young. Twenty-three is old. A conversation I had with two users was telling in a number of respects. Valery and Ivan (not their real names) were 19 and 21, respectively. They had both been shooting up since they were about 14 years old. They shot white heroin, which costs about $50 a gram. They also shot speed, which goes by the name of “vint.” Cocaine was way out of their price range. I asked about black tar, and also about a sort of opium poppy soup I had heard was common. They told me that tar was a pain in the ass because you had to cut it with vinegar, and it was full of crud. The opium soup—boiled buds and seeds of opium poppies—is mostly used by younger kids. As Ivan put it, “I would have to inject two liters of that into my arm to get off.” I asked them about syringe access: did they ever have a hard time getting syringes? In Moscow, syringes are sold at every pharmacy. It is illegal for the pharmacist to refuse to sell you a syringe. Surely it can’t be that easy. In fact, it is. The only time Valery and Ivan had a problem was when they don’t manage to cop until one in the morning and everything is closed, and then it’s your own stupid fault for not thinking ahead and spending a few cents for a syringe at the pharmacy.

Next I asked them about syringe sharing. Had they ever shared syringes? Both of them gave an emphatic no. Never. Stupid thing. Surely it can’t be that easy. In fact, it is. The only time Valery and Ivan had a problem was when they don’t manage to cop until one in the morning and everything is closed, and then it’s your own stupid fault for not thinking ahead and spending a few cents for a syringe at the pharmacy.

Then I asked if they ever knew anyone who had HIV. They both knew of one person. They had met him in a detox program. While he was in the detox, he had been tested for HIV and found out he had AIDS. I explained that a person could have HIV and feel strong and healthy, and have no visible signs of having HIV. The expression on their

Above: Students of Moscow Architectural Institute inject black-market pharmaceutical Ketamine. A 10cc bottle cost about $10.00 and is good for 10 doses. ©John Ranard
faces was the one people get when they realize that the person they’re talking to is crazy.

This lack of awareness that people can be HIV positive and not have AIDS is widespread in Moscow. I visited an HIV testing clinic run by NAN. I asked the counselor what made people come in to be tested. Were they worried about high-risk activity they were involved in? Had they read a brochure? Had they found out that a former sex partner was HIV positive? It was explained to me that people come in to be tested because they are sick, and they want to find out if HIV is the cause of their illness.

Without the knowledge that someone could be HIV positive and appear to be the picture of robust health, there’s no perception of risk. The only “face of AIDS” that many Russians are familiar with is the devastation wrought by end-stage AIDS. Obviously, you would hesitate before sharing works with someone so visibly afflicted.

In the context of Moscow, education, rather than syringe access, becomes the crucial point. This is where harm reduction gets tricky. Here in the U.S., the way we connect with drug users is by offering syringe access. This radical yet simple act communicates a great deal in and of itself. The user doesn’t need it explained to him or her that this person offering them sets sees them not as just an addict to hassle into drug treatment, but as someone who can make choices, who can be educated and whose life is worth saving. Working in our exchange, I see it all the time. When someone comes in for the first time, they’re expecting a hassle. They’re preparing themselves for a counseling session, where they’ll have to give their whole life story and the theme is, “Gee, I’ve tried to get off drugs again and again. I’m so miserable I hate myself. Please help me.” When they realize that to the extent that the regulations of the Department of Health of the State of New York permit, there’s none of that—no questions, no coping to an identity that isn’t real to them, and, if you don’t have to rush off, stay and have a cup of coffee and relax on the sofa for a while—there is an immediate sense of ownership of the space. This is a place for people who use drugs. That’s basically how I look at harm reduction. Safe space. Come in out of the drug war outside, put your feet up and feel at home.

But what will it be like for NAN? Because syringes are available, offering syringes is less of a radical act. What will be involved in gaining the trust of users in this context, given the fact that syringe access is not the meaningful act we New Yorkers experience it to be? Furthermore, what if the street outreach worker doesn’t happen to be a medical doctor? Will the information have any weight?

Attempts made by agencies informed by the Dutch model of harm reduction, coming out of self-organizing among communities of drug users, have not been successful in Moscow. This model is seen as alien (and it doesn’t help that the people trying to introduce this model are, by and large, not Russian but American and European). The users I spoke to thought that the people running such programs were crazy.

Russians also have a completely different way of looking at social services. For one thing, they are completely materialist in their approach. Treatment is treatment: it is a procedure or a medication. The talking cure, psychotherapy, and its numerous variants have all the usefulness of bathing suits in the Arctic. At the same time, psychiatry was used as a means of political repression in the past. Furthermore, there is the pervasive thinking that if you don’t have a doctorate, what you have to say can’t be of much value. AIDS activism here in the U.S. has worked to diminish this “cult of the expert.”

When offered free syringes, users won’t necessarily be grateful or open or feel that they are being treated with dignity despite their drug use; rather, they’ll probably just be perplexed. You, and not your doctor, is the expert on what goes on with your body. Similarly, a drug user is the best person to speak authentically about drug use, not a doctor or researcher. Giving people a role in shaping and determining the policies and decisions that will affect their lives is called empowerment, and this idea seems wholly alien to every Russian I’ve spoken to.

For example, I had described to me by an Irish woman working in Moscow the horrifying scene she witnessed at a clinic for treatment of STDS. On a tour of the clinic, she was given a white lab coat to wear and shown into a room where about sixty men and women in white lab coats were sitting around in a circle. One by one, women who had syphilis were brought in and sat down in the center of the room. They were questioned about what symptoms they had, how they had gotten syphilis, why they didn’t use a condom, from whom had they contracted syphilis. At one point, an older woman was asked to take off her tunic and walk around the room so that each of the people in the lab coats could see the rash on her lower back. The women subjected to this sat stone-faced through the probing questions. The woman who related the story told me how she had voiced her outrage to the person giving her the tour of the clinic. He explained that the women agreed to take part in the study and it was explained to them that it was being done in the interests of medical science. Many of the women had done it before. He didn’t see what the problem was.

At the same time, Russians haven’t quite gotten around to criminalizing drug use the way we have. Drug use is viewed as a medical problem (to be addressed by doctors), not as deviant behavior. However, this may be changing. There are new laws that make possession of even a small amount of a controlled substance enough to put you in prison for several years, and there is even a law that makes it illegal to “promote” drug use. However, these laws were viewed by many people I talked to as attempts to address the threat of American cultural imperialism, rather than drug use. Lyrics of rock songs were the real target, not people in the

When offered free syringes, users won’t necessarily be grateful or open or feel that they are being treated with dignity despite their drug use; rather, they’ll probably just be perplexed.
these women he thought were injection drug users. He answered, “very few.” He explained that if a manager suspected one of the women to be injecting, the woman would be fired. That would leave the woman with no money, forcing her to work on her own at a Metro station on the outskirts of the city.

Strangely, everybody doing street outreach in Moscow seems to be focusing on the downtown area. True, there is lots of action there, but it’s a lucky break that NAN wants to work in a far-flung corner of this immense city. (This is where the sex workers get fired for being injection drug users have to work.) We visited the neighborhood. It looked very different (large, slab architecture apartment buildings, bare streets and sidewalks and, of course, sparkling clean), but it felt just like the Lower East Side. It’s also far from the center of power. Mayor Lushkov probably doesn’t keep very close tabs on what happens out there.

In October, some of the staff here at the Lower East Side Harm Reduction Center will go back to Moscow to give a training to NAN’s staff on HIV, harm reduction, street outreach, the works. Then, NAN will head out into the streets, armed with literature, condoms, socks, gloves, hats, bleach kits, syringes and folks ready to do on-the-street counseling and referrals to services. And then what? When they approach a group of people hanging at the Metro station waiting to cop, what will happen? I don’t think there’s an answer to this question. The Russian context is different in so many ways, that the same act—giving a syringe to a person who injects drugs—will be perceived differently. Yes it will be low-threshold, yes it will be non-judgmental, yes it will meet people where they’re at. But when offered free syringes, users won’t necessarily be grateful or open or feel that they are being treated with dignity despite their drug use; rather, they’ll probably just be perplexed. Since it will be a drug using peer—not an “expert” with a string of letters following his name—who is doing the street outreach and education, any information offered might be viewed with suspicion. Hopefully, the project will take on a life of its own. Like any living thing, it will adapt to its environment, but also change its environment by the very virtue of the fact that it exists.

MOSCOW POSTSCRIPT

By Drew Kramer.
Photo by John Ranard.

For a little over a year, the Lower East Side Harm Reduction Center has been working with Nyet Alcogolismu y Narcomani (NAN, or No to Alcoholism and Drug Use), providing technical assistance in developing a HIV prevention program for users. This article is a follow-up to the preceding one, which Drew originally wrote last September for our Fall, 99 issue.—ED.

In May, 1999 LESNEP staff traveled to Moscow to meet their counterparts at NAN. In August of 1999, prior to LESNEP’s October return trip to Moscow, NAN’s project coordinators—Sergei Polyatkin and Natalya Dolzhanskaya—came to New York. The ostensible reason was training. What I really wanted to do was give Sergei and Natalya an idea of what their project could look like, and also, what the whole continuum of care looked like here in New York City. For two frantic, fast paced weeks, we shuttled them around the city visiting other syringe exchange operations [New York Harm Reduction Educators, Positive Health Project, peer educator programs (Exponents/Arrive], AIDS day treatment centers, drug treatment facilities, methadone clinics, researchers. Anyone who could make time in their schedule, we were there. Comparatively, I was amazed at the disparity between options and services available to drug users living with HIV here in New York City (even with all the barriers that exist) and those in Moscow. Again and again Sergei and Natalya came back to the same question: who pays for all of this? We would then explain about Ryan White funding, CDC funding, funding from the State and City Departments of Health. (In Moscow—where things cost about as much as they do in New York—doctors who work for the government get paid about $300 a month, and often go for months without pay because the government can’t pay its bills.)

There was, however, a problematic development during the trip. I noticed that Sergei and Natalya seemed to have a fixation on training and research. This concerned me more than I let on. Although elements of training and research are built into our collaboration, they are ancillary. The overall goal is to ensure that injection drug users in Moscow get the education, tools and resources necessary to stem the tide of new HIV infections. Training and research are ways to make that happen, but not ends in themselves. However, even at our agency, the temptation is great. It is the rare individual who, in the freezing rain of February, would rather be out in the street doing sex worker outreach than in a nice cozy conference room sipping coffee and eating a danish and listening to a training on outreach strategies targeting sex workers. I didn’t want the project derailed by this trap.

Although training was the primary focus during most of the first year, in setting out the work plan, I made sure that it was on-the-job training. In October, I traveled again to Moscow, this time accompanied by Van Asher, our Outreach and Volunteer Coordinator, and Steve Finkel, our Substance Use Counselor. The night we arrived, we walked up to Red Square. Snow was falling.

The fledgling NAN outreach team started out simple: condoms, alcohol pads, prevention literature.
And what about NAN, the agency that’s going to be doing this work? My agency was started at the grass roots, by a group of activists from ACT UP. We were breaking the law for the first three years of our existence. NAN is the Russian equivalent of the United Way. Their work with users to date has been all about drug detox. And yet NAN, “No to Alcoholism and Drug Use,” is going to be doing harm reduction work in Moscow.

What is incredibly refreshing is that Sergei, the program director at NAN who will be running the project, sees none of these contradictions. When he says that he is a harm reductionist, he means that he’s willing to do whatever it takes to prevent the people he knows through doing this work for the past ten years from being wiped out by HIV. If that means braving the Russian Winter on a Moscow street corner to hand out syringes by the fist full, then so be it. When I would try to describe for Sergei the controversy surrounding harm reduction, and the battles that rage even among people working in harm reduction, he grows impatient. “It works. What’s to argue about?”

So here I am back at the Lower East Side Harm Reduction Center, working the exchange counter on a Monday night. I record syringes in, syringes out. I talk to people about the recent overdoses we’ve seen in the neighborhood, asking what they’ve heard, reviewing the basics of OD prevention. Making sure there’s milk for the coffee because I hate that powdered stuff and I’m sure everyone else does, too. Saying hello and catching up with the people I see every Monday night. Explaining to someone that if they left their ID card at home they have to stop at the desk and get a new one because that’s the best hope you have if you get stopped by the cops. Syringes in, syringes out. This is harm reduction, I’m sure of it. It only it were possible to figure out for myself just what that means. As my saintly white-haired grandmother would say, “If you could put that in a bottle and sell it, you’d make a goddamn fortune.”

Drew Kramer is Executive Director of the Lower East Side Harm Reduction Center.

John Ranard has been photographing the HIV story in Russia since 1995 when he discovered Moscow college students home-cooking and injecting their own chemistry. His photo-documentary project “Inside a High-Risk Community” has been supported by the International Harm Reduction Development program of the Open Society Institute and Medecins Sans Frontieres - Holland. A collection of these photographs will be exhibited at OK Harris Gallery, 383 West Broadway, New York City from November 18 to December 8, 2000.

Above: Outreach workers talking to users in Moscow. ©John Ranard
The culture of the healthcare and the drug treatment systems—bureaucratic, rule-driven, schedule-driven—is polar opposite to the street culture of its marginalized customers. On the street timing rather than timeliness is valued; personal loyalty counts above blanket rules and quick wits, courage and streetsmarts are valued above competence in filling out forms. The two cultures are so foreign to one another that when they meet, they are clueless about how one another behaves, and the customer comes out the loser. I’ll give an example. New York Harm Reduction Educators (NYHRE), where I work as a therapist, has a needle exchange site on 110th Street. One time we had a visiting case worker come out there to meet potential clients. I came in on the tail end of a conversation between her and a homeless guy who was HIV positive and totally unconnected to services.

Case Worker: “So, you’ll see me on Thursday at four o’clock. Please don’t be late, because I have people coming before you and people coming after you, and I don’t want to waste the time slot.”

Homeless Guy: “Okay, good. I’ll be there...”

Case Worker: “Anything else you want to ask?”

Homeless Guy: “Yes. When I come see you on Thursday, does it matter if I come in the morning or the afternoon?”

Was the homeless guy just being dumb? No. He was lost in a culture whose rules made no sense to him. Just as if the case worker had been told to come down to 110 Street and Lexington and cop a bag of dope. She would have made a lot of elementary mistakes negotiating that system. Of course, we in the mainstream culture believe our world is the “real” world. That’s natural enough. What’s not okay is when the marginalized customers get left flailing in the wind because they have trouble adapting to mainstream ways. Someone has to cross the great divide between these two island universes, and the people who should do that are the ones who get the paycheck.

Let’s take a step back and look at private industry’s version of lowering barriers between themselves and their customers. Back in the fifties corporate America discovered that if you clustered all your shops under one roof you could sell more stuff than when they were separated off one by one. We call that The Gap, a flagship store attracting a core volume of customers, these other services have been

Harm reduction wants nothing to stand between itself and its customers.

Needle exchange has not just been effective in reducing the transmission of HIV; it has also been successful in reaching out to a population of customers that no-one else seems able to get to. It makes sense to invite a few more “shops” into the needle exchange “mall” because, as we know from real malls, the more hot stores you have, the more successful the whole place is going to be. At NYHRE we have started that process.

Now that the U.S. government, the AMA and the World Health Organization have figured out that needle exchange is a good thing, we can look beyond fighting for our mere existence. Needle exchanges, occupying a unique place between the culture of providers and the culture of our most underserved people, are in a position to provide a host of services, like healthcare, case management, legal services, psychotherapy and so on. But to do this successfully, we have to cater to our customers.
If the client reveals a significant drug abuse, rather than a mental health setting, there will probably be a cat-and-mouse game between client and therapist where the therapist sees the client as an untrustworthy “addict.” Most of these elements represent barriers to service, and the customers who choose not to shop at the mental health clinic or the outpatient substance abuse program are considered “unready for treatment,” “in denial” or “recidivist.” The therapy at NYHRE, on the other hand, works on the low threshold approach of the needle exchange. The exchange itself takes place at tables on the sidewalk under a rather festive blue-and-white striped canopy. Acupuncture is given inside the van, workers for the various outreach initiatives combine the local streets and service providers like the lawyer and the referral person “work the line” of participants waiting to exchange syringes. Sidewalk psychotherapy takes place a few yards away from the hubbub of the needle exchange tables. The “office” comprises of two folding chairs and a card table to hold my files. A little like the lawyer and the referral workers, I mill around collecting clients by chatting with people who are making exchanges; and sometimes other workers at the site refer people to me. We then sit in the “office” and conduct a therapy session which is remarkably similar to what you might find in any other therapist’s office. But here are some of the ways in which sidewalk psychotherapy, being a low-threshold service, differs from the indoor variety:

- Service is immediate and, if necessary, anonymous.
- Intake takes two minutes; if it seems like it might discourage a customer, we skip it.
- There is no psychosocial assessment, no formal diagnosis, no formal treatment plan.
- There are no insurance requirements.
- There are no appointments.
- The client determines how long the session will be.
- The client determines the course of treatment.
- People who are high are as welcome as anyone else.
- To the client it be may like chatting; I know it’s therapy.

Street people, whose homelessness or drug use may have put them the wrong side of the law, are not always happy to reveal their identity to someone who could be connected to “the system.” But they live incredibly stressful lives and often have a pressing need for therapy. So we don’t ask for information that might compromise them. And unlike the rigmarole of appointments, intakes and assessments that takes place at a clinic, the client will have a session immediately—or as soon as I have finished with the person before them. Since we don’t ask for insurance, we don’t discourage people who have lost their cards, been thrown off Medicaid or who don’t want to endure waiting to have their card processed. Appointments may be king in the world of watches and calendar books, but they don’t carry much weight on the street. So the service is purely drop-in.

We don’t even respect the 50 minute hour (or is it 30 minutes these days?) The client sets the length of the session, which in turn depends on the client’s interest in staying in the chair. Some people can only bear to sit down for five minutes, others may go over the hour. Those who sit down (or stand up) and counsel for a brief amount of time may eventually be coaxed deeper into the process—or they may get their needs met as is. Since the client is in charge of the process, the course of treatment is not defined by the therapist or the insurance company, but by whether or not the client wants to come back. And like the FBI, no case is ever completely closed.

Diagnosis can invite a labeling mentality, so I don’t do it. In my notes, however, I do record the length of the session and its main themes, which might be something like, “Depression/Housing,” “Legal/Anxiety” or “Family/Drug Use.” Interestingly, over the course of any given month, the subject of drugs comes up less often than emotional concerns or the need for concrete services. For the customers then, drugs are not the paramount issue—even though providers divide up their whole service provision according to whether or not these customers are using.

Of course I see clients while they are...
Co-sponsored by the American Foundation for AIDS Research • Advocates for Recovery through Medicine • AIDS Action Council • Broadway Cares/Equity Fights AIDS • Center for Health Policy Development • Center on Crime, Communities and Culture • DanceSafe • Florida AIDS Action • HCV Global Foundation • International Women and Drugs Network • Latino Commission on AIDS • NAMA • National Association for People With AIDS • National Minority AIDS Council • North American Syringe Exchange Network • North American Users Union • Red Latino Americana De Reducción De Danos • Palm Beach Institute

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October 22–25, 2000
Wyndham Hotel Miami-Biscayne Bay
Miami-Dade County, FL

Exhibitors:
If you would like to exhibit call: Paula Santiago @ 212 213-6376 ext. 15

Keynotes
Carmen Vazquez, Lesbian and Gay Community Services Center, NY
Lynn Paltrow, National Advocates for Pregnant Women
Augustin Loya III

Potential speakers
Raquel Algarin (Lower East Side Harm Reduction Center, NY), Paola Barahona (Prevention Works, DC), Scott Burris (Temple University, PA), Patt Denning (Addiction Treatment Alternatives, CA), Karen Dodge (Palm Beach County HIV Care Council, FL), Delaney Ellison (CARES, MI), Heather Meschery (Santa Cruz Needle Exchange Program), Ethan Nadelmann, (Lindesthm Center, NY), Richard Needle (Office of HIV/AIDS Policy), Denise Paone (Beth-Israel Chemical Dependency Institute, NY), Dave Purchase (North American Syringe Exchange Network, WA), Emanuel Sferios (DanceSafe, CA), Carol Shapiro (La Bodega de la Familia, NY), Susan Sherman (Johns Hopkins School of Public Health, MD), Harry Simpson (Agouron Pharmaceuticals, MI), and Evelyn Ullah (Miami-Dade County Department of Health, FL) presenting the results of the Crisis Intervention Teams in Miami.

Confirmed Caucus Meetings:
International Women and Drugs Network/Women’s Network Meeting 10:00 a.m. Sunday October 22 All women welcome. Contact hrcconf@harmreduction.org for more information. NEX Youth Caucus Tentative meeting time Monday October 23 7:00 p.m. Contact Ro Guillano 415 436-9005 for more info. Methadone Consumers meeting time Monday, October 23, 7:00 p.m. Contact hrcconf@harmreduction.org for more information. CaSEN meeting day/time TBA. Contact Brent Whitta 619 602 2763 for more info. Mental Health Professionals in Harm Reduction, meeting day/time TBA. Contact Andrew Tatarsky 212-633-8157.

Free Pre-Conference Institute
Saturday October 21 9:00 a.m. to 4:30 p.m. Club Drugs and Harm Reduction: In conjunction with the 3rd National Harm Reduction Conference, DanceSafe will host a one-day event at the Wyndham Miami Biscayne Bay Hotel, October 21, 2000. DanceSafe provides harm reduction information and services within the rave and nightclub community, and is launching a national “safe settings” campaign in conjunction with the Right To Dance Coalition, to reduce dance-related medical emergencies and demonstrate a practical alternative to the zero tolerance approach: “Zero deaths! Zero arrests!” For more info. contact DanceSafe@ 510-834-4654, or surf http://www.dancesafe.org/ and http://www.righttodance.org/.

Rapid Assessment
In response to the HIV emergency mandate of the Congressional Black Caucus, the Federal government has launched a Rapid Assessment tool. This tool allows cities and communities to quickly create an epidemiological profile of HIV in their area, and is vital in creating an effective response to the spread of HIV among drug injectors and their partners. So far, projects have been completed in Miami, Philadelphia and Detroit. HRC’s conference will feature a training on Rapid Assessment implementation presented by Drs. Richard Needle, Eric Goosby and Chris Bates of the US Department of Health and Human Services. The conference will also feature reports from Miami and Detroit on Rapid Assessment.
Bad Attitudes in the ER: It’s a Two-Way Street!

This article is a presentation made by the author to Emergency Room physicians, residents, and interns at the University of California, Davis Medical Center and at the Heroin Overdose Prevention Conference in Seattle, January 2000. The ideas presented in this article are more conceptual and come from personal observation rather than empirical data. The ideas evolved naturally from Knowledge, Attitude, and Behavior (KAB) work with drug users and 25 years of experience as a health care provider.

The Problem—Health Care Providers

Health care providers often hold negative, stereotyped beliefs about drug users, beliefs which influence attitude as well as care. Drug war rhetoric has had a significant effect on health care providers, in spite of mounting scientific, medical and public health evidence to the contrary. There is widespread ignorance of the data supporting harm reduction approaches to care, and an absence of harm reduction curriculum in medical training and Continuing Medical Education (CME) programs. Often these beliefs are based on bad experiences with individual drug users, and on personal use of drugs, rather than on medical/scientific knowledge; the better health care providers personally know their drug-using patients, the more positive their attitudes toward drug users are.

The Problem—Drug Users

Drug users, who often expect to be treated poorly by emergency medical technicians (EMT) or emergency room (ER) staff, frequently appear to have “a chip on their shoulder.” These attitudes result from prior negative experiences with health care providers. Users are often in a great deal of pain when they seek treatment, and are irritable. In addition, there is a fear of exposure of their drug use to family, friends and employers—not to mention their health insurance provider. There is also the possibility that they will be turned over to the police by hospital workers (and arrested and prosecuted), should they have any drugs in their possession. Drug users are estranged and marginalized from the non-drug-using society, and frequently have un-addressed mental health issues. All of these issues contribute to the poor patient-provider relationship that develops.

The Survey

We conducted a brief, rather informal survey of 22 ER health care providers in Fall, 1999 regarding their KAB about drug users. They were presented with several statements, prior to a harm reduction talk, and asked to agree or disagree. The percent of those who agreed with each statement is in bold text following the sentence. The results follow:

Drug use (other than alcohol) per se is bad. This includes marijuana, opiates, cocaine, methamphetamines and hallucinogens—36% affirmative. This response suggests to me that harm reduction is a concept that might find fertile soil among emergency care providers.

People who use drugs other than alcohol deserve to go to jail—0% agreed. This response is even more heartening.

Sending people to jail for drug use is more effective in dealing with the problems of drug use than is any other use of taxpayers’ money—0% agreed. Once again we see that ER staff may be potential converts to the harm reduction philosophy.

Most of the resources the U.S. devotes to addressing drug use are used for law enforcement—14% affirmative. We can introduce a little cognitive dissonance here by educating these providers that, despite the empiric evidence which supports alternative uses of our tax dollars, most of the money thrown at the problem lands in the law enforcement pocket—not the treatment pocket.

Public money would, in general, be better spent if a public health (disease prevention, health promotion) and medical model (drug treatment) rather than a criminalization model were to inform U.S. drug policy—68% agreed. If they only knew!

When drug users are difficult to work with in the ER, and on the hospital wards, the “blame” for it is mostly theirs—45% agreed. Over half recognize their own contribution to the problem. The great majority of these health care providers are people...
Most drug users couldn’t control their drug use and be productive citizens if they had unlimited access to their drug of choice (sterile, known potency), at reasonable cost—36% agreed. Here again we see that almost 2/3 of these health care providers have somehow heard, processed and agreed to some extent that drug users can be responsible for themselves, given opportunity.

Possible Solutions—Health Care Providers

■ Improve health care providers knowledge of the various drug use cultures and drug use itself.
■ Put a human face on drug users.
■ Appeal to health care providers innate compassion and humanity—nothing hits us harder than to be accused of insensitivity and lack of compassion. It is our Achilles’ heel!
■ All levels of medical and nursing education should include more training on these issues. A concentrated effort to include principles of harm reduction in CME and basic training will pay dividends for harm reduction.

Health care providers need a better understanding of psychosocial aspects of drug use. Often times, mental health issues probably preceded drug use. In fact, drug use may be ameliorating symptoms. Many drug users were abused as children. Health care providers should call loudly for policy makers to provide for comprehensive treatment on demand.

Health care providers should also have a better knowledge of the pharmacology and effects of opiates, cocaine, methamphetamines and hallucinogens (most have tried marijuana). It wouldn’t hurt to compare these drugs to alcohol and tobacco products for safety, potential for injury, abuse, etc.

They need better guidelines for judging analgesic needs of drug users as well as a better understanding of abstinence syndromes (withdrawal)—and proper alleviation of these symptoms.

Training should demystify drug users and debunk the myths surrounding them. Drug users are not asking to get or stay high in the hospital. Heroin users want to be as comfortable and free from pain as the person in the next bed, but this often requires a significantly higher opiate dose than for the non-habituated, and health care providers don’t fully understand this.

Health care providers should examine their attitudes and “attitudes.” Health care providers should be more hospitable and feel free to use humor—“I’m sorry, but heroin isn’t on the menu yet, may I offer you sustained release morphine or perhaps methadone?”

We must continue to point out the cruelty of the present system. We can give health care providers an alternate vision of drug users, with much of the violence, hostility, anger and self-loathing removed: we can call it “decriminalization.” Shame on us for buying into and supporting the drug war—we (health care providers) should know better, leading the way to harm reduction.

After the session, the participants were asked, “Has this discussion changed your opinion of drug users in the ER in a significant way? Four out of 22 (14%) said yes. We will revisit these issues with ER staff in six months.

Possible Solution—Drug Users

Expose drug users to drug user-centered primary and secondary healthcare. Assertiveness training should be provided during drug user-centered healthcare, and in peer advocacy programs. Because every health care provider’s contact with a drug using-patient is an opportunity to change minds, we need to get drug users on a mission to teach health care providers. At least half, or more, of drug users can become patient (double entendre) teachers of health care providers. After all, it is a two way street.

Summary

Although this was a small survey, and needs to be repeated on a larger scale, its results were not surprising. Health care providers have bought into the drug war as ordinary citizens and haven’t applied their professional expertise to the problem. When they do they will think differently. More training is needed: make it the CME topic du jour.

Drug users psychological reintegration into society will also go a long way toward improving professional and private lives of both drug users and health care providers.

Acknowledgements: I am indebted to the personnel of Harm Reduction Services, Sacramento, the talented group of research personnel with whom I work: (especially Ms. Rachel Anderson, Ms. Lynell Clancy and Mr. Jim Britton), and the many drug users who have, and will, undoubtedly, continue to teach me of our common humanity.
What drug treatment options would you like to see more available?
- Methadone
- LAAM
- Ibogaine
- Buprenorphine
- Inpatient Detox
- Outpatient Detox
- Acupuncture / Herbal remedies
- Rapid Opiate Detox
- 21/28 Day Detox
- Other
- None / Not Applicable

What drug treatment options would you like to know more about?
- Methadone
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- Acupuncture / Herbal remedies
- Rapid Opiate Detox
- 21/28 Day Detox
- Other
- None / Not Applicable

What incentives would motivate you to receiving treatment?
- High likelihood of success
- Money
- Non-judgmental staff
- Easily accessible
- More personal care
- Nothing / Not Applicable

How difficult is it for you to get treatment?
- Very difficult
- Somewhat difficult
- Not that difficult
- Not at all difficult
- Don’t know / Not Applicable

What is the most important drug-related health problem to you?
- HIV
- HCV
- Overdose
- Abscess
- Tracks
- Endocarditis
- Other
- None

What is the most important reason for NOT receiving help for a drug-related problem?
- Financial cost
- Incarceration or arrest
- Others finding out you use
- Losing your job
- Losing custody of a child
- Feeling like a failure
- Being judged by people
- None / nothing

How much harassment or abuse have you experienced from the police?
- A lot
- A little
- Very little
- None
- Don’t know / Not Applicable

Have you ever been stopped by the police for carrying syringes, or arrested or charged for syringe possession?
- Yes, but not arrested
- Yes, but not arrested because I was a participant in a needle exchange program [NEP]
- Yes, arrested but later released because I was a participant in a NEP
- Yes, arrested and kept in custody for more than an hour even though I was a participant in a NEP
- No
- Don’t know / Not Applicable

Age
- Bubble in left column is for tens, right column for ones.
- Example: For age 27 mark the left column bubble by 2 and the right column bubble by 7

What is your drug of choice?
- Speed
- Powder Cocaine
- Crack Cocaine
- Heroin
- Speedball
- Other

What is the drug you use most often?
- Speed
- Powder Cocaine
- Crack Cocaine
- Heroin
- Speedball
- Other

Do you use more than one drug at the same time?
- Yes
- No

How do you use most often?
- Inject
- Snort
- Smoke
- Other

Sex
- Male
- Female

Ethnicity
- African-American
- Caucasian
- Asian
- Native-American
- Hispanic
- Other

How often do you currently use drugs?
- (More than 1 x/day)
- (1 x/day)
- (1-4 x/week)
- (1 x/week)
- (less than 1 x/week)
This month we’re going to focus on herbs that are good medicine when picked and eaten raw or cooked simply, and herbs that can be made into medicinal tea without using hot water. Many of these herbs grow wild in city spaces, so depending on where you live, you may find that you have a whole medicine chest just waiting for the picking.

As winter turns to spring, many folks who stay in shelters or doubled and tripled up with friends find places to sleep outdoors. Other folks live in squats with no electricity or hot water. So while these herbs and recipes are of clear benefit to folks who don’t have housing with all the facilities, they have an added advantage. When we use just-picked or recently-dried herbs, we are using the plants when they are still full of living energy. The herbs smell fresh, and they are at their most potent. When we prepare our teas using cold water instead of boiling water, we activate the plant’s enzymes instead of killing them, so the nutrients are easily absorbed and digested.

Most of these herbs can also be bought at the herb store or the natural food store. Some harm reduction programs may have herbs for program participants. But if you decide to pick your own herbs, please remember these points:

- Never pick and use a plant unless you are absolutely, 100%, positively sure that you know what you are picking. The best way to know is to be introduced to the plant by someone who knows it.
- These days, most cities have several herb identification walks (also known as weed walks) every month. Check in the alternative press or health food store bulletin boards for notices. These walks are usually inexpensive, and often have a sliding scale. If you can’t afford the price, it’s worth turning up anyway and asking if you can go along.
- Some plants are protected by law, and most parkland doesn’t allow foraging. If you get caught, you can be fined. Best to pick on private land, with permission.
- Don’t pick in sprayed areas, too close to busy roads or where dogs congregate.
- Only pick plants where they grow abundantly, and don’t pick more than a few plants in one place. Leave most of them to reproduce so there will be plenty next year. When you leave a stand of plants, it should be impossible to tell that you were picking there.

**Common Weeds/Super Healers**

You can find these plants in most places where you find people. It’s as if they are saying “Here I am! I can help you—use me!”

**Yarrow (Achillea millefolium)**

Yarrow grows in city and country, east and west. This green ally is a good one to know. It is used in first aid to stop bleeding (chew up a leaf or use powdered, dry leaf, and put it on a scrape or shallow wound; the bleeding will slow right down). It’s also antimicrobial, so it helps to keep the wound clean. A leaf of yarrow (or sniffing some powder or tea) will stop a nosebleed. The root can be chewed to ease the pain of a toothache. Traditionally, the roots were put in a jar with whiskey, whether to preserve them, to increase the effect or to make them taste good—who knows? But for IDUs, one of the best things about yarrow is this: Yarrow improves circulation and supports good vein health. The tea is drunk in small quantities throughout the day, or can be used as a skin wash before and after shooting up.

**Violet (Viola odorata)**

This lovely little plant is deceptively pretty, hiding her strong medicine under purple flowers and green leaves. Violet leaf relieves pain and heals. Some crushed (or chewed) violet leaf can be placed on the temples, forehead, or the back of the neck to relieve headaches. A chewed leaf, placed over a sore gum speeds healing and reduces pain. Violet tea, made with fresh or dried leaves and hot water, can be used as a herbal wash, or drunk. Violet is a natural source of salicylic acid, the active ingredient in aspirin. Ladies, a poultice of the leaves (wilt the leaves in a little hot water, let cool) is heavenly for sore breasts, especially before that time of month. And don’t forget to put a few violet leaves in your wild salad: they are brimming with vitamin C.

**Mugwort (Artemesia vulgaris)**

This magical plant is at home in the city. In New York, by summer’s end, mugwort covers the old tires, broken fences and vacant lots all over town. Sleep with a sprig of this plant if you want to have vivid, easily remembered dreams. Otherwise, use it early in the day and keep it away from the place you sleep. Mugwort opens the third eye and lets psychic energy flow. On a more basic level, the cold infusion of the leaves helps when you have problems digesting fats, but crave the donuts that leave you feeling awful after you eat them. Put a few spoonfuls of leaf into a pint jar, cover with cold water, and steep overnight, then strain off the water and drink it before meals.

**Dandelion (Taraxacum officinale)**

Dandelion is a goodie. The leaves and root can be eaten as a bitter tonic, perfect after a long cold winter. Bitters stimulate the digestion and the liver, clearing and detoxifying. Having a dandelion leaf or two and a nibble of root before meals while increasing fiber will stimulate the appetite and get sluggish bowels moving. It may take a while for the full effect to be seen, but over time it is extremely effective. As a salad green or cold infusion, the leaves detoxify by increasing urine output, so drink plenty of water when you call on this green ally. The leaves are rich in vitamin A, vitamin C and minerals. The white sap can be used to dissolve warts and soften calluses. Try not to get it on other skin, though: it can cause a rash.

**Brew**
**Burdock (Arctium spp.)**

Burdock grows in many cities. The low-growing leaves are huge (up to 2-3 feet long), and the thistle-like flowers form seed pods that look and act like Velcro. Burdock root is good for the liver, skin and lungs, and helps the body eliminate toxins. It’s delicious when it’s cooked and eaten, or dry it and make the tea using either cold or hot water.

**Cleavers (Galium aparine)**

This plant grows in cool, moist places from city to country. Look for it in a shady spot before the weather gets too hot. Once you know cleavers, you will see it everywhere. Its leaves circle the stem like daisy petals, and the whole stem feels rough and sticks to clothing, hair, other stems; everything. Cleavers is one of the best plants for the skin and lymph, and assists in cleansing and removing wastes from the body. Pick it on a dry day, let it dry and make tea from hot or cold water.

**Chamomile Flowers (Matricaria spp.)**

This one does it all—stimulates digestion, aids sleep, calms frazzled nerves and fights off bacterial infections. Make it into tea with hot or cold water, and sip it for stomach cramps or drink it before bed. It also makes a great skin wash, before or after shooting up, or any old time.

**Pine Needles (Pinus spp.)**

Pine trees grow everywhere. The needles, twigs and bark support the formation and strength of veins and capillaries. The new growth (young needles) is especially rich in vitamin C, which is found in all parts of the plant. Pine needles, fresh or dried, make a delicious tea (use boiling water) that clears the lungs especially rich in Vitamin C, which is found in all parts of the plant. Pine needles, fresh or dried, make a delicious tea (use boiling water) that clears the lungs.

**Rose Hips (Rosa rugosa)**

Rose hips form after the roses have blossomed, faded and blown away. The hips are rich in Vitamin C and flavonoids. They support the immune system, and they are yet another herb that helps maintain good circulation and tends to the veins. Pick the hips from unsprayed rose bushes, in the fall, winter or spring. Or ask your favorite gardener to save the hips for you after she prunes unsprayed rose gardens. Rose hip tea is easy to find in natural foods stores and markets.

**Stinging Nettles (Urticaria dioica)**

Anyone who has brushed into a nettle plant can show you this one. Ouch! The whole plant is covered with tiny hairs that sting like the dickens when they are touched. Nettle plants let you know when you’ve found them! They like to grow near running water, so watch for pollution. The tiny nettles of early spring are delicious. Even the little ones sting when they are fresh, so use gloves to pick them (dried or cooked nettles don’t sting at all). Nettles are a storehouse of vitamins and minerals, and here’s yet another plant that removes toxins from the body. Nettle tea (hot or cold infusion) gives deep energy; it’s a great choice for times when you’re exhausted from too much stress or to help rebound after a speed run or a detox.

**Plantain (Plantago major, P. lanceolata)**

Here’s nature’s Band-Aid! Chew up a plantain leaf and use it to soothe insect bites, scratches and skin rashes. The tea can be used externally as a wash, and internally to clear the lungs during acute infection or persistent dry cough. [N.B.: This is not the banana-like plantain. It’s a low-growing plant that loves lawns and likes to keep dandelions company.]

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**GOOD TEA FOR GREAT VEINS**

1 Part Pine Needles  
1 Part Rose Hips  
1/2 Part Yarrow

You can make any amount of the herb mix. Use dried herbs in the proportions above. (If you use 2 ounces of pine needles, use the same amount of rose hips, and 1 ounce of yarrow. Make as much as or as little as you like.) Store the herbs in a clean, dry jar or a paper bag.

Place 1 ounce of the herb mix into a quart jar. (One ounce is a good full handful for most people.) Fill the jar with boiling water, cover tightly. Let steep for 20 minutes. Strain, and drink throughout the day for strong, flexible veins and improved circulation. Throw away any leftover tea. Start again with a fresh batch of herbs every day.

**GIMME STRENGTH SUN (OR MOON) TEA**

1 Part Burdock Root  
1 Part Nettles Leaf  
1 Part Cleavers Herb

Combine the herbs, and store in a clean dry jar or a paper bag. Place one ounce of herb mix in a quart jar. Fill the jar with cold water, cover tightly, and let steep all day or overnight. Shake it up every now and then. Strain, and drink the tea throughout the day, and throw away any leftover tea. This works best over time, and will assist the body with deep cleansing and will improve energy.

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**SOME BOOKS THAT CAN HELP YOU LEARN ABOUT PLANT USE AND IDENTIFICATION:**

- *Medicinal Plants of the Pacific West*, 1993, by Michael Moore, (Also MP of the Desert and Canyon West, MP of the Mountain West)  
- *The Complete Medicinal Herbal*, 1993, by Penelope Ody  
- *Peterson’s Field Guide to Eastern/Central Medicinal Plants* by Steven Foster and James A, Duke

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**SOME WEBSITES TO CHECK OUT:**

- http://www.herbs.org/ (Michael Moore’s site-see above booklet.)  
- http://www.egregore.com (A general site with a large herb glossary-ed.)  
- http://herbsforhealth.about.com/health/herbsforhealth (One of about.com’s sites-a little on the commercial side but lots of info-ed.)  
- http://www.allexperts.com/getExpert.asp?Category=991 (Interesting, an online q & a site. I can’t vouch for it-ed.)  

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Donna Odierna is a herbalist, nutritionist, and health educator. She is in private practice and also works with IDUs at Casa Segura in Oakland, CA.
I’ve been watching the primaries. Absent from the debate is any conversation about the drug war and its ramifications. No one at a town hall meeting has talked about this failed intervention’s cost in dollars or human suffering. “Junior” Bush can’t admit (or deny) cocaine use! Is this related to Texas’ drug laws that target the poor? (There are some poor, poor people in deep Texas!)

Black leaders are out of touch with the truly marginalized in this country—sometimes, it seems, by choice. Black leaders have been forced into inaction by the old carrot/stick approach: a promise of middle class status vs. the threat of economic decimation. Even though these leaders can’t be blamed for their inaction (what good would it do?), they are sorely lacking in challenging amerika’s current drug policy.

I’m old enough to remember the 60’s. I know Martin Luther King would not be silent when faced with a failed policy that continues to destroy young Blacks through incarceration and violence. Malcolm, even after the enlightening trip to Mecca, would have picked up a rifle! And Rap...well, since I first wrote this, Rap has done just that!

Historically, in this country, Black leaders have challenged white privileged ideas and policy. Black leaders have devised humane and effective ways to address social and political issues that white politicians couldn’t or wouldn’t face. Black men and women have shown this country the way out of hunger, segregation and disparities in education and health care. The involvement of morally outraged black people hastened the end of an obscene, illegal war in Southeast Asia. Today, however, after assassinations, political condemnation and dismissals, the leadership has discarded compassion and it’s all about the money. The most insidious threat to civil rights, constitutional protections and even foreign policy (consider Columbia) is our current drug policy.

Let’s be real clear about one thing: The War on Drugs is a Race War! This is illustrated by the recent murders of innocent, unarmed black men by police in New York, and the corruption and brutality of the LAPD’s Rampart Division. Police are warped by the soldier vs. protector mentality of the drug policy in this country. According to the FB&I, since 1981 roughly 100,000 people have died in the drug war cross-fire. Half of them were innocent bystanders. Ninety percent were black and brown.

In Michigan the drug war, through its main weapon, the criminal justice system, continues to decimate the black community. On September 24, 1999, a “drug court” judge sentenced Letisha “TT” Bennett to five days in the Kalamazoo County Jail for giving a cocaine-contaminated urine sample. Ms. Bennett was married, employed, had two school age children and was pregnant! (She was originally arrested and charged with manufacturing and sales of a controlled substance, and in Summer, 1995 sentenced to lifetime probation. TT was assigned to drug court by her probation officer because of the enormous probation caseload.) This judge, in his infinite wisdom, sentenced her to an overcrowded county jail. A jail where there is a guarantee of no pre-natal care, nutrition or stress reduction. A jail where there is a concentration of people who are likely to have a variety of communicable diseases and infections. Felons were released that weekend while TT sat there! Are we missing something?

It should be noted that TT is black, as are 71% of the people in this country who are convicted for non-violent, drug crimes (while whites make up roughly 80% of arrests and only 15% of convictions). The rate of incarceration for African American women is eight times higher than that of white women (Amnesty International, “Not Part of My Sentence.” Violations of the Human Rights of Women in Custody, Washington D.C. 1999, March, p. 19).

No minister protested in TT’s behalf. No civil rights activist wrote an opinion. When TT came home she had an upper respiratory infection...
It is a challenge of conscious black people to re-locate this conversation to a public health paradigm.

People used to say a lot of shit to me. And I even used to listen: I gotten the message. Children are sensitive to fair play and peer pressure. The message is: "If you don't look or sound like the white privileged culture you are doomed to stigmatization and death. See, it isn't cost effective to take care of the sick or the old or the weak. And if you can't solve your problems any other way, violent confrontation works." To prove it drugs and guns are readily available to anyone who wants them!

I don't wish to sound insensitive, but 13 children died in Columbine, and the media and nation were paralyzed. How many black children died in the streets of our cities that day? I wonder if anyone talked to those kids at Columbine about race and class? One more child died in Flint. Their kids are murdering each other in school, the violent caul-dron of the drug war froths over and the beat goes on.

Where are black leaders when it comes to this failed, ineffective Drug Policy? The problem is that there is no conversation surrounding this class/privilege paradigm. This must be addressed. As the industrialization of amerika has wound down from the late 1960s and the information and technological advances have driven a new econom-ics, I have observed a decimation of the black community. At the same time I have observed absorption of the black leader class into the uber-middle class.

Black leaders have been leaders, first, in the black church. Drug use is framed as a moral issue. Therefore, black leaders are hobbled in any conversation considering any tolerance of drug use and drug users. Herein is the reason why so few have condemned the current drug policy in amerika. It is the challenge of conscious black people to re-locate this conversation to a public health paradigm. Anyone who opposes this shift, is by default supporting the current unregulated crim-inal black market in drugs—or their job depends on it!

While there is no bigger threat to civil rights, no more insidious enemy to the health and well being of black and brown communities, minority leaders who consistently speak out against the War on Drugs are few and far between. Chris Rock said, "We don't have black lead-ers, we got substitute teachers!"

Australia has the right, common sense and compassionate approach. Families and Friends for Drug Law Reform, who worked to get sterile shooting rooms in Australia, are people who have lost loved ones and have committed themselves to a controversial heroin trial and other life saving interventions. If national Black leaders took the stand of Reverend Edwin Sanders II, that of inclusion and ethical treatment of drug users in the midst of HIV/hepatitis epidemics, we could effectively change the course of infection and incarceration rates with the same blade of the sword. Harry Simpson lobbying Clinton for needle exchange needs maximum support! (maybe Jesse Jackson at his side!) Efficacy's Cliff Thornton has it right, as do Joycelyn Elders and Maxine Waters, but we need many, many more who will take the necessary political risks. Reicki Waiss and Dana Beard were eloquent, loving spokespersons. There are Black heroes in this war, just as there have always been in this coun-try's conflicts.

It is paternalistic and condescending to assume that any single in-tervention, solution or paradigm will work to the benefit of the masses of people in this country. I don't think I am a paranoid, but in Michi-gan, the Engler administration has quadrupled the bed space to ac-commodate drug arrests and still 5000 people—mostly young, black men—are farm-ed out to prison systems in West Virginia every fiscal quarter—on trains! What does this bring to mind?

I always hear from the drug warriors: "What message would we send to children if we were not hard on drugs?" I think the kids have
If the primary goal of welfare reform in New York State is to move people off of the welfare rolls, then reform in New York is working. If its goal is to assist people in improving their lives and moving them towards healthy, housed and employed self-sufficiency, then it has been a dismal failure. The City government periodically announces with great fanfare the number of New Yorkers no longer receiving public assistance because of welfare reform. The Commissioner of the State Office of Temporary and Disability Assistance, Brian Wing, has given an actual figure: in New York State, over 671,000 fewer people are on the welfare rolls today than in 1995. According to the Mayor of New York City, Rudolph W. Giuliani, 500,000 people have left the welfare rolls since 1995. The Mayor proudly proclaims that this number is “more than the whole population of Cleveland.” Giuliani has managed to reduce the welfare rolls by nearly 45%. These statistics are dangerously misleading. While some have moved from welfare to work, a significant number of people have been cut from the rolls for failure to comply with some requirement or other, or because they’ve simply given up trying. Many of these people are not employed, they are not housed and they are not doing well—by anyone’s standards.

Thousands of New Yorkers on public assistance have lost their benefits for such offenses as arriving late to a meeting with a caseworker or a doctor. Still others have simply given up what often feels like a daily fight to retain seriously inadequate benefits. (In New York City, where a one-bedroom apartment is difficult to find for under $1,000, the monthly rental allowance for a single person is $215.)

In New York City, one of the most serious threats to this already vulnerable population trying to retain benefits is the State’s drug and alcohol screening and treatment scheme. Nearly everyone receiving public assistance in New York City1 (in the form of rent, cash benefits, Medicaid and food stamps) has gone through the City’s screening process for alcohol and substance abuse since the regulations implementing the screening system went into effect. Heralded by treatment professionals as an innovative way to open the doors to people who haven’t had access to treatment in the past, the screening process, which consists of an initial 9-question form followed by a more formal interview with a Certified Alcohol and Substance Abuse Counselor (CASAC), has instead become an insurmountable obstacle for those whose addictions are the hardest to treat.

While some people who might not otherwise have access to treatment benefit from a referral, others are deterred from seeking food stamps and other subsistence benefits for fear of eventually losing the assistance because of unwillingness or inability to participate in or complete a rehabilitation program. Still others are cruelly set up to fail in a system that is not equipped to deal with the complex issues facing substance users. 2 It is common to say that if someone leaves a treatment program before completing it, he or she has “failed” in drug treatment. However, addiction is the only disease where society attributes blame to the individual if treatment is ineffective. And it is the only disease where those afflicted are penalized for exhibiting the symptoms of their disorder.

But it is not only those who are seriously debilitated by their addictions that have been put in jeopardy by the new screening and treatment requirements. Advocates working on behalf of public assistance recipients with alcohol and drug problems have noted several structural and practical barriers that have made it difficult for even the most diligent recipient to retain his or her benefits.

**CLINICAL PRACTICE GUIDELINES**

New “Clinical Practice Guidelines” went into effect in October 1999. They remove the discretion—granted to treatment providers by law—to determine when someone is “in compliance” with a treatment plan. Many treatment providers expect a majority of their patients to “fail” by welfare standards and lose Medicaid and other benefits. The Guidelines, issued by the welfare department itself, place stricter standards of “compliance” on welfare recipients than treatment providers themselves do. Under the Guidelines, it is conceivable that a single relapse after only 30 days in mandatory treatment (or even a marijuana-positive mandatory urine screen) could cost a long-time user his or her benefits. What would look to a clinician like entirely appropriate progress in treatment spells failure to the welfare department, and requires a loss of benefits.

**NAVIGATING THE SYSTEM**

A large number of applicants for and recipients of public assistance in New York City risk the loss of their benefits because the way these requirements are being implemented. Both clients and their advocates have found it nearly impossible to navigate the bureaucracy of the city welfare department, its Office of Employment Services, its “job centers,” its Substance Abuse Case Control Program and the many other offices and systems that are sent to and through.

**INAPPROPRIATE REFERRALS**

Once someone on welfare is found to be “in need of treatment,” he or she is referred to a program approved by the State Office of Alcohol and Substance Abuse Services (OASAS). As with coerced treatment in other forums, such as the criminal justice system, almost any treatment program that has a bed or a space available is considered “appropriate treatment.”

Certified Alcohol and Substance Abuse Counselors (CASACs) spend an average of 45 minutes conducting “in depth” interviews with applicants and recipients, assessing the level and severity of their addictions, determining an appropriate level of care and finding a treatment program to “match their needs.” Unfortunately, little attention is paid to whether the recipient should be in an inpatient as opposed to an outpatient treatment program; whether simple groups, or talk therapy, is appropriate as opposed to more rigid Therapeutic Communities (TCs); or whether an assigned treatment program is far from the recipient’s home.

Neither the regulations governing this process, nor the city welfare agency itself make any provision for those individuals who suffer from the dual diagnosis of “mentally ill-chemically dependent” [MICA]. Mental health issues are rarely identified by CASACs, and even less frequently prioritized. Therefore, people with a MICA diagnosis are often
sent to treatment programs that are ill-equipped to deal with their special needs. Untreated mental health issues can also contribute to a person’s inability to successfully adhere to and complete a substance abuse treatment plan.

Additionally, because referrals must only be made to those programs approved by OASAS, recipients cannot be referred to effective harm reduction programs which provide low-threshold counseling and other services to active drug users. Sometimes with components called “treatment readiness” programs, harm reduction programs work to sustain engagement with active drug users who are often profoundly disconnected from other services and who cycle in and out of treatment, the criminal justice system, and the hospital. Not surprisingly, many people have been sent to programs that are not appropriate to their needs.

INABILITY TO COMPLY

If someone has been assessed as being unable to work because of a drug or alcohol addiction, is it so surprising that the same person may be unable to comply with a program that requires his or her attendance beginning promptly at 8:30 every morning, six days a week? Many people are unable to comply with the strict requirements of drug treatment programs, and when they falter, instead of offering additional support, or reassessing the level of care they have been given, their cases are closed, and their benefits terminated. Recently, in a ruling against a homeless welfare recipient who couldn’t keep up with his treatment program’s schedule, a judge found that it was the recipient’s responsibility to recognize the inadequacy of his program, where the CASAC-trained addictions specialist had not.

EVERYDAY MISTAKES

Both recipients and the system are bound to make mistakes. Mistakes that may be an inconvenience in the life of someone not dependent on the state for subsistence benefits have many more severe consequences in the lives of public assistance recipients. As if the loss of rental assistance, food stamps and cash assistance for necessities were not punishment enough for failing to submit proper documentation of a change in treatment plan, those found to be impaired by drug or alcohol addiction are the only public assistance recipients who are sanctioned with the loss of medical benefits. Thus, they are not only shut out of the very treatment they need, they are also prevented from accessing routine medical treatment, exacerbating existing health problems and placing these individuals, their families and their communities at risk.

Welfare recipients have been sanctioned for transferring from one drug treatment program to another, for failure to consult with city welfare personnel before making a change in treatment plans within the assigned treatment program, because treatment programs submitted the wrong code to the city welfare agency to characterize a patient’s status in treatment and even for failing to attend programs to which they’d never been assigned. Treatment programs have not received adequate training to report the status of their patients to the city welfare agency; therefore, it is common for an inadvertent mistake in paperwork to result in a sanction.

A SYSTEM UNEQUIPPED TO DEAL WITH TREATMENT-RELATED ISSUES

Although it is well noted by drug and alcohol treatment professionals that relapse is a part of treatment, there is little tolerance in a system that punishes recipients who do relapse by cutting off their food stamps, cash benefits, rental assistance and Medicaid. While abstinence-based programs prove extremely effective for some, dismal drop-out and recidivism rates among those in treatment point to the general inadequacy of drug treatment as we know it. People struggling with problem drug use continue to be the only people punished for exhibiting symptoms of what the system terms a “disease”—drug addiction.

The traditional remedies provided for applicants and recipients to redress these mistakes and grievances are wholly inadequate to address due process rights. Case conferences and conciliations are held with welfare caseworkers who are untrained in the area of addiction treatment, and are thus rarely resolved in favor of a recipient—even where evidence in favor of the recipient may be clear. For example, in a recent conciliation, a recipient who was mandated to one methadone treatment program was sanctioned for failing to report to an entirely different program (a clinic at the Veteran’s Administration) to which he had never been sent. Although he brought proof that he was attending the program he was mandated to attend, because he didn’t bring proof that he was never referred to the VA, he lost at the conciliation level. This, despite the fact that the welfare caseworker’s file on him clearly indicated that he had never been referred to the VA.

Administrative Law Judges charged with determining the merits of a recipient’s case are likewise untrained, and yet are called upon to judge the merits of treatment decisions. Treatment professionals are rarely present at these hearings, nor are welfare’s own CASACs. It is left up to the recipient to explain his treatment plan, and his difficulty in meeting his treatment goals. The recipient’s testimony is then weighed against several sheets of data printouts, and, often unrepresented, the recipient loses. While there are as yet no statistics reporting the success rates

Thousands of New Yorkers on public assistance have lost their benefits for such offenses as arriving late to a meeting with a caseworker or doctor.
of recipients challenging sanctions at fair hearings, anecdotal evidence points to the fact that unrepresented recipients sanctioned for drug and alcohol screening and treatment violations lose their cases in larger numbers than recipients sanctioned for other reasons.

WHAT PROVIDERS CAN DO

Treatment providers can have a tremendous impact on the way that the new screening and treatment regulations affect their patients. Providers can learn how to correctly fill out reporting forms used by the city welfare agency to monitor the progress of public assistance recipients. Entering certain codes, or failing to attach appropriate documentation, can result in the loss of benefits for patients, and the loss of Medicaid coverage as well. Providers can advise patients of their rights to challenge welfare decisions to terminate their benefits, including requesting a fair hearing. Continuing aid pending an administrative decision is available to those who challenge benefits within 10 days of receiving a notice from the city welfare agency.

Providers can also assist patients unable to request fair hearings themselves due to their disability. Some patients are so impaired by substance use that they are unable to navigate the welfare system themselves. Providers should know that if they are transferring a patient to another facility or another modality of treatment that these decisions must be made with the knowledge and consent of the city welfare agency.

If welfare is not consulted on these treatment decisions, the patient will be sanctioned and will lose his or her benefits. Providers can also resist pressure to adopt policies that run counter to sound clinical principles, such as implementing punitive internal sanctions or reporting patients who experience periodic relapses to welfare.

We are in an era of welfare reform in New York State where collaboration is the catch-word, and criminal justice agencies, social service officials and medical and substance abuse treatment providers are all examining ways to work with one another to streamline service provision. State and local welfare officials can ameliorate the devastating effect these policies are having by exploring the concept of collaboration with the client, instead of seeing the client as an adversary, and by understanding that treatment decisions should be made by clinicians and treatment professionals—in collaboration with their patients.

If you, or someone you know, is being sanctioned for failure to participate in or complete a drug or alcohol treatment program in New York City, and you’d like legal assistance but can’t find a lawyer to represent you, please contact Corrine Carey at the Legal Harm Reduction Project, (212) 533-0540, extension 323, or by e-mail: carey@urbanjustice.org. Corrine Carey is a Criminal Justice Fellow with the Open Society Institute’s (OSI) Center on Crime, Communities & Culture. She is currently a staff attorney with the Urban Justice Center, and is working at the Lower East Side Harm Reduction Center/Needle Exchange Program.

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high—we’re a needle exchange. One of the most successful people in our program, for whatever reason, would only do therapy when he was high. Perhaps when he was straight he wanted to assert his autonomy. What I do know is that with a combination of individual therapy, group work, volunteering, work with the legal system and case management, he is in a far more productive space now than he was a year ago. And if he had had to go about town for each service separately, I don’t think for one moment that he would have done it.

My version of an “office” may not seem very intimidating, and you might say that it is barrier-free, but that’s not true. Quite a few people at the exchange feel trapped when they put their bums in that folding chair, though they would stand and chat forever. So we stand and chat. A recent conversation made this progression: a) general comments on the shitty, hot the weather, b) broader observations on the topic of global warming, c) the client expresses a sense of a over-all impending doom, d) disclosure by the client that his fear of contracting the HIV virus has led him to give up sex and get tested every few months even though he cannot identify any risky behaviors and e) a question/answer session in which the client gets a better understanding of the virus. Did the client see himself as “client”? Who knows? He’s now joined a site-based group, and we’ll see where he goes from there. I believe he was a client because what I call a “therapeutic intervention” took place.

Do people mind the lack of privacy? Actually, sidewalk psychotherapy is much more private than it seems, since passers-by do not stop to listen, and usually do not know that therapy is going on. People may in fact be a lot more comfortable counseling on their own turf than in the clinic, where thin walls, crowded waiting rooms and inefficient little noise-maker machines only give an illusion of privacy.

Are the methods of sidewalk psychotherapy different from other therapies? Not really. I work indoors as well, and my methods are the same in both cases. I sometimes use the reflective listening approach of Miller and Rollnick in Motivational Interviewing, while clients who just want to be heard by another human being demand supportive therapy. And others again are best helped, in my estimation, by the cognitive approach of rational emotive therapy. And when people are highly “stressed” I do a little very simple biofeedback. My one unchangeable maxim is to remain respectful and non-judgmental towards the client, and to remember that they are where they are not because they are bad or weak, or genetically conditioned, but because our Western culture, with its insatiable appetite for scapegoats, has identified drug users as top-notch scary scapegoats.

So, the needle exchange holds a unique position at the juncture of the provider culture and the drug-using culture. It was only the AIDS crisis and the need for some sort of desperate action that created such a hybrid form. But now we are there, the therapists, the case managers, the welfare workers, the housing specialists, the job training counselors, the doctors and so on, can collect at places like ours and work to make the “whole” of clustered treatment a lot larger than the sum of its parts. But for this to work, each service must be re-tooled along harm reduction lines, so that the customers can manage through the barriers that will undoubtedly still exist. If you offer a high threshold service in a low threshold setting, you’re wasting a wonderful opportunity to reach a population that some people say can’t even be reached.

That’s why a needle exchange is a terrible thing to waste.

Brian Murphy, CSW, is Director of Clinical Services at New York Harm Reduction Educators, in New York City, where he leads counseling groups, does individual therapy and ‘sidewalk psychotherapy’ on the street in NYHRE’s mobile East Harlem needle ex-
The U.S. Government finally funds a harm reduction manual! (However, it’s for Asia!) The Manual for Reducing Drug Related Harm in Asia has been produced by the Centre for Harm Reduction, Macfarlane Burnet Centre for Medical Research in Australia and by the Asian Harm Reduction Network and is available for free ($15.00 P&P). For more info. check out their website at www.ahrn.net. Congratulations to everyone involved, especially to the towering man among men Nick Crafts. And yes USAID partially paid for the manual and then bought some. Crafty buggers, these Australians.

At the tail end of 1999 the African Harm Reduction Network was formed in Lagos, Nigeria. Representatives from Ghana, Gambia, South Africa, Kenya, Tanzania and Nigeria were present, as was Pat O’Hare of the International Harm Reduction Association. Again congratulations, and upwards and onwards.

LATIN AMERICAN HARM REDUCTION NETWORK (RELARD) REPORTED BY GRACIELA TOUZE

In January 1998 representatives of Brazil, Argentina, Uruguay, Chile, Paraguay and Colombia met in São Paulo, Brazil, to found the Latin American Harm Reduction Network (RELARD). These past two years other countries such as Bolivia and Mexico have been involved, too. This entire process has been supported by UNAIDS and IHRA and has allowed Latin American issues to be present in the global agenda.

The main objective of RELARD is to promote actions towards the reduction of drug related harm, with priority in the prevention of HIV/AIDS transmission, within the boundaries of public health, human rights and citizenship in Latin America.

Since its founding, RELARD has encouraged links between research and intervention efforts and has improved co-operation within the region and with other regions as part of the Global Voice. RELARD enhances national networks and discussion on harm reduction strategies. It also contributes to capacity-building and to the dissemination of information and experiences through its newsletter and its website.

Some initiatives seek to consolidate the development of alternative policies and programs. The Latin American Travelling Seminar (LATS) is an initiative of a group of drug experts from Latin America and Europe. We had the first LATS in Curitiba, Brazil last March and will have the next ones in Santiago, Chile and Recife, Brazil. RELARD is also planning two Parliamentary Seminars for this year, in Medellin, Colombia and in Mexico with the partnership of Fundación Universitaria Luis Amigó and Programa Compañeros.

Together with the Brazilian National Coordination on STD/AIDS, the State of Rio Grande do Sul and the Municipal government of Porto Alegre, RELARD is organizing the South American Seminar on the Reduction of Drug Related Harm, which will be held in Porto Alegre, Brazil on May 15th to 19th, 2000.

RELARD has also established and maintains strong links with the AIDS networks in the region. A permanent consulting group has been formed with the participation of:

- RELARD,
- Latin American People Living with HIV/AIDS Network (REDLA+),
- Red Latinoamericana de Reducción de Daños (RELARD)

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RED LATINOAMERICANA DE REDUCCION DE DAÑOS (RELARD)

En enero de 1998, representantes de Brasil, Argentina, Uruguay, Chile, Paraguay y Colombia se reunieron en São Paulo, Brasil, para fundar la Red Latinoamericana de Reducción de Daños (RELARD). En estos dos años, otros países como Bolivia y México se han unido. Este proceso ha sido apoyado por el ONUSIDA y la IHRA y ha permitido que las cuestiones latinoamericanas estén presentes en la agenda global.

El principal objetivo de la RELARD es promover acciones de Reducción de los Daños Asociados a las Drogas, con prioridad en la prevención de la transmisión del Vih/Sida, en el marco de la Salud Pública, los Derechos Humanos y de Ciudadanía en América Latina.

Desde su fundación, la RELARD ha alentado los vínculos entre investigación e intervención y ha mejorado la cooperación en la región y con otras regiones como parte de la Voz Global. RELARD promueve las redes nacionales y la discusión sobre las estrategias de Reducción de Daños. También contribuye a la construcción de capacidades y a la diseminación de información y de experiencias mediante su boletín y su Página Web.

Algunas iniciativas buscan consolidar el desarrollo de políticas y programas alternativos. El Seminario Itinerante Latinoamericano (LATS) es una iniciativa de un grupo de expertos de Latinoamérica y Europa. Tuvimos el primer LATS en Curitiba (Brasil) el pasado marzo y tendremos los próximos en Santiago (Chile) y Recife (Brasil). RELARD también está planificando dos Seminarios Parlamentarios para este año, en Medellín (Colombia) y en México, en asociación con la Fundación Universitaria Luis Amigó y el Programa Compañeros.

Junto con la Coordinación Nacional de ETS/SIDA del Brasil, el Estado de Rio Grande do Sul y el Gobierno municipal de Porto Alegre, la RELARD está organizando el Seminario Sudamericano de Reducción de los Daños Asociados a las Drogas, que tendrá lugar en Porto Alegre (Brasil) del 15 al 19 de mayo.

RELARD también ha establecido y mantiene sólidos lazos con las redes de Sida de la región. Se ha conformado un grupo de consulta permanente con la participación de:

- RELARD,

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Harm Reduction Books and Videos,
BY ALLAN CLEAR

HEPATITIS C HANDBOOK
By Matthew Dolan

We used to talk about harm reduction being about options more frequently than we seem to now. The harm reduction approach takes into account the totality of an individual. Matthew Dolan’s third edition of the Hepatitis C Handbook provides options and subject matter covering the whole person with a balanced emphasis on western treatments and traditional eastern approaches to illness. It’s a terrific educational resource. And how this book has grown from the first edition. This is probably the most authoritative book on HCV—and also the best for drug users. Although Matthew pulls no punches in saying that drug use is generally bad for someone with HCV he’ll also recommend prescription of diamorphine over methadone or eating hash over smoking it. One of the joys of this book is that it will be reassuring to people living with HCV who find themselves “feeling ill” but having their symptoms dismissed by their medical provider. Armed with information from this book, patients can more capably advocate for their own needs or take independent, positive steps that can improve the quality of their lives. This book should be available at any good bookstore and can always be ordered from any of the online companies. The Hepatitis C Handbook Matthew Dolan published by North Atlantic Books, Berkeley, California 1999.

SAFER INJECTION, BETTER VEIN CARE VIDEO, @ 20 minutes
Produced by Maureen Rule, Health Care for the Homeless Harm Reduction Outreach Program

By the time you read this the Oscar’s will have been long gone. Michael Caine will have his achievement award tucked away in his bedroom closet. American Beauty will have been christened film of the year and Kevin Spacey will be safely tucked away in his closet. However, the film most deserving for best documentary won’t have been mentioned at all. “Safer Injection, Better Vein Care,” based on the post card series that the Chicago Recovery Alliance produced a couple of years ago is an excellent short (20 minutes) presentation. None of the very picky HRC staff who has watched the tape has quibbled at all with the content except for the lack of information on booting. Principally geared towards empowering injectors, this video is also an amazing instructional tool for agency workers. It runs the gamut in content from improving injection techniques, tying off, preparing crack for injection, scarring prevention, and emphasizing the need for sterile surfaces and sterile equipment. It covers overdose prevention and response, safe disposal of syringes, needlestick prevention and much, much more. There’s no redundancy and no waste. All of this for $3.50 incl. P&P from Maureen Rule, Health Care for the Homeless, Harm Reduction Outreach Program, PO Box 25445 Albuquerque, NM 87125-0445. Phone: (505) 266-4188 Fax: (505) 266-3199. All proceeds go to the agency although it’s being sold at close to cost. The video is also available in Spanish. And the winner is...anyone who buys the tape.

Global Voice continued from page 29
■ International Community of Women (ICW),
■ Latin American and the Caribbean Council of AIDS Service Organizations (LACCASO),
■ International Gay and Lesbian Association (ILGA),
■ Latin American Sex Workers Network.

In this way, we are building a coordinated community response to HIV/AIDS challenges. A good example of this co-ordination is the HIV/AIDS Forum 2000, which will be held in Rio de Janeiro next November. Latin American networks are the co-organizers together with the Group on Horizontal Technical Co-operation on HIV/AIDS, formed by AIDS National Programs.

Drug-related problems in Latin America are increasing and the prevailing policies usually encourage prejudice and misinformation. Critical discourses and practices are often isolated. We are conscious that as part of harm reduction global community, we are involved in a movement for social change, where solidarity and respect are needed. RELARD has boldly decided to play its role to face this global challenge.

You can contact Graciela Touze by email: gratouze@cvtci.com.ar. You can visit Global Voice at http://www.global-voice.org, and from there go to RELARD’s site.
HRC’s THE STRAIGHT DOPE education series meets your need for accurate, practical and non-judgmental information in straightforward language on drugs and drug use.

H is for Heroin, C is for Cocaine, and S is for Speed each describe their respective drug and the forms in which it comes; how it is used; its physiological and subjective effects on the body and the mind; tolerance, addiction, and withdrawal; detoxification; overdose prevention and management; legal issues; and stigma. Written by users themselves, each gives an honest account of the benefits that users report as well as the risks, dangers, and negative effects of their use.

**Overdose: Prevention and Survival** Often the difference between life and death depends on what actions someone takes to care for a person who has overdosed. Step by step “what to do’s” and “what not to do’s” are specifically outlined in this brochure. Tips on how to prevent an overdose are also included.

**Hepatitis ABC** Hepatitis is a disease that causes inflammation, swelling and sometimes permanent damage to the liver. For people who inject drugs it is especially serious. This brochure was created for people who inject drugs and want more information. It is also appropriate for anyone who wants clear, general information on Hepatitis A, B and C.

**Hepatitis ABC** (en Español) La hepatitis es una enfermedad que causa inflamación, hinchazón y a veces daño permanente al hígado. En las personas que se inyectan drogas es especialmente peligrosa. Este folleto fue creado por personas que se inyectan y quieren más información acerca de la hepatitis ABC.

**Getting Off Right** is a plain-speaking, how-to survival guide for injection drug users. Written by drug users and service providers, it is a compilation of medical facts, injection techniques, junky wisdom and common sense that aims to provide the necessary information to keep users and their communities healthier and safer.

STRAIGHT DOPE brochures can be purchased in bulk at 20 cents each. Getting Off Right is available at $5.00 per copy for 1-10 copies, $4.00 per copy for 11-50 copies, and $3.50 per copy for more than 50 copies. Package deals (with free shipping!) are also available—see the price list below for complete descriptions. Shipping charges: For orders in the Continental US: up to 200 brochures or 10 manuals, add $4.00. For 201-1000 brochures, or 11-50 manuals, add $6.50. All other orders, call HRC first.

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