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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.

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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Please write in your comments, feelings, responses—we want to hear from you. If you would like to submit an article, or photos or artwork, we would be happy to look at your material. [See our website www.harmreduction.org/news/submission.html for submission guidelines.] HRC gives a voice to communities that are ignored by conventional media: drug users, people of color, individuals who are HIV or Hepatitis C positive, and sexual minorities. If you have never written something for publication, assistance is available: just ask for it. (You can call the editor at 212 213 6576, or include a note with your submission.)

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first off, if any of you are wondering about our curious publishing schedule and/or about why this letter isn’t about drug use in the workplace, skip to the end for a brief explanation. This is our first issue since September 11, and though I’m not one to look at things in terms of pre and post 9/11, I do acknowledge that things have changed, primarily for the worse. Where we once had our government fighting one war against its citizens, we now have it fighting a second—and on a much broader front. (If you’re not of South Asian or Middle Eastern origins, not a Muslim, don’t travel, don’t use the internet, talk on the phone or use the US mail, or live in a small town or in the country, you may be a non-combatant. Of course that doesn’t make you 100% immune from friendly fire, which in this case might resemble what happened to Dionne Warwick, who was popped for pot possession at the Miami airport security gate while enroute to LA.) At times, the government appears to want to combine the War against Terrorism with its Drug War. I guess they’d call it the War Against All Purpose Bogeymen. What it would really be is a war against everyone.

So what does this have to do with harm reduction? Plenty. Prior to last September we had a government at war with some of its citizens, mostly the poor, people of color living in urban poverty and white people living in rural poverty, plus young people who haven’t been wholly assimilated into the system, and others who choose not to toe the line, with drug use being a symbol of that opposition/alienation. Now we’ve added a whole bunch more to the list: the aforementioned Middle Easterners, South Asians, Muslims (plus people with dark skin or funny names that may be mistaken for them) and anyone who travels are now primary suspects. In this case, the situation is the inverse of the one described in Corinne Carey’s brilliant article, “Those We Leave Behind: Drug Policy and the Poor.” Corinne writes about how the government has consistently drawn wider lines of exclusion, so that more and more people are cut off from the rest of society, left to mire in poverty and hopelessness. The War against Terrorism is about an obscene form of inclusion, making larger numbers of people suspect. Of course this isn’t really that much different from the situation Corinne describes; in fact it’s just the flip side. Whether you’re included in “them” or excluded from “us,” you’re still part of the “other.”

Much of our work is about making life more bearable for those of us who, by virtue of any combination of drug use, homelessness, HIV or HIV infection, happenstance of sexwork or drug dealing as an occupation, poverty, race/ethnicity—the list goes on, are included in the ever-expanding categories of people excluded from access to the rights and privileges enjoyed by the rest of society. Most of the articles in this issue acknowledge this “otherness” to varying extremes, the experiences of people who are in some ways—or many—outside of the realm of the norm. Rachel MacLean talks about the otherness of the street kids she worked with; yet she felt it herself, not fitting in with the straight world, but not being a part of the kids’ scene, either. Donald Grove writes about people who work in harm reduction (many of us who have been shamed by society ourselves) shaming drug users, reminding them of their otherness. Pam Iynho talks about communication, and makes a point that we need to be able to engage people who aren’t part “of the choir,” people who are “other” than harm reductionists. (Hers is a more micro examination of otherness, but nevertheless she raises some interesting points.) Delaney Ellison, as always, writes about the struggles of users on the streets, and the outreach workers and agencies that offer services to them—or don’t. (His “On the Ground” column has always been a celebration of the otherness of drug users of color!) Anna Forbes writes about the search for workable microbicides, products that can offer the protection of condoms in an unobtrusive manner as possible. These are products that can help all of us, but especially people for whom condoms aren’t always a workable solution: sexworkers, women (and men) in Third and Fourth World countries, sexual partners of abusive individuals. Finally, Donna Giusarma’s “Witch’s Brew” is about Casa Segura, an agency that’s been shunted aside by the City of Oakland and serves a portion of the East Oakland population the community wishes would just go away.

But we won’t go away, at least not without a struggle. This issue celebrates that struggle, while acknowledging the toll it sometimes takes on us. Yes, we have faults, we make mistakes and sometimes we make compromises that come back to haunt us later. The payoff is in every overdose our education has helped revive, every drug user who stays healthy with our assistance and each family that retains their housing thanks to our advocacy.

Publication Note: We published our last issue just prior to the attack on the World Trade Center this past September. It’s easy to forget now, but for weeks after the attack concentration was not an easy thing to find—or keep. We eventually made a decision to revise our heroin brochure, that being the easier task for me, considering my intimate knowledge of the drug. Publication of the newsletter was put off until the completion of the heroin revision. The new “H is for Heroin” brochure came out, but then there were new projects and priorities, followed by a series of personal calamities culminating in my father’s death in April. Weeks turned into months and now here we are almost a year later.

What we have here is the first installment of the Fall 2001 issue, which we’ve chosen to call Spring 2002. It will be followed by its better half (rather, other half) later this summer. Due to size and topic constraints—and to new material arriving in the intervening time—some of the original articles submitted for Fall 2001 will be in this issue, others in the following one. We certainly apologize for the delay. Though, in the end, things worked out and I believe we have some good reading coming your way.

One final note: At the end of the Spring 2001 issue’s letter I said I’d offer some suggestions on drug using employees (DUEs) in my next one. I’m sure thousands of people have been sitting on the edge of their seats waiting for this. No? Well, in the off chance that a few of you remembered the “promise,” I do intend to return to this subject in an upcoming issue. In fact, I’d love to put out an entire newsletter devoted to this topic or, alternatively, to this topic and similar ones like housing and health care for active users. So if any of you are seized with inspiration to contribute an article, or artwork, send it over!
I would like to thank the International Harm Reduction Association Programme Committee for asking me to speak to this conference on a topic so close to my heart, and a topic that has so little political capital attached to it: drug policy reform and those we leave behind. When I speak of those we leave behind I’m referring to drug users who are homeless, or who are at risk of becoming homeless, because they are unable or unwilling to achieve and maintain abstinence. I want to dedicate this paper to two such individuals, people without whom I would not be able to speak to these issues. My friend John Becker died this past March in New York City. He was a wonderful man whose life was extended by a number of years because of the brave advocacy efforts of Housing Works in establishing supportive housing for active users living with HIV and AIDS. He was also a man who, despite years of heroin addiction, never once put his neighbors in jeopardy because of his drug use. I would also like to dedicate this paper to a client of mine who became homeless in April, evicted—despite dozens of his neighbors attesting to the fact that his tenancy posed no danger or nuisance—because he engaged in small-scale drug sales from his federally-subsidized apartment.

Let me begin with one caveat. I am speaking as a harm reductionist, and as an advocate for the rights of the poor in United States, drawing on my experiences there. However, I hope that the concepts that I will discuss here, about how we negotiate changes in policy in hostile political climates, are universally applicable and can inspire discussions about the difficult political decisions that all of you face in your own countries.

I have chosen to discuss exclusion and inclusion—the theme of this conference—in terms of how we choose to draw those lines in the course of fighting difficult political battles. In drawing lines, we must acknowledge the classes of people that we leave behind, as well as the fact that we will always be fighting to maintain those lines from a position of defensiveness. Sometimes we can push the line to include more people in the protections and civil rights that we are fighting for, but most of the time we are trying to hold the line, to limit how far our opponents can push it to exclude more marginalized people.

I had originally planned to use a moral position and argue that it is simply not right—or not ethical—to make political compromises that marginalize those with the least power for the sake of making small gains and inroads against truly immoral prohibition laws and policies. The more I thought about the current precarious political position of the drug policy and harm reduction movements—for example, the links our enemies have recently made between drug use and terrorism—the more it appeared to me that the experiences of the anti-poverty movement have immense relevance for us today.

DEMONIZING THE POOR

The rhetoric surrounding what we have called “welfare reform” in the United States—which, like our drug policy, has sadly become a leading export to the rest of the world—shows that advocating for the rights of the poor is a lot like advocating for the rights of drug users. People on welfare in the U.S. were demonized in our national media, and once they were demonized and portrayed as lazy, immoral drains on our national resources.
economy, it was easy to take away what little rights they had left by the time our national welfare reform law passed six years ago. Once our opponents had divided up enough classes among welfare recipients into those “deserving poor” and the “undeserving,” it was almost impossible to talk in terms of any “rights,” let alone some of the basic international human rights to healthcare, food and shelter that we have heard about throughout the week.

Once upon a time, not too long ago in the U.S., people who fought for the rights of the poor to basic sustenance were able to establish what looked like an entitlement to government aid. Early on in the struggle for these rights, advocates for the poor made compromises that foretold their demise a short 60 years after they were established; for, as I will argue, drawing lines of exclusion makes it very easy for our opponents to move those lines around and exclude more and more of us until there is no longer a “right” at all.

RIGHTS OF THE POOR
Advocates for the poor believe that everyone has a right to the means to lead a decent life, and that poverty is actually created by a system of capitalism that depends on maintaining a permanent underclass. Poverty and homelessness are not symptoms of moral failing, but rather a necessary by-product of capitalism, or, some would argue, a deliberate tool to keep certain kinds of people powerless. Despite these core beliefs, advocates for the poor accepted early on, aware of the risks, but out of perceived tactical necessity, lines of exclusion that were clearly racist and attached to moral norms, lines that were defined by those in power who were, at the time, white, male and of the highest economic classes.

The first types of aid to the poor were only available to white women who were widows, then expanded functionally to all white women with children. It was not until the civil rights movement in the 50s and 60s that we saw aid to the poor expanded equally to all women with children, including women of color, the elderly and the disabled. Early welfare laws excluded able-bodied single men and women who were thought “undeserving” of these benefits. Elaborate eligibility guidelines, rules and regulations were established which reined the line in tighter, excluding those “undeserving” among the limited set of people entitled to the benefits in the first place.

When the government later began implementing more and more restrictions on accessing welfare, advocates for the poor fought battles over whether the government could limit, for those receiving welfare, those rights guaranteed to citizens by the United States Constitution: the rights to privacy, freedom of speech, the freedom to associate with whomever one chooses and the freedom to travel. In the early days of those battles, the movement won the right, for example, to not have government welfare inspectors make unannounced home visits to search for evidence that would make a family ineligible for benefits. It is worthwhile to note that the most common searches conducted at that time were searches of the homes of women of color to disqualify those women who had men living with them who were not listed as economic resources.

That mattered little to the government, though, because not so many years later the police established their right to routinely conduct early morning raids on public housing apartments to find evidence of drugs and then began to share information with welfare officials anyway.

In its latter days, shortly before we lost the federal entitlement to welfare assistance altogether, we lost battles around the government’s right to fingerprint welfare recipients, and different categories of people began losing meager welfare benefits as the government reined the lines of exclusion in tighter and tighter. Most notably, in terms of our work, people who were disabled and unable to work in a market economy because of a problematic addiction to drugs and alcohol lost their government disability benefits in the early 1990s.

Not only will thousands of families lose their government-subsidized housing and become homeless, the whole idea of turning to one’s family for assistance will become impossible—even for people in recovery.
The people who are most likely to “fail” in court mandated drug treatment and face incarceration—because they are either unable or unwilling to maintain abstinence—are those who are homeless or lack access to stable housing.

EXCLUDING DRUG USERS
In 1996, what was left of any entitlement to basic, below-poverty level assistance ended in the United States. A new system of time-limited and heavily regulated benefits, administered by individual states, emerged. Not surprisingly, in the initial legislation that established this new system of aid to the poor, one class of individuals was specifically singled out and disqualified from even the most basic assistance of food subsidies and health-care: people who were convicted of drug-related crimes.

The other group singled out for special limitations in this new system? Drug users. The new law gave the power to individual states to test the urine of each welfare recipient for illegal drugs and deny benefits to those who test positive. Advocates fought very hard against urine testing, but we faced a difficult political compromise. In most states, we’ve been able to avoid this universal urine testing by accepting a system where drug users are now required to comply with drug treatment by maintaining abstinence, in order to receive welfare. This means that if someone cannot or will not stop using illegal drugs, they will not be able to receive subsistence-level benefits.

The lines were drawn: people who had been convicted of drug crimes and people unwilling or unable to stop using drugs are now the “undeserving,” those willing and able to comply, and lucky enough to have been able to avoid arrest, are “deserving”—for now.

SHIFTING THE LINES OF EXCLUSION
What made the basic welfare system in the U.S. vulnerable to being dismantled was the idea that lines were initially drawn between the deserving and the undeserving poor. Once we accepted the notion that some people deserve the basic necessities of food, shelter, and healthcare and others do not, those fighting to end the system of aid to the poor are constantly able to shift that line to exclude more and more people as the political climate changes and becomes more hostile to human and civil rights.

Those of us in both the harm reduction and drug policy reform movements have also drawn lines, or accepted them as political inevitabilities. In our fight to establish needle exchange programs, for example, how many of us drew the line between drug users and drug sellers? Conceding to our governments that yes, we agree that those who sell drugs are bad people and deserve to be in jail, but people who are addicted to drugs (some even went so far as to say the “victims” of drug sellers) deserved the right to protect themselves against HIV and AIDS. Drug dealers, in fact, as the Australian user activist Annie Madden has noted, highlight for us the complex dynamic of inclusion and exclusion in our movement, a dynamic that deserves continued dialogue in the coming year.

When we finally did convince our governments that some people had the right to protect themselves against deadly blood-borne diseases, we made other compromises that excluded more people from the right to participate in our programs. We accepted rules that established one for one exchange—despite the fact that we knew this was a political compromise and in no way related to public health goals—rules that restricted us to handing out only 10 clean syringes at the first visit while demanding used syringes back at every subsequent visit. We drew lines, or accepted already drawn lines, that excluded the noncompliant drug user, the user who needed more than 10 needles at a time or the drug user who could not get it together to return their used needles.
bers should not lose their housing and be home less for the drug crimes of their like her, argued that “innocent” family members—people who commit even the lowest-level drug offenses—possession of small amounts of marijuana—of access to housing. In arguments before the court, lawyers defending the innocent family members accepted some of the harshest and reactionary drug war rhetoric, conceding that the government has the right, indeed the responsibility, to protect people who live in public housing from the “scourge” of drugs.

Those of us who work with the “guilty” family members—people who break the law against drug possession either out of economic necessity or because they find themselves chemically dependent on illicit substances, or those who consciously break the law because they believe that they have the right to put whatever they want into their bodies, so long as they don’t hurt anyone else in the process—are in a very bad position. Even if the court had decided in our favor, we still would be.

If Pearlie Rucker had won, with the court deciding that the government couldn’t evict “innocent” family members, the government would still feel that it had a free hand to evict the “guilty.” Because they clearly constitute a “scourge” on public housing, a danger to other tenants, even according to their families and the legal advocates who spoke in court on their behalf, it would be as difficult, if not more so, than it was in pre-Rucker days to convince a court that someone who has committed a drug crime should be allowed to remain in his or her apartment.

Since Pearlie Rucker lost, however, not only will thousands of families lose their government-subsidized housing and become homeless, the whole idea of turning to one’s relative or friend for assistance will become impossible—even for people in recovery. Post-Rucker, a new class of people will be excluded from civil society by the lines drawn—and constantly expanded—by the drug war.

I believe that we ended up in this situation, which will affect vast numbers of poor people dependent on government-subsidized housing, for two reasons. First, I think drug law reform advocates, focusing on other issues, did not pay sufficient attention to the ones that affect the poor, and they may have underestimated the ability of the law to reach beyond drug users to affect their family members. Second, I think it was easy to accept the notion that some drug users are criminals, and that those criminals do not deserve government-subsidized housing to begin with.

These issues are complicated, in particular with regards to the rights of the poor to live in safe and secure housing. They are divisive, too, in a way that few other issues are: after all, we’re talking about living situations, neighbors, friends, the right to a roof over ones head and a safe place for your kids to play. While it’s easy for a middle class civil libertarian to invoke human rights principles in support of the right to public housing for even drug dealers, it’s just as easy for a conservative to invoke scenes where “young children can’t visit a neighbor without running into the local pusher.” (Editorial, Boston Herald, March 27, 2002, in support of the Rucker decision.)

More and more harm reductionists—especially those working on the front lines for agencies providing direct services in our hardest hit communities—find themselves presented with these kinds of dilemmas, pitting the needs of drug users against others affected by the drug war. I believe we can accommodate these competing needs by re-
calling a fundamental tenet of harm reduction: that people should not be judged by what they put into their bodies, but rather by how their conduct affects others. Certainly those buying or selling drugs should be held accountable for any danger, community disruption or nuisance that accompanies their business. By the same token, if these activities are carried out in non-disruptive manner, with minimal impact on property and the neighbors, it becomes easier to argue that the basic right to housing should prevail—and easier to accommodate the rights and needs of the community, individual drug users and dealers.

It’s one thing to find a solution that works for harm reductionists, but we are still faced with the damage done by cases like this, where our allies draw lines of exclusion to save their clients, lines that will eventually come back to hurt future clients. While we cannot dictate how our colleagues operate, we can definitely approach our work with a greater awareness of both future and unexpected consequences of our actions.

DRUG COURTS: PRESCRIBING FAILURE

I am particularly concerned about our movement’s advocating for drug courts as an alternative to the absurdly lengthy prison sentences faced by drug users. Considering American rates of incarceration—the United States jails more people for drug-related offenses than all of the countries of the European Union imprison for all crimes put together—the issue of alternatives to incarceration is quite literally a matter of life and death for individuals and communities in the U.S. particularly people of color, who bear much of this burden. Recognizing this, I do not assert my critical view of drug courts lightly. Of course, for an individual facing a jail sentence for possessing drugs, drug treatment is almost always preferable. But unfortunately, I don’t think it is that simple.

Most of the research about the efficacy of drug courts is biased and methodologically flawed, as it has been completed, for the most part, by drug treatment professionals. The same individuals who stand to reap huge benefits from a system that will force thousands of additional people into treatment, ensuring an endless stream of patients, with the tab picked up by state and federal governments. A stream that will continue to flow through their doors, it is worthwhile to note, without regard to whether the treatment methods they employ are effective or not.

But one constant among even the most biased studies is that the people who are most likely to “fail” in court mandated drug treatment and face incarceration—because they are either unable or unwilling to maintain abstinence—are those who are homeless or lack access to stable housing. Other fairly common factors that can have a negative impact on treatment outcomes are: gender, sexual orientation, histories of physical and sexual abuse, ethnicity, access to primary healthcare, access to sufficient economic resources and the existence of other complicated life problems. To explore why these factors influence the efficacy of treatment would demand an article of its own, and is certainly beyond the scope of my present discussion. But this research clearly demonstrates the cost of the political compromises we make when we accept alternatives to incarceration that condition the person’s freedom on their success in treatment.

These compromises, supposedly made on behalf of the people who are most vulnerable—those who are struggling with economic, racial, sexual and gender discrimination and a multitude of other problems—are actually made at their expense. The result: longer and harsher prison sentences for those who “fail” in mandated drug treatment, because they will be forced to serve out sentences for crimes to which they were made to plead guilty. So, far from alleviating long prison sentences, the system sets the most vulnerable people up for failure, and then subjects them to harsher sentences than they would have faced had they been able to engage in traditional plea bargaining—or even taken their case to trial before a jury. (In order to participate in most drug court systems, defendants must plead guilty and give up the rights they would have had in the larger criminal justice system.)

Accepting drug courts as a politically feasible alternative in a system of prohibition that demands punishment for drug related crimes forces us to draw a line of exclusion that sacrifices the freedom of those unable or unwilling to maintain abstinence. These people are likely to be people of color, women, gays/lesbians/transgendered people, the poor and the homeless. If we make this political choice, we must recognize that these are the people we leave behind for the sake of alleviating the harsh sentencing laws for people more likely to respond to drug treatment—by implication, people who are in a position of relative power in our society.

As Ethan Nadelmann has said, if we are the pre-eminent social movement of the new millennium, let us not make the same mistakes as social justice movements have made in the past, making themselves vulnerable by creating or succumbing to lines of exclusion.

I realize that by agreeing to my suggestion that we refuse to impose lines of exclusion, political compromise is almost impossible in the context of prohibition. I hope that my remarks will serve as both a reminder and a warning: we need to be clear about those we leave behind in our efforts to reform drug laws, and we need to be aware that by doing so, we make ourselves vulnerable to our opponents being able to shift the line to exclude more and more people, in ways we can’t currently imagine.

LARKIN STREET YOUTH SERVICES, SAN FRANCISCO

Substance Abuse Services Coordinator

Larkin Street Youth Services (LSYS) is a nationally recognized San Francisco non-profit, which provides a full range of care to homeless and runaway youth between the ages of 12-23. Learn more about us at www.larkinstreetyouth.org.

We are accepting applications for our newly created position, the Substance Abuse Services Coordinator: Successful candidate will implement our Substance Abuse initiative, coordinate 7 Substance Abuse Specialists, directly supervise 3 Peer Counselors, and coordinate the substance abuse training curriculum. The SABC will lead the agency in the modification of the substance abuse intervention to address the unique needs of the homeless and runaway youth population ages 12-23. Salary is $39,428K, DOE/DOQ, plus excellent benefits.

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Larkin Street Youth Services is an equal opportunity employer. We place high value on workforce diversity.

Corinne Carey is a 1998 summa cum laude graduate of the University at Buffalo School of Law. She founded the Harm Reduction Law Project at the Urban Justice Center in New York City, which represents people struggling with addiction in public housing, welfare and family court proceedings, as well as in law reform litigation around issues of access to needle exchange and disability discrimination.
Drug-related evictions after Rucker

On March 26, 2002, a unanimous US Supreme Court voted to reverse the 9th Circuit Court of Appeals’ decision on *Dept. of Housing and Urban Development Vs Rucker*. The Circuit Court’s decision, which had found that the federal government was wrong to interpret public housing leases in a way that allowed local housing authorities to evict “innocent” tenants (tenants who knew nothing about, nor had any control over, drug offenses committed by other people visiting or staying in their apartment), had put a stop to these evictions. Now the U.S. Supreme Court has given public housing officials the green light to resume the evictions.

In 1988, Congress passed the Anti-Drug Abuse Act to deal with drug dealers who were “increasingly posing a reign of terror on public . . . housing tenants.” The Act required public housing agencies to use leases which clearly state that the tenant can lose his or her apartment if the tenant, any member of the tenant’s household or any guest or other person “under the tenant’s control” engages in “any criminal activity that threatens the health, safety or right to peaceful enjoyment of the premises by other tenants, or any drug-related criminal activity” in or near the tenant’s apartment. In 1994, Congress amended the Act to include drug-related criminal activity that took place on or off public housing property.

In the days and weeks following the decision, everyone seemed to be asking three main questions: How did “innocent” tenants lose, and why was the decision unanimous? Will public housing authorities now become more aggressive in evicting families that they may not have evicted before *Rucker* was decided? And, is there anything that families, people who have committed drug offenses or their advocates can do?

How did they lose?
There are many reasons, some easy to explain and some complicated, for why “innocent” tenants lost. The Court in *Rucker*, however, was clearly persuaded by the fact that local housing authorities have a tremendous amount of discretion in enforcing the lease provisions agreed to by the tenant. The government argued, and the court agreed, that local housing authorities were in a good position to determine whether or not a tenant would pose a risk of safety to other tenants in the building. Whether or not local housing officials will exercise the discretion that they have under law to allow people who are addressing problem drug use to remain in public housing is another question.

Will public housing authorities become more aggressive in evicting drug users and their families?
Commenting on the decision in the *New York Times*, the New York City Housing Authority, which is the country’s largest provider of public housing, said that the decision “would strengthen its policy [of] ‘zero tolerance for drugs and violent criminal activity.’” It is likely that many public housing authorities will see the Supreme Court’s decision in *Rucker* as a green light for evicting more and more families that are struggling with addiction.

What can we do?
Tenants and their advocates can fight for the right to remain in public housing, despite the *Rucker* decision. Under federal regulations, tenants have the right to request a hearing to determine whether or not they should be subject to eviction. Public housing authorities can exercise the discretion that they have under the federal law at these hearings, and if public housing officials are persuaded that a tenant does not pose a risk to the health and safety of other tenants, the tenant may be able to remain in his or her apartment. Providing records of a tenant’s enrollment in and participation in substance abuse treatment; proof of involvement in volunteer, church or community-based organization activities; character references and live testimony or notarized affidavits or letters from neighbors are all helpful in successfully advocating for the tenancy of drug users and their families.
“In our tightly connected world, infectious disease anywhere is a threat to public health everywhere.”

You would think that a man who said these words would support syringe exchange. In fact, Bill Clinton said these words on August 19, 2000, as he signed a bill to create a global trust fund for AIDS prevention, health care and education in countries hardest hit by the epidemic, including African countries. But here in the U.S., we still have drug laws that prohibit public health work to prevent transmission of infectious disease. How did we get here? This situation results from a hundred-year chilling effect of our drug laws on public health.

In the 1890s, as in the 1990s, sex and drugs intertwined to excite public concern. In pool halls, dance halls, brothels and other entertainment venues in urban working class neighborhoods, young men (and fewer women), many of them recent immigrants, were sniffing heroin or cocaine or injecting morphine under their skin. This drug use, completely divorced from any medical context, alarmed puritanist, middle class observers who worried about the corrosive effects of urban vice. They also feared that rising rates of syphilis and gonorrhea seemed to be eroding the health and fertility of respectable wives and mothers. Concerns that alcohol contributed to domestic abuse helped shift the goal of a longstanding temperance movement from moderation to prohibition of alcohol. Reform groups formed a loose coalition with the goal of addressing these social problems.

By about 1910, vice commissions in many cities had focused on prostitution as the central problem in the tangle of urban vice. At this time, there were no federal laws regulating the sale of drugs, and pharmacists were free to sell any drug they wished to whomever they chose. Some states and localities, however, had begun passing laws banning non-medical use of opiates and cocaine. Reformers also sought federal laws to control behaviors that they believed were harmful to society, as well as individuals.

The policies which resulted from these reform efforts reflected a consensus that prohibition would work better than regulation. Vice commissions examined European systems of legal, regulated prostitution but rejected these options, recommending instead absolute suppression. As reform mayors replaced machine politicians in a number of cities, they moved to close down red light districts that had been tolerated for decades. Prostitution was driven underground; for many women, this meant shifting from a fairly stable, female-centered social world in a brothel to a more dangerous, isolated existence under the management of a pimp or an organized crime syndicate.

The first federal law to ban the use of any drug was the Harrison Antinarcotic Act, passed in 1914. Public support for drug prohibition was fanned by appeals made to racist fears: from our earliest attempts at prohibition, a mix of racism, ethnic divisiveness and moral puritanism has been employed by those who wish to rid the nation of drug use. In the 1870s local ordinances enacted in California, Oregon and Nevada targeted opium consumption by Chinese immigrants. In the late 19th and early 20th centuries segregationists stirred up the Southern public with images of cocaine-fueled black supermen turning against their white neighbors. Similar images have reappeared in connection with the drug problem “du jours,” including marijuana in the 1930s, heroin in the late 1960s and early 1970s, PCP in 1979, crack in the mid-1980s and methamphetamine in the late 1990s.

Physicians supported Harrison because they believed that outlawing the nonmedical sale of opiates and cocaine would protect people from addiction. (In the late 19th century it was widely agreed that most opiate addiction resulted from physicians’ prescribing these drugs as medicines; supporting efforts to reduce the incidence of addiction was the politically astute thing to do.) Alcohol prohibition followed five years later, but while it lasted only until 1933, prohibition of opiates and cocaine has continued to the present day. The Marijuana Tax Act added marijuana to the list of proscribed drugs in 1937.

Following passage of the Harrison Act, a number of cities opened clinics to help people who were addicted to morphine or heroin, but had suddenly lost legal access to the drugs. Although many of the clinics were planned with the idea they would simply help people through a series of reduced doses to a state of abstinence, some offered maintenance, or ongoing doses of morphine or heroin, to addicts unwilling or unable to give up their drug. However, the Treasury Department authorities charged with enforcing the Harrison Act (because it was framed as a tax measure) vigorously prosecuted physicians they believed were prescribing opiates too liberally. In 1919, the Treasury Department secured a Supreme Court decision which declared that maintenance was not a proper form of medical practice; it then moved against the municipal maintenance clinics. By the mid-1920s, they had all been closed.

In the meantime, private practice physicians became increasingly reluctant to treat addicts as patients. In 1920, the American Medical Association passed a resolution opposing maintenance, and it cooperated closely with the Treasury Department and state enforcement groups as they sought to identify and punish physicians who violated the Harrison Act. Physicians who wanted to maintain addicted patients on opiates faced the possibility of prison if they were discovered. Other physicians questioned the effectiveness of existing forms of treatment, and saw...
Once legislation had made opiate addiction a federal concern, the Public Health Service (then also in the Treasury Department) undertook to study the problem. In the early 1920s it assigned psychiatrist Lawrence Kolb to examine some 200 addicts and determine what he could about the nature of opiate addiction. Since the 19th century, a branch of psychiatry called inebriety had treated alcoholism and opiate addiction. At the time he began his research, Kolb had no professional experience with addiction. He had spent several years examining immigrants at Ellis Island, screening them for mental conditions that might disqualify them for entry into the U.S., and he had managed a specialized Public Health Service psychiatric hospital.

Kolb’s research did not bear out the racial profile suggested by lurid media coverage of the day. Among the 200-plus heroin or morphine addicts he interviewed, Kolb encountered mostly white working-class men—many of whom were first generation Americans—who lived and often worked in urban neighborhoods where dance halls, speakeasies and other entertainment venues continued to flout middle class ideas of respectability. Kolb saw the typical addict as a man whose ambition exceeded his modest capabilities and who indulged in flashy behavior and easy pleasure instead of working hard and saving for the future. (His assessment reflected the demographic pattern in which most addicts were men, but he also described the addict character almost exclusively in masculine terms.)

American opiate addicts were living in a world that made managing their habits increasingly difficult and dangerous. Even most city hospitals had closed the narcotic wards where addicts could seek help in the 1910s. As treatment venues disappeared, the likelihood of serving jail or prison time for possession of opiates increased. By 1928, the largest category of federal prisoners were violators of the Harrison Act. In response to the problem of addicts in prison, and with some hope that lengthy incarceration would actually rehabilitate addicts, Congress passed legislation in 1929 authorizing the creation of two large prison/hospitals for opiate addicts. The more famous of these, the Public Health Service Narcotic Hospital at Lexington, Kentucky, opened in the 1935 with Lawrence Kolb as its medical director; a companion institution began operations in Fort Worth, Texas in 1938. Addicted federal prisoners were sentenced to these two prisons; in addition, probationers were sent there to stay until the medical staff pronounced them cured (a process expected to take at least six months), and voluntary patients (always a tiny minority of the total) could check in and leave when they wished.

By the mid-1930s, opiate addicts in America were forced to live as criminals with virtually no recourse to humane treatment. Although planned as both hospitals and prisons, the Narcotic Hospitals at Lexington and Fort Worth functioned more overtly as prisons, and follow-up studies of released inmates, showing high rates of relapse, further undermined any therapeutic optimism that had originally been associated with them. This trend was consistent with the deepening stigma associated with addiction and an increasingly harsh enforcement attitude at
Following World War II, opiate addicts became even more powerful negative symbols as mainstream American society embraced conformity and anticommunist fervor mounted. Like communists, opiate addicts were seen as people who could subvert and destroy but who were insidiously difficult to recognize. Harry Anslinger, Commissioner of Narcotics from 1930 to 1962, made this symbolic link explicit when he charged that Communist China smuggled opiates into the country to weaken the populace in preparation for a takeover. The national mood was symbolized by passage of the Boggs Act of 1951 and the Narcotic Control Act of 1956. Both enacted harsh penalties that implicitly equated drug trafficking with murder and rape. The first introduced mandatory minimum sentences; this was just one example of how drug laws have been used to introduce measures which increase the power of law enforcement and erode civil liberties. By the mid-1930s, opiate addicts in America were forced to live as criminals with virtually no recourse to humane treatment.

In the 1950s, many physicians questioned the appropriateness of imprisoning addicts. Prominent among them was Lawrence Kolb, whose experience at the Lexington Narcotic Hospital and continuing study of addiction had led him to conclude that criminal justice management of addiction was both cruel and ineffective. However, in 1958 when the American Medical Association joined with the American Bar Association in issuing a report arguing for medical management of addiction, nothing significant changed.

The wave of youthful drug experimentation that began in the 1960s prompted many young people, parents and growing ranks of professional observers to urge a new approach to drug problems. Vincent Dole and Marie Nyswander introduced methadone maintenance in the early 1960s, although they had to overturn the idea that addiction arose from character flaws to persuade clinicians that methadone maintenance could support positive changes in addicts’ lives. Before there was a movement called harm reduction, activists in this earlier era created entities like STASH in Madison, Wisconsin, the Do It Now Foundation in Phoenix, Arizona and Up Front Drug Information in Miami, Florida. These groups developed flyers with accurate information about drugs, based on users’ experiences and users’ needs. Some, like Up Front and Pharm Chem in Palo Alto, California, had laboratories where people could anonymously send in samples of street drugs for qualitative testing.

At the same time, some physicians found that the drug users they encountered didn’t match the sociopathic profile described in the psychiatric literature. In the context of the free clinic movement of the 1960s and 70s, a new set of ideas about addiction was formulated, based upon a nonjudgmental approach and observed similarities in dependence on a variety of drugs. Around 1980, these ideas coalesced around a definition of addiction that focused on patterns of use rather than on the user’s character. This definition holds that addiction is present when an individual uses a drug in ways that are compulsive and out of control and that continue in spite of adverse consequences. An emerging cohort of drug counselors adopted and adapted two approaches to addiction that had been developed by users—the Twelve Step approach of Alcoholics Anonymous and the therapeutic community idea based on Synanon. As demand for help with drug problems grew in the 1970s and 1980s, a treatment infrastructure arose in both the private and public sectors, and for some,
By mid-century, prostitution no longer seemed a threat to the sanctity of the family in the way it had to Progressive Era reformers. Also, at about that time penicillin became widely available. Discovery of the antibiotic alone did not bring syphilis and gonorrhea under control; this happened through a concerted public health campaign to identify infected individuals and provide them with medication. When STD rates began to rise again in the 1960s and 1970s, many blamed sexual permissiveness; they failed to note that, once prevalence levels had fallen, state governments had reduced funding for the STD clinics responsible for the reduced rates.

AIDS invoked not only the social fears associated with other sexually transmitted disease but also prejudices against gays and drug addicts. For addicts, it represented yet another risk made even more dangerous by public policy. HIV was spread through the sharing of syringes; syringes were scarce because of longstanding controls over their sale, like the paraphernalia laws of the late 1970s, which made sale or possession without a prescription illegal. When the fairly obvious idea of using sterile syringes to reduce transmission of HIV was borne out by research, a recalcitrant bureaucracy refused to remove existing barriers to their access. Syringe exchange programs faced laws which essentially banned good old fashioned public health: the control of infectious disease based on an understanding of how the pathogen is transmitted from one body to another. One of the most fundamental responsibilities of the state is to protect the public health, but even as injection drug use accounts for over a third of new cases of HIV infection, American drug policy continues to put the lives of drug users, and all of us, at risk.

One impact of repression is the erasure of historical memory. As I spoke with them and listened to their presentations, it was discouraging to see that they knew little about what had been learned a generation earlier. The move toward a zero tolerance drug policy in the 1980s interrupted a flow of wisdom and experience from the 1970s that today’s young activists could build from. Instead, they are having to relearn much that had been accomplished but forgotten. They shouldn’t have to; we need the new generation’s energy and insight to meet new challenges, like those posed by hepatitis C—and by new drugs and new patterns of use.

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1 Surveys of drug use, conducted in the late 1800s and early 1900s, found women to outnumber male users by as much as a 3 to 1 ratio, with average ages ranging from 40-50. The majority of these users were middle to upper-class, from small towns or rural areas. By 1929, 15 years after the passage of the Harrison Act, most users were male, urban, poor or working class—and much younger.

2 This period of renewed vigor in the prosecution of narcotics users corresponded to a population change in our largest Northern cities: whites of European descent moved out to the new, postwar suburbs, to be replaced by African Americans, and in the Northeast, Puerto Ricans. The heroin using population underwent a similar transition.
any syringe exchanges and other harm reduction programs talk about having a non-judgmental attitude, but what does it mean? For some, it means meeting drug users “where they’re at.” For others, it means creating a safe place to talk about personal issues. For some people involved in 12-step recovery, it can be summed up as “live and let live.” Non-judgmental can apply to other issues besides drug use, including HIV status, family and relationship issues, literacy and much more. But there are times and situations where a non-judgmental attitude can be about life and death.

American society sends a powerful message of shame and exclusion to drug users, an extra dose on top of the familiar helping served to all of us. Many of us create public personalities that hide difference (or divert attention), affirming the shame. Some shaming is rooted in racism, sexism, homophobia or classism. Syringe exchange staff and volunteers are placed in a difficult position, because shame is a built-in part of our culture: none of us are immune to its power, and all of us shame others in various ways. Sometimes when shame isn’t offered, we seek it out. But there are certain kinds of shaming that must be challenged in order for syringe exchange programs to make and maintain effective contact with drug users.

Here are some basic shaming scenarios:
1. A dedicated outreach worker has gotten a participant into a detox program.
   A few days later, that participant shows up at the needle exchange program, obviously still using. The outreach worker expresses anger that the participant wasted his time.
2. A participant shows up late (or early) for needle exchange. When the participant says she wasn’t able to come at the official time, a volunteer accuses the participant of trying to “get over.”
3. A sex worker participant says she doesn’t always use condoms with her johns. Instead of talking with the participant about the circumstance around this, the outreach worker tells her she should “know better.”

These scenarios raise a lot of issues about participant/provider relations. But I would like to focus on three things in this discussion: ethical questions, proper boundaries and the role of 12 Step Recovery in working with active users.

ETHICAL ISSUES

1. The whole community benefits when an injector uses sterile syringes and prevents the spread of deadly infections. If an injector is uncomfortable using your program, it isn’t just that injector who suffers, it is the whole community.

2. You must understand why you are doing this work. Are you doing it for yourself or for the people who use the program?

It is perfectly allowable to do the work for yourself. That is a normal thing for many people. They do the work because it is fulfilling for them. Many people with a history of drug use place strong value on “giving back” by working with drug users.

But drug users aren’t coming to the program to make an outreach worker’s life fulfilling. They are coming because they need sterile syringes, treatment, health care and other forms of support. Ultimately, if they feel they will be treated shamefully, many will not come. There are other places an outreach worker can go to seek fulfillment, but there probably isn’t any other place the participant can go. The real priority needs to be on making sure the participant can use the program comfortably, because he/she is the one without options.

It is unethical to offer something to someone in need, then shame them for needing it. This is not “giving back,” and it doesn’t benefit the participant or his/her community.

3. Does a shaming message provide useful support to the participant?

Although staff and volunteers may have a personal investment in advocating abstinence, they should also remember that these messages are everywhere. Drug users are often stereotyped as ignorant of the message of abstinence. But they are extremely aware of it. Drug users are closed out of most services, hunted by police and publicly ridiculed by politicians, preachers, teachers, children and practically everyone else, including other drug users.

It is undeniable that chronic drug use has many harms, and abstinence is a goal that many drug users strive for. A participant’s life may be devastated by drug use, but an outreach worker has to consider that the participant may know this already, and carry shame for it. Most of the participants I know have been in and out of treatment and recovery more than once, and already have very strong feelings of shame about the problems their drug use creates for themselves and their families. You cannot protect a person from shame they already feel, but it is completely unethical to remind someone of their wound by rubbing salt in it.

Remember, you offer access to treatment and rehabilitation, but you ALSO offer access to sterile syringes. Just because the participant is using drugs does NOT mean they are ignorant of the message of abstinence, and they NEED those sterile syringes either way!

HOW ABOUT SOME SHAME WITH THOSE SYRINGES?
by Donald Grove
BOUNDARIES

Boundaries are a normal part of life, and everyone is entitled to them. This goes for participants of the program as well as staff.

There is a popular belief that whatever a drug user gets is what they deserve. Drug users face closed doors most places they go. If they get attitude from the needle exchange program too, then they really don’t have anywhere to go. Is that really what they need?

These closed doors are usually presented as “boundaries” by the provider. “We can’t provide services if we have users coming in here, nodding out, ripping us off, creating problems.” This may be true for some services. But the problem is that many providers also tack on the following part: “It’s good for those users to close them out. It teaches them about right and wrong. It requires them to act responsibly.”

Consider the drug user who has been in and out of prison. This person has lived in a heavily restricted setting, intended to foster the deepest social concepts of responsibility. Consider the homeless drug user, whose ability to survive may already hinge on very careful control of one or two meager resources. Consider the sex working drug user, who must weigh a program’s version of responsibility against the conditions they face in their struggle to support themselves and their children. All of these people have important responsibilities already in place, before the program comes with it’s own message of responsibility through restricted access.

The bottom line is this: we are all entitled to boundaries, but we should not claim our boundaries are in place to benefit the participant. Using boundaries to reinforce “responsibility” is a fallacy. It denies the genuine personal importance of boundaries, while claiming to address a preconceived notion of a drug users’ social capacity. Can we pick and choose who gets HIV and who gets a clean needle based on using boundaries that “teach responsibility”? People who want to enforce boundaries in this way really shouldn’t be working in a needle exchange.

RECOVERY

People in recovery need to take care of themselves, and need to give a lot of consideration to their process of healing. I’m only guessing, but it is likely that more than half the people working at syringe exchange programs are in recovery, or have spent time working a recovery program. The 12 steps were created by users themselves, rather than clinicians, and 12 step groups speak directly to issues in a way that many users can understand. Nevertheless, as with any spiritual movement, human nature can distort the message.

The message of the 12 steps is not one of shame, but some people in recovery treat drug users very arrogantly and shamefully. It’s a question of human nature. It takes many years of devoted effort to develop an attitude of grace and humility. In working with other drug users to prevent HIV and bring them into services, many people in recovery are confronted by their own shame. Some people re-examine their attitudes and learn a different approach to talking with drug users, but for some this is too difficult, and maintaining recovery becomes confused with shaming active users. In all cases, a person must do what is right for themselves, but this may mean avoiding needle exchange work.

According to the 12 steps, it is the grace of a higher power, combined with fellowship with other addicts, that supports a member in not using drugs. The shaming message is not coming from that place, and shaming other drug users won’t help them get clean. Put bluntly, you are not a higher power yourself, and your contempt for active users will not support them. It’s a spiritual program, and people get the message of recovery because they have souls, not because they are treated like no-good junkies.

The 12 steps teach that all people in recovery share their disease with all active users. As someone in recovery, the most valuable thing you can offer an active user is empathy and understanding—not shame. You don’t know more than they do and you aren’t better than they are. You only know what they know, that’s why you’re an addict! Reach out and share about what recovery has done for you, and leave the shaming to people outside the fellowship. If your message to others about recovery is shaming, your recovery may be at risk, and you should consider where you will get services if your disease becomes active.

Your recovery is IMPORTANT. Your boundaries are IMPORTANT. Taking care of yourself, and making your needs a priority is the first step to health and sanity! But those ARE NOT the same thing as what the needle exchange participant needs. Drug injectors need access to health care, sterile syringes, housing, support, legal advocacy and more. Who offers it, and how it is offered can make the difference between life and death.

Donald Grove has done both above- and underground syringe exchange since 1990. He currently is Technical Resources Coordinator at the Harm Reduction Coalition.

Can we pick and choose who gets HIV and who gets a clean needle based on using boundaries that “teach responsibility”? People who want to enforce boundaries in this way really shouldn’t be working in a needle exchange.
Until recently I worked as an outreach worker/advocate with young injectors in San Francisco. In the course of those four years I experienced enthusiasm, martyrdom, burnout, and all sorts of changes in between. This is my attempt to extract from my experiences ways that, as providers, we can take better care of each other and ourselves.

**MY HISTORY**

My involvement with the street scene started when I was fourteen. Squatting in downtown San Francisco, I drank, sparechanged and table-dived with the rest of the homeless punks. But I was still a housepunk, one of those kidz who talks too loud about the few drugs they do and still has a job scooping ice cream two days a week. Nor was I like the kids I worked with later, who’d been homeless for years on end. I had enough social support to return to and eventually graduate high school by living with a friend.

By age twenty I had quit alcohol and other drugs and begun working as an outreach worker for the Haight Ashbury Youth Outreach Team. I’d been living indoors for several years but some of the people I’d squatted with were still on the streets and would come into the drop-in center. Being in a provider role with old friends felt awkward and difficult. Until I knew better, I dealt with my discomfort by overzealously attempting to prove that I was still “down.” I eventually realized that “the kidz” (homeless youth ages 14-29) could see through my insincerity, and learned to just be myself—a housepunk.

**THE WORK**

Without knowing what it was called, I did everything a good harm reduction counselor/outreach worker/everything-else-under-the-sun could do. I met the kidz where they were at: in the park, on the concrete, high as fuck, numb or happy, twacked on sleep deprivation or down, down low. I let them hang out at the drop-in high when other programs wouldn’t, keeping them awake to prevent them from overdosing. I sat by their sides in hospital waiting rooms for hours on end to ensure they got proper care.
from oftentimes judgmental doctors. I listened to horrific stories of pain and abuse, and gave support, talking about hope, safe shooting, taking breaks. I survived evictions and agency funding nightmares to defend the kids against NIMBYs, and pled with probation officers to keep them out of jail. I loved those kids, and became integrated into their lives like the mothers they never had would’ve, could’ve, should’ve if things had been different. It was me and the kidz against the world and I was going to take it all on. On rainy nights I lay awake, struggling to believe that I was not inherently evil for having a bed to sleep in when others were cold, unsafe, freezing outside. Early on I was offered a raise and refused it, saying we should spend the money on socks. I thought that if I just fought hard enough, things would be okay. I was a guerilla fighter on the frontlines of the never-ending battle called harm reduction.

But it was never enough. For every kid off the streets, two came on, and one was inevitably someone who’d just left the year before. Operating in an entirely different context than the mainstream, I had to learn to define success in totally different ways. I soon learned not to have so many expectations because things didn’t always change for the better. When one of the kidz would die, we’d have a memorial in the park to remember her. I learned that all I could really do was love unconditionally and hope that people would stay alive long enough to realize their own dreams. I gave a million pep talks to other service providers to remember these things. Yet, amidst all this non-judgmental, fatalistic serenity, my heart broke daily.

**BURNOUT**

With every overdose, every rape, every stolen backpack, every beaten up girlfriend, every back-to-town-&-strung-out-again-after-a-year-of-doing-so-damn-good-kid, the grief continued to build. In time I felt like I was going to lose my shit from the cumulative heartache. We bought a book for one of the memorials and with every death it just sank in that the book would eventually fill with the names of kidz and friends, loved and lost. I began to wonder, not if anyone else would die, but just who would be next. I obsessed about overdose, hoping to somehow stop it, rein it in. I felt panicked and traumatized, numb with constant mourning in the way that I imagine medics feel, bandaging and burying soldiers on a battlefield. Only this was the War on Drugs. I was afraid to feel, fearing what would happen if I really let myself go. I spent Friday nights watching depressing movies, waiting to release the tears I had been withholding during the week. After several years of this, I realized that as much as I immensely valued the relationships I’d taken so long to build, I was no longer putting my all into the work.

I was exhibiting the classic signs of burnout, “psychic numbing,” “compassion fatigue” and “post traumatic stress syndrome.” I felt unable to feel or give anything emotionally. I found myself hiding in the office, hoping no clients would come in. I would spend hours piddling around with paperwork, organizing the outreach supplies closet, attempting to establish some sense of control and order amidst the chaos around me. When new kidz came to town, I found that I no longer had the same enthusiasm I’d once had for establishing rapport with them. I was less and less able to listen to the kidz I already knew, and quick to snap when they went on and on about how they were going to change their lives.

After years of the work, I felt like a sopping wet sponge, so saturated with grief that I could not absorb another drop.

I will never forget this one kid, “Jeffrey” (not his real name) who told me he only smoked pot and would never touch injection drugs as long as he lived. Without even realizing it I said something like, “Yeah, right. That’s what they all say. You’ll probably just get strung out and OD like the rest.” I had heard people say that line so many times before and still get strung out, only in the past I had been able to censor the cynical reaction in my head. This time however, my cynicism got the best of me, and my sense of boundaries totally failed. Luckily, Jeffrey called me on it and I apologized profusely telling him I’d just seen so many kidz go down hill and it was a hard process to watch. Jeffrey never did progress to the hard stuff, but even if he had, that comment would have been totally uncalled for. I could have expressed my concern, and told him what other street kidz had experienced without treating him like his fate was already written. Although I sometimes see Jeffrey and we laugh about it, that experience was a painful wake-up call for me. I saw that I could not continue on the path I was on; that something had to give.

**THINKING ABOUT USING**

As burnout settled in, I felt overwhelmed by such immense suffering and sought ways to shut off. For a while all I could think about was wanting to shoot up. I had been straight-edge (abstinent from alcohol, cigarettes, coffee and other drugs) for years and had no...
Like so many others, I had become so identified with the provider role that I could scarcely take care of myself, or ask for the help or support that I needed.

experience using heroin. The people I was surrounded by were not happily moderating their drug use, taking their time to find a vein in a clean, well-lighted place for shooting up. They were fucking miserable, and told me so daily. Their lives were marked by dopesickness, hustling, cops, abscesses, hepatitis C, jail, inaccessible treatment programs and friends dying. I saw the ramifications of heroin addiction daily, so why was I at home looking at the phone thinking, “I could call so and so, she’d show me what to do. I’ve got syringes, I know where people cop, it would be so easy”?

I have heard it said that the mind imbibes the qualities of the things it contemplates, so it makes sense that I would want to use when I was surrounded by it everyday. I was also a harm reductionist operating without much support on an agency or community level, which led to feelings of martyrdom and accelerated the burnout I was feeling—and contributed to my desire to use. Like so many others, I had become so identified with the provider role that I could scarcely take care of myself, or ask for the help or support that I needed. Nor could I think outside of the box; in my world the only roles available were of helper and helped. Feeling like I could not handle being the helper anymore, the only other option was to do what the “helped” were doing: shooting up.

WHITE PRIVILEGE & SURVIVAL GUILT

Working as a provider, I wanted to use in order to deny my privilege, and to “feel the pain” of the kidz. Part of me felt pulled by the Drugstore Cowboy romanticization of heroin use. Using represented the forbidden permission to lose control. It would enable me to absolve myself from responsibility, and simultaneously merge into the chaos of one-ness with the kidz, thus absolving myself of my white/middle-class/living-indoors privilege. (Or so I thought.) Shooting up seemed like a viable option, since I had friends in the harm reduction field who had done exactly the same once they’d started doing needle exchange. I envied their release, the street cred that came with being an out IDU/provider and the manner in which they were taken care of—in a way that their clients rarely were—by other providers. Yet, as much as I felt tempted to, I did not return to old modes of coping. I realized that using would only decrease my abilities to deal with my own issues and to help the kidz.

MY ROLE AS A PROVIDER

The kidz had peers on the streets; the role that I played was different. I wasn’t someone to rip off, nor someone who would take advantage of them if they let down their guard. I was someone outside of the scene that they could trust, because I wasn’t like them. I believed that my role in their lives was to show that it is possible to hold onto your values, freedom, anarchy, etc., while taking care of yourself. Using and getting sloppy strung out would hardly have supported that role. (I know myself—I would’ve gotten sloppy.) If anything, absolving myself from responsibility through drug use would have communicated a message that was contrary to the one I claimed to teach. If I expected drug users to be responsible for their behavior, then the same should be expected of me. My starting to use, however “responsibly,” would not have been a responsible decision. It would be me not dealing with my own problems. I did not want to use to “get high,” although not feeling would have been an added bonus. I wanted to use to fuck up, to destroy the life and responsibility that I had created for myself.

COPING STRATEGIES

I worked as an outreach worker for four years, and never used. I decided that it wasn’t an option for me, that I wanted to feel even if it brought on a flood of emotions I didn’t want to face. Choosing to feel meant I had to find new ways to deal with my burnout. To cope, I baked cookies, I wrote, I went dancing, I talked to friends, I watched sad movies and poured myself into my work and school. For a long time I knew that these things would only tide me over but that I needed a long break from the work. For personal and programmatic reasons I felt like it was never the right time to leave. I felt guilty, like I would be abandoning the kidz to struggle against adversity alone. Like leaving would mean I was an uncaring sellout, who wasn’t down for the struggle. It had to get to the point where I just couldn’t put off taking care of myself any longer. And it did.

I quit my job and spent three months traveling in Mexico and have since returned to take an extended break from direct service work. It’s been a challenge to remember that taking care of myself is actually the best thing I can do for the world right now but I have faith that I am doing the right thing. This article has been my attempt to make sense of my experience, with the hopes that those still doing the work might learn from them. Is it inevitable to burnout on this work? Maybe. But I don’t believe we should have to get to the point of no return before we stop to take a break. There must be better ways of taking care of ourselves while we do this work. To that end, I offer these suggestions.

1. Prioritize taking care of yourself, personally and professionally.

   a. Personally, this means staying active in other areas of your life. Seek out and keep up the things that are fun and that give you peace of mind. For me this is writing, dancing, long walks, but most importantly, drinking tea, eating toast and talking with my closest friends. For you this might be painting, reading, cooking, doing graffiti, playing sports, bike-riding, camping, swimming, listening to and playing music, lighting candles, taking a hot bath, meditating, or any combination of an infinite number of possibilities. It also means recognizing the signs of burnout and giving yourself permission to contribute in ways that are less demanding emotionally.

   b. Programmatically, this means providing short and extended breaks, a realistic workload, decent pay (or if there’s no money, some decent appreciation), clinical supervision, counseling, mental health days, staff retreats and training. People that take care of themselves run sustainable programs. For programs with little funding (i.e., most programs), taking care of staff may mean providing less comprehensive services, a hard but necessary choice.
2. If you’re from a privileged background, acknowledge your privilege and move on. It is important to be an ally to oppressed people without trying to take on their oppression. The best way to be an ally is to take care of yourself and make good use of your privilege.

3. If you’re using or not, evaluate how you feel about it and go from there. If your level of use feels good to you, then please use safely and with company. If not, find support to change it to a level that feels better, even if that means abstinence. For some, moderated use is not a realistic option and that’s okay.

I believe in harm reduction, and know how revolutionary it is to believe that users deserve health and dignity. In an ideal world it would be possible to use without so much harm to the individual, but we do not live in an ideal world. This is the real world and not all use is implicitly okay for everyone.

4. Dialogue, of course. Talk about what’s going on with you, even if it seems pale in comparison to what you see other people going through everyday. Talk to your friends, your co-workers. If you don’t feel like you have anyone you can trust to talk to, or even if you do, check out individual therapy. If it’s not provided by your agency, there are usually sliding-scale programs around. You may also think about starting a harm reduction workers’ support group.

5. Keep an eye out for your friends; drag ’em along to your support group!

I don’t buy the racist bullshit line in *Traffic* where the Mexican Drug Czar says that overdose acts as treatment. I’m not waiting anymore for my friends in the harm reduction movement to be dead or suicidal before I tell them I care and am concerned about their welfare. No more waiting until I’m too numb to be real with people before I start taking care of myself. The biggest tragedy of my own burnout was realizing that I’d become so numb from grieving for all the ones I’d lost that I was doing a shitty job of being there for the people that were still alive. So, instead of forever listing the names of the ones that are gone from my life, whom I will always love and remember, this is my shout out to holding onto the ones that are still here. Please, for fuck sake, remember that loving yourself is the greatest gift you can give to the world. Now, give away!

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*Choosing to feel meant I had to find new ways to deal with my burnout. To cope, I baked cookies, I wrote, I went dancing, I talked to friends, I watched sad movies and poured myself into my work and school.*
Communication: an ingredient we recognize as vital for the success of any endeavor. People express themselves through their behavior, body language, facial expressions and, of course, written and oral expression, with varying levels of ease.

Many of us in the harm reduction movement have been in situations where we are preaching to the choir, so to speak. Those are the easy gigs. The tough ones constitute the very challenge we currently face in the advancement of our movement. At last year’s Drug Policy Alliance conference in Albuquerque, Ethan Nadelmann recounted an experience he’d had upon seeking advice from the renowned spiritual leader Ram Dass. Ram Dass advised him that in order for us to progress further in this movement, we had to learn to love Bill Bennett or people with whom our ideas were in conflict, as well as people who were “in the choir.”

Although many of us admit that we’re not quite “there” yet, hopefully we all recognize the wisdom and truth in this statement. It was interesting to me to walk in to an opening plenary session and hear this, as only two nights earlier I had found myself in precisely this situation on the plane headed for Albuquerque.

It’s always interesting to see whom the universe deems it karmically appropriate for me to spend time next to during an airplane ride. I have had some tremendously interesting and magically synchronistic opportunities for conversation simply through pre-assigned seating arrangements. Once, on a plane ride back from Cuba where I had been overwhelmed and impressed by the culture of a system NOT based on capitalism, I sat next to an employee of Bacardi, of Bacardi Rum fame. The Bacardis were one of the families most affected by the 1958 change of power in Cuba, and are still movers and shakers behind a lot of the current anti-Castro politicking and propaganda in the U.S. It was interesting to hear his perspective at a point in time when I had been so recently and completely enchanted by a resourcefulness nearly unheard of in our country.

Here I was in a middle seat on a full plane bound for Albuquerque. The girl on my left was very into her book. The guy on my right was just hanging and riding along, as I was. I don’t remember who started the conversation. We both talked about the usual stuff: where we were going, and where we were from. When I learned he worked for the American military, and had spent time working for the DEA in Colombia, I found myself shutting down and withdrawing from the conversation. At that point it hadn’t yet clicked in my mind that I was headed to a conference on drug policy reform. I caught myself performing that stupid human trick called making assumptions. This particular stupid human trick seems to occur when we have not bothered to communicate effectively with others. All of my old crap about the military and authority came creeping into my head and started helping me form assumptions about what this man’s position...
would be in regard to the issues that we’d be discussing at the conference.

Then, suddenly, I had an epiphany. I thought to myself that it wasn’t often that I actually had the opportunity to sit next to someone who’d personally had the experience of working for the DEA in Colombia. Certainly not in a situation where he would be a captive subject of conversation for almost 3 hours on an airplane 33,000 feet above Nebraska, where neither one of us could walk away if the conversation became uncomfortable. I decided this was a prime opportunity for an interesting exchange of ideas, or communication, one where I’d have a shot at learning maybe not quite to love, but to at least communicate with a man who I ASSUMED essentially represented Bill Bennett. I have never been adept at confrontation, and was avoiding this opportunity because I didn’t want to later wind up being dissatisfied with how I’d handled it. In fact, as so often happens when we are busy making an ASS out of U and ME, I had been dead wrong about this man’s stance on a number of issues. Interestingly, I found him fairly anti-American for a man who had spent his entire life (2nd generation even) making a living from the U.S. government. It was fascinating when he stated that, in his opinion, most everyone who had ever been employed at some point in time by the DEA supports legalization or regulation of drugs in the U.S. As so often happens, I ended up with an intriguing outcome by rising up to the challenge and engaging in meaningful communication.

Ironically, sometimes the toughest situations of all are when you have to communicate with members of the choir, but at some emotional risk for yourself. I recently experienced this first hand, in a very illuminating way. In October 2000, like many others in the harm reduction movement, I attended the 30th National HRC conference in Miami. For a variety of reasons it was a very unhealthy period in my life, and quite frankly I looked like shit at the time. The interesting part is how most of my colleagues and “friends” in the movement demonstrated their concern about me. Most chose to approach others who knew me, or my co-workers, or even my boss at the time, to ask how I was doing. Most chose NOT to approach me directly. My boss told me that no less than 20 people approached him with concerns about my health and wellbeing. I even heard a story from a co-worker who had been invited to lunch by a complete stranger who wanted to know what was going on with me, and get advice as to how he could help.

What was especially interesting was that most of these 20 or so people were avoiding direct communication with me because of assumptions they were making about my life at the time, based on how I looked. Only four people had the nerve to confirm or deny their suspicions and relate their concerns directly to me. Now, please don’t get me wrong. I am sincerely happy that so many people cared. Nevertheless, I have to let people know how it felt to be talked about instead of talked to: not so great, in fact, very hurtful and frustrating.

I felt the need to examine this phenomenon: what was the most frustrating part about it? Although there were many layers; what bothered me the most was the way this experience demonstrated the inability or unwillingness of people within the harm reduction movement to communicate with each other. I was puzzled. Didn’t many of those in attendance consider themselves professionals, or at least para-professionals, in the realm of counseling, a realm of communication?

It’s often said that harm reduction is about meeting drug users “where they’re at.” In order to successfully do that we have to be able to ask our clients/participants tough, personal questions. We need to be able to listen to them, not only when they respond to our direct entreaties, but also when they approach us on their own initiative. Furthermore, we need to be detectives sometimes, discerning other forms of communication—whether non-verbal clues or just day to day signs of a person sinking into despair—and then acting upon our findings. Nor is our work conducted in a vacuum, solely between ourselves and our clients: interaction and collaboration between co-workers and colleagues are vital components of successful provision of harm reduction-oriented services. All of this points to a need for good communication skills.

Yet during my experience in Miami I saw exactly the opposite happen. While people seemed to be aware of my personal situation, they were unable to voice their concerns to me directly—either keeping them to themselves, or sharing only with select colleagues. This points to a communications failure, something that should be a cause for concern for all of us, if it’s any indication of the level of communication practiced in the harm reduction field.

Most of these...people were avoiding direct communication with me because of assumptions they were making about my life at the time, based on how I looked.

It behooves us to know why this is so. Even if it’s solely an inability to deal with these issues amongst persons viewed as “friends,” it still resonates with other work we do. Who is to say whether providers will become friendly with clients, but it does occasionally happen. The real issue is the barriers we put in our own way, usually motivated by fear because the emotional stakes are perceived to be “high.” High stakes usually exist when we have personal investments in the other individual. Any harm reduction worker who takes his/her work seriously will undoubtedly develop close relationships, or just simply begin to care about the people they serve. The real point is not about the ability to communicate with various groups—friends, colleagues, clients—but to communicate in difficult circumstances.

I want to talk for a moment about why people are hesitant to say tough things to people they care about—or think they should care about. I imagine there are a few things going on here: one, people are afraid of being wrong in their assumptions and maybe getting a verbal brushback for their trouble, and two, people are afraid of insulting others or being accused of being judgmental. Let’s briefly look at these possibilities, because if we can diffuse our fears, then the communication may come a bit easier.

Sometimes we pay a price for expressing our concern, as when we get a hostile reaction from the individual we’ve approached. Most of us avoid conflict, and the fear of saying or doing something that will generate conflict in response is often strong enough to keep us from getting involved. Choose your battles: there’s a time to bring stuff up, and a time to keep your mouth shut. And there are ways to say things, and ways not to say things. Telling someone you’ve only just met that they look like they’re strung out sounds judgmental, and is likely to offend and generate a hostile response. Asking if they’re well is more likely to make it past a person’s defenses; even if they insist that they’re fine you’re less liable to get your head bitten off. There are also times when things are better left unsaid, when bringing up your concerns might
cause more damage than not doing so. If you aren’t prepared to deal with the consequences of your comments, or don’t have the skills or the time, then consider leaving it for someone else. Sometimes discretion is the better part of valor. If you’re truly acting out of concern, and not because you want to feel good about yourself, you should know how far to go.

It’s important to keep things in the realm of feelings as much as possible. Telling someone that you’re worried about them says that you care, doesn’t sound judgmental—and isn’t insulting. Your feelings might not be accepted by others, or they might seem misplaced, but they’re feelings, which in sane people aren’t usually characterized as right or wrong. On the other hand, our perceptions can be wrong. As harm reductionists, we’re often operating in uncharted territory. That means taking risks is an integral part of our work, and being “wrong” about things is the downside of risk taking. Being wrong is also part of the learning process, and often serves just as good as a guidepost for future actions as getting things right.

It was suggested that I give you some examples of effective communication conducted in difficult circumstances by including some of the things said by the four people who chose to address me directly, all of which were heartfelt, meaningful and appropriate. (I realize that what’s appropriate is also influenced by the nature of the relationship that you have with the person.)

One of the people was a woman who is a very good friend. She is NOT someone I have known long, but she IS someone with whom I connected with immediately. I respect her, her knowledge of addiction, drug use, harm reduction and, most of all, her judgment. Part of the reason she is good at her work is that she reads people well; therefore she probably sensed I trusted her, making it easier to say difficult things. When we ran into each other in the lobby, she flat out stated that I looked like shit. I laughed and nodded my head in agreement. Saying something like this often falls upon more open ears if you use a caring and gentle tone of voice. We ended up having dinner and talking quite a bit about what was going on.

Another colleague and friend (who I didn’t know well but to whom I have gotten closer since) ran into me outside the elevators. She expressed her concern by just saying that she was worried about me, and that she wanted me to know that I meant a lot to her, and that she would like to extend herself for support.

The two others who spoke to me directly waited until after the conference. One emailed to say how he felt when he saw me in Miami. He said that he was worried, but that he had felt awkward and wasn’t sure how or what to say. He also just expressed a desire to offer support in any way I saw or felt fit.

And finally, the fourth person called on the telephone. He simply asked if I was happy. When I told him that no, I wasn’t, he matter-of-factly offered a variety of ways to support me as well.

All of these individuals chose to approach me directly. They did this in various ways, usually depending upon how well we knew each other. The combination of their honesty, caring attitudes and personal approach meant a lot to me. They can serve as examples for others in this situation, each appropriate in their own level of familiarity with me.

So...in short, what I am suggesting is that we look at our efforts in communicating effectively with each other, and that we choose to do so in as DIRECT and caring of a manner as possible. I am asking that we search within ourselves to try to find the words and the skill to take on the emotional challenges inherent in communicating effectively, whether it is with the choir, and emotionally risky but intellectually safe, or with the Bill Bennetts of the world, and intellectually risky but emotionally safe.

Memorial Day weekend 2001, I watched Andy Rooney (of 60 Minutes fame) speak about the people that he knew and lost in WWII. I realized that I personally don’t know a single person that has died in an official war. No one I know even fought in the Gulf War, nor in other recent U.S. military involvements in Haiti or Central America. My Dad just missed WWII, and I am too young to have had friends die in Vietnam or Korea. I have, on the other hand, lost many, many friends to AIDS, HCV, overdose and the other consequences of our current political climate and the War on Drugs. It really drove home the fact that we are in a civil war here, and that we have to move wisely, efficiently and strategically if we ever expect to advance. Effective communication within our own movement has to be a part of it.

Pam Lynch has been working with HIV/AIDS for ten years, specializing in disease prevention with the injection drug using population. She is multi-lingual and is responsible for having started two syringe exchange programs in the state of Michigan.
ON THE GROUND

A TALE OF THREE CITIES...

These are the best of times...some people just don't get it!

A long time ago Dan Bigg answered the question, you know the one we've all asked ourselves if there's still enough scar tissue left functioning as a heart. I had asked: "Should we be doing this?" Dan's answer: "It saves lives!" Never hesitated after that...

"I'd rather beg forgiveness than ask permission."—Mae West

Jackie Moore would get angry when I’d say fuck it, fuck the providers...she’d call me a dirty motherfucker! She’d ask: "You forgot, they’ve tried everything, but no one’s tried loving junkies yet...that’s the only thing they haven’t tried and it’s the only thing that might work. And who do you think you are? You love this, you can’t walk away!" She’d laugh that little insane laugh, it rings in the streets...she could tell people what to do, not only would users do it, they’d adhere. She don’t judge, "if you do this, we’ll do that." We need to be telling people what they can do, not what can’t be done....!

Kalamazoo: September of 2000, Community AIDS Resource and Education Services of Southwest Michigan [CARES]. Cyril C. Colonius, Executive Director, of the second highest funded agency in the state of Michigan, said to me: "You are no longer an outreach worker...in your mind now you’re a needle exchange coordinator, that’s what you should be!..." Kalamazoo, Battle Creek were on their way to accepting harm reduction with a syringe distribution component.

Eventually I wanted to make a change, so I moved to New England and went to work for a local health department’s HIV/AIDS Office. BIG MISTAKE! I learned that bureaucracies should not run something as fragile and controversial as harm reduction services. Health departments are driven by current drug policy paradigms, entrenched in white, paternalistic, social worker ideas and methods. I fucked up! Health departments help many pregnant people, compliant females and children and men who show up with symptomatic STDs. Bureaucracies use caution when working with anyone controversial, like sick people. Health departments extrapolate that idea to its logical extreme.

Health departments that cater to the values of the white middle class treat the HIV epidemic as a matter of pity, not empowerment. "Those poor users, let’s save their lives!" Users lives were never theirs to give or take! White run health departments, along with the highly funded white male-run AIDS agencies, should close their doors, redirect their funding to minority-based community service agencies and hang their heads in shame! Whenever one of these misguided do-gooders come within ten feet of a user, they inquire about substance abuse treatment readiness: "ARE YOU READY FOR TREATMENT YET?" (Most health departments really believe that abstinence-goaled drug treatment is effective.)

Did you know that Connecticut boasts the fourth highest HIV infection rate (15 per 100,000) in the country? And one of the smallest populations, three million people—most of whom are middle class? There are 3 million people inside the Boulevard in Detroit and between the Loop and 63rd and Halsted in Chicago—most of whom are poor. And the infection rates are lower, too—12.5 and 12.6, respectively. Health Departments run needle exchange services in Connecticut. Is there any wonder?

April 2, 2001-Casa Segura, Oakland. Chris, Sno, Benji, Street-wise, Puerto Rican, Gloryanna, Courtney, Cindy, Donna, a core group outreach staff, potential the best in the world. I drive from the East Coast to Oakland in less than 72 hours. By the time I climb down from Reno across the Sierras and the Cali border, I can feel every one of the body parts that have been touching this vehicle. My hands, my right toe, my ass—all imagine pain and fatigue. Sno meets me on the street.

April 3rd, I meet staff and set up my first site-based needle exchange at 6:00 pm in the Fruitvale District of Oakland. One hundred people show up, an estimated thirty thousand are shooting dope in Alameda County. My work is cut out: reach those in the Deep East Oakland ghetto. Practically zero services, abstinence-goaled providers, no medical detox, a narrow view of client driven approaches, burned out buildings and singed dreams. As Jackie would put it: "Love’s the answer!" Dazed, I approach the problem with the assistance of those intimate with the lunacy of the current drug policy. These workers are willing to collaborate (I dislike words like collaborate and network) with providers.
A week later Sno and I are talking to one of the Imam at a Muslim temple in the Deep East Oakland ghetto. She says: “Harm Reduction Services.” I say: “Needle Exchange.” He says: “Huh?” I say: “This is the hook to get people into services.” Allah has enlightened this one, he says: “I see, OK, we can support that! Will you (Sno and me) be doing it?” Short con works!

No straight-as-in-I-don’t-touch-the-stuff white people micro-managing shit they don’t understand, just the curb and the asphalt, and users!

In California, health departments declare a state of HIV/HCV and “substance abuse” emergency. (When is public health going to get it? Drug use is profoundly normal.) Needle exchange services will be allowed, but the paraphernalia laws are firmly in place. So users are practicing harm reduction by ditching syringes when they encounter the Oakland patrol units…and the blacks and whites are everywhere. They even have mini-stations in Walgreen’s strip malls. But they can’t catch the people who set the fire at Casa Segura! Off the hook! They hate Bengi! The police are busy sweeping the homeless along the Southern Pacific tracks (quality of life laws, gentrification), and harassing users. Southern Pacific Railroad put up barriers to the exits and entrances of Casa Segura. The Gestapo harass and arrest the undocumented, mostly El Salvadoran, and users.

The mix knows no race or class; Lexus and Mercedes mix with the homeless at the 8th and Pine Exchange Site. The .com kids with the minority homeless. Look at California.

Casa Segura, one of the few voices in Oakland for harm reduction policy and health services for users: eloquent, and after years of advocacy, brutalized by rooms full of politics and indifference to the human condition—and felony arson of Casa’s building on New Years Night, 2001. Senobia Ellis, Program Director, doggedly standing in defense of users and providing services in the adversarial environment of the Fruitvale. I observe and marvel at the resilience of the people struggling to reduce the impact of the drug war horror on user lives. And you know I love the users…

May 30, 2001: It’s one hundred degrees at 85th and International Boulevard. The players stand around dazed after the Memorial Day Law Enforcement sweeps. I ask: “Where’s the regulars?” The people look at me like, “Where you been?” Tomorrow it will be record heat.

George W. was here in Cali today and he said we need to protect the environment. A black man was killed in the Hayward BART Station because a BART cop woke him up. The sleeper took his baton, and the cop shot him in the chest. The beat goes on.

Back East, in Bridgeport, Connecticut the ACLU won a federal ruling in courts that a user could carry up to thirty (30) new or used syringes and could not be harassed, arrested or detained for paraphernalia. Might work if you have the resources to hire a lawyer to defend you. Funny, when on some streets some people could be arrested for being there. Charge: WWB, Walking While Black. The problem in Bridgeport is it costs $99 for some people to be on the street, the cost for trespassing or loitering. No one’s thought about that…except Cameo and me.

This is the reality, here, on the ground!

Illustration by Sun Jensen

Health Departments are driven by current drug policy paradigms, entrenched in white, paternalistic, social worker ideas and methods.

Delaney Ellison has been a front line worker in harm reduction for the past nine years in the Midwest and East and West Coasts.
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.

**Sobredosis Prevención y Supervivencia** Este folleto ofrece información importante de lo que es una sobredosis y cómo evitarla, y los pasos a tomar que pueden salvarle la vida a una persona en esta situación.

**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 A, B y C.

**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 $1.50 per copy. Shipping charges: For orders in the Continental US: up to 200 brochures or 10 manuals, add $4.00. For 201-1000 brochures, or 1-50 manuals, add $6.50. ALL OTHER SHIPPING: Please Call HRC @ 212 213 6376, ext. 12 for prices. PLEASE NOTE: WE WILL NOT FILL ANY ORDER UNTIL THE SHIPPING COST IS CORRECTLY CALCULATED!! For agencies placing large orders (over 1000 brochures, or 50 manuals), you will have to call us for shipping costs. PURCHASE ORDERS: Any agency using a purchase order must call us (212 213 6376, ext. 12) for shipping rates prior to submitting the P.O. **All prices subject to change. Please check our website (www.harmreduction.org) for current prices!**

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**Send orders to:** Brochures, Harm Reduction Coalition, 22 West 27th St., 5th fl., NY, NY 10001
BEYOND CONDOMS: REducing risk during sex without Condoms

by Anna Forbes, Illustrations by Michael Winikoff

SOMEWHERE today a woman is exchanging unprotected sex for a rock of crack cocaine.

SOMEWHERE a woman is doing it because she’s afraid her man will walk out on her if she doesn’t—and take his paycheck with him.

SOMEWHERE a man is barebacking because he thinks real men don’t use condoms.

SOMEWHERE a woman wants to use a condom but is afraid to tell her husband that she knows he’s cheating.

SOMEWHERE a young man is having unprotected sex today to get the money to buy food or because his boyfriend insists.

SOMEWHERE in the world a woman will get HIV when she exchanges sex for being allowed to draw water from the village well.

CHEMICAL CONDOMS

What if you could go into the drug store right now and buy an over-the-counter product—a gel, a lube, a suppository—that would help protect you from getting infected with HIV or an STD during sex? What if it were inexpensive, didn’t cause irritation and, best of all, your partner didn’t have to know that you were using it?

What if some formulations of this product were for vaginal use and some were packaged as “Super Lubes” that you could insert rectally for protection during anal intercourse? What if it came in both contraceptive and non-contraceptive forms so a woman could use it to protect herself from pregnancy, or choose to block infection but not conception? Best of all, what if it worked not only HIV risk but also transmission of other STDs including gonorrhea, Herpes Simplex Virus (HSV), chlamydia and syphilis.

These products are called microbicides. Although the word just means “germ killer,” it is now used to mean substances specifically designed to be used vaginally or rectally to prevent sexually transmitted infections (STIs), including HIV. This new approach to disease prevention could provide both a back-up for condom users and a viable alternative for those who can’t or don’t use condoms.

The bad news is that microbicides aren’t on the market yet. The good news is that the first microbicides could start showing up on drug store shelves within the next five years. Over 50 new potential microbicides have been identified and four of them are expected to go into large (Phase III) human trials in the coming year. How soon we get access to them depends on us.

Many people first heard of microbicides in connection with news reports about Nonoxynol-9 (N-9), the active ingredient in most over-the-counter birth control products and some sexual lubricants. N-9 kills HIV in a test tube but recent data has shown that it can also irritate both rectal and vaginal tissues—thus possibly making it easier for HIV to get into the blood stream of the receptive sex partner. The CDC is now recommending against the use of N-9 products for disease prevention. Even condoms lubricated with N-9 may be slightly riskier to use than plain lubricated condoms, according to the CDC.

Unfortunately, this news about N-9 led some people to think that developing a safe, effective microbicide is impossible. Not true! The N-9 research data don’t say microbicides can’t happen. They only tell us that N-9 isn’t the one we’re looking for. Researchers are now exploring dozens of other potential compounds that don’t contain N-9. The goal of the researchers developing these products is to make them just as I described: safe, effective against HIV without a condom, unobtrusive so they can be used without the partner’s knowledge if necessary, inexpensive, etc.

Many interesting approaches to this challenge are being tried (see sidebar for a complete list). At Laval University in Quebec, researchers have developed something called the “invisible condom,” a gel that goes in as a thick liquid, spreads out and coats the vaginal or rectal walls and then thickens up to form...
What if you that you could go into the drug store right now and buy an over-the-counter product—a gel, a lube, a suppository—that would help protect you from getting infected with HIV... during sex?

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a protective barrier. This coating is designed to prevent HIV and other pathogens that may enter during sex from being able to attach to the cell walls. If HIV can’t attach, it can’t infect. After a few hours, the gel reverses itself, turns liquid again and is discharged by the body. It’s a brilliant concept. Does it really work? We don’t know yet because the “invisible condom” is only just entering human trials this year. But in the lab, it has shown possible efficacy against both HIV and HSV.

Scientists at Johns Hopkins University in Baltimore, Maryland, have developed a product called Buffer Gel™ that works simply by maintaining the vagina’s acidic environment, even after ejaculation. They based this on the observation that an acidic environment can kill up to 90% of the HIV it receives within 6-10 minutes.

These are just two quick examples of the inventive strategies being pursued. The challenge is to develop products that are gentle enough not to harm the vagina or rectum but strong enough to kill HIV, both in semen and vaginal secretions. Some microbicides may be bi-directional; giving HIV+ people a way to reduce their partner’s risk—by disabling virus in their vaginal secretions or rectal cavity before it can infect the partner—as well as a way of protecting themselves from possible reinfection.

THE PUBLIC CAMPAIGN FOR MICROBICIDE ACCESS

The great African-American abolitionist, Frederick Douglass, wrote that “Power concedes nothing without a demand. It never did and it never will.” We have not yet expressed a loud, emphatic, public demand for microbicides. But we need to start doing that now. Here’s why.

As things now stand, good, potentially effective microbicides are sitting on laboratory shelves—not going anywhere because the researchers who developed them simply can’t afford to test them. There isn’t enough money available right now to efficiently get promising products through the research pipeline and onto the drug store shelves.

In fiscal year (FY) 2001, the U.S. National Institutes of Health invested only $47 million in microbicide R&D—less than 2% of the Institute’s AIDS-related research budget. Two percent: that’s ten times less than the U.S. is spending on AIDS vaccine research. This is despite the fact that no effective AIDS vaccine is expected to become available for at least 10 years, while a microbicide could be on the market within half that time. This $47 million budget presents a big problem because microbicide research is inevitably expensive to conduct. The Alliance for Microbicide Development estimates that it costs at least $20 million to get a single potential product from discovery through safety trials and another $20-30 million to get it through the necessary trials on effectiveness. But the money to do those trials simply isn’t available. We have a log jam: product leads are stalled because developers can’t afford to move them to the next phase of research. (Advocates are calling for a doubling of the current US government investment from just under $62 million in FY 2001 (including NIH, CDC, and USAID) to $124 million in FY 2003.)

The lack of public money, of course, wouldn’t be a problem if these products were being developed by the big pharmaceutical companies. Big Pharma is clearly the largest source of dollars and supplies most of the $56 billion that the World Health Organization estimates is spent per year on health research. The Global Campaign for Microbicides estimates that it would take just $75-$100 million per year for the next five years to assure that microbicides reach the market as rapidly as possible. To Big Pharma, that amount is pocket change.

Big Pharma’s lack of investment in microbicides is generally attributed to two factors: concerns about possible liability and doubts about how profitable such products would actually be. They are waiting for products to emerge that have proven effectiveness and that could be profitable enough in developed countries to offset the fact that they will have to be provided to the developing world at prices that yield little, if any, profit. Currently, microbicide research and development (R&D) is being done almost exclusively by non-profit entities, academic researchers and small bio-pharmaceutical companies, all of which depend on government and foundation grants to pursue their research.

The Alliance for Microbicide Development is addressing these concerns and trying to cultivate Big Pharma’s interest in microbi-
Good, potentially effective microbicides are sitting on laboratory shelves—not going anywhere because the researchers who developed them simply can’t afford to test them.

In the US, we are organizing grassroots Campaign sites in 10 key legislative districts. The Microbicides Development Act of 2001—legislation that would boost the federal budget for microbicide R&D enough to assure that testing moves forward without delays—was introduced last year by Representatives Connie Morella (Rep-MD) and Nancy Pelosi (Dem-CA) in the House as House Resolution 2405, or HR 2405. Senator Jon Corzine (Dem-NJ) and Senator Olympia Snowe (Rep-ME) introduced similar legislation in the Senate as Senate Bill 1752, or S 1752. (Versions of this legislation have been introduced in the last three terms and, each time, have failed due to lack of bi-partisan support.) The Global Campaign is working hard to get this law passed by generating grassroots support for it across the country. To find out how you can get involved in demanding microbicides, contact the Global Campaign for Microbicides.

In the US, the Global Campaign is working hard to get the Microbicides Development Act of 2001 (HR 2405 and S 1752) a passed by generating grassroots support for it across the country. To find out how you can get involved in demanding microbicides, contact the Global Campaign for Microbicides:

- in Washington at Planned Parenthood of Western Washington, 206-328-7733
- in Northern California at Microbicides as an Alternative Solution (MAS), 510-642-0105
- in Southern California at the California Family Health Council, 213-386-5614
- in Illinois at the AIDS Foundation of Chicago, 312-922-2322 (ask for Grisel Robles)
- in Connecticut at the HIV Action Initiative, 860-280-2493
- in New York at the Harm Reduction Coalition, 212-213-6376 (ask for Donald Grove)
- in Pennsylvania at the Health Federation of Philadelphia, call Kerri Barthel at 215-787-9620
- in Iowa at Planned Parenthood Quad Cities, 319-449-1000 (ask for Libbett Brooke)
- in Canada at the Canadian AIDS Society, 613-230-3580, ext. 116
- or in Washington DC at the Global Campaign’s main office, 202-454-5048

Microbicide advocates are active elsewhere, too. To find the Global Campaign folks nearest you, call the Washington, D.C. number above or drop us a line on our web site at www.global-campaign.org.

A WORLDWIDE NEED
I want to close with some thoughts about why it is important for all of us, even given the huge number of critically important other things we are doing, to lend our voices to demanding access to safe, effective microbicides.

Although this legislation is in the U.S. Congress, we know it’s not just about us. Microbicides are even more urgently needed in developing countries, where insisting on condoms is a cultural impossibility for the majority of women, and AIDS is causing truly massive devastation. How can we possibly respond to the fact that in some parts of the world 30-40% of the women are now HIV-infected? How can we even begin to respond to the massive injustice of the Global Health Gap: the fact that only 10% of that $56 billion spent globally on health research and development goes to address the primary health problems faced by 90% of the world’s people while, conversely, 92% of the resources spent globally on HIV prevention, research and care go to benefit only 8% of the world’s people living with HIV?

These inequities seem overwhelming. Yet, North Americans can play an instrumental role in getting state of the art prevention tools into the hands of a world that needs them. While we fight for worldwide access to state of the art HIV treatment, we must also demand state of the art prevention. We can demand that the pittance in additional research funding it will take to get microbicides on the market be supplied by our governments. We can play an instrumental role in getting state of the art prevention technology into the hands of people who need them worldwide. We may not be able to afford state of the art treatment for the millions already infected, but we sure as hell can afford state of the art prevention. We have the technology; now we just need the political will and the money that follows it.

The Jewish sage Hillel said, “If I am not for myself, then who is for me? If I am for myself only, then what am I? And if not now, then when?” We need to do it for ourselves. We need to do it for our sisters and brothers and sons and daughters around the world. We need to do it—20 years into the AIDS pandemic—in the name of simple justice. If not now, then when?

Anna Forbes is community organizer, teacher and writer specializing in HIV/AIDS risk reduction issues. She has published widely on microbicide advocacy and serves as US Field Organizer for the Global Campaign for Microbicides. Contact: aforbes@critpath.org.
Products in the Pipeline

There are eleven products with various targets and mechanisms of action currently in clinical trials, both in the US and globally. However, no single product, even if clinically successful, will be a “silver bullet microbicide.” It is crucial that products with different mechanisms of action be tested simultaneously, to increase the probability and speed of finding a successful microbicide.

- Carraguard™ is made from carrageenan, an inexpensive substance derived from seaweed that is widely used as an additive to foods and cosmetics (for example, to thicken ice cream). Carraguard™ is a fusion inhibitor. Based on laboratory work, Carraguard™ is assumed to be non-contraceptive.

- BufferGel™ keeps the vagina acidic even during intercourse and creates a physical barrier that inhibits the passage of pathogens into the vaginal and cervical epithelium. Acidform™ is also an acid buffering agent.

- Pro-2000 contains a synthetic polymer that binds to the HIV virus, thereby disrupting binding of the virus to target cells. The gel probably works in a similar fashion to block chlamydia and HSV-2 (herpes) infections. Other “fusion inhibitors” include Emmelle™, cellulose sulfate and polystyrene sulfonate.

- Lactin Vaginal Capsules re-colonize the vagina with Lactobacillus (LB). LB helps keep the vagina free from infection by producing hydrogen-peroxide, a substance that is highly acidic. When the ecology of the vagina is somehow disrupted—through infection, douching or poor hygiene—the LB bacteria can die off, leading to a condition known as bacterial vaginosis (BV). BV has been linked to increased risk of HIV infection.

- Savvy™ is a surfactant that disrupts the outer surface of pathogens. Other such products being explored as potential microbicides include sodium dodecyl sulfate (common in shampoos and toothpastes) and benzalkonium chloride (a substance frequently used in contact lens solution to prevent the growth of bacteria). The surfactant Nonoxynol-9, the active ingredient in most over-the-counter spermicides, was once explored as a possible microbicide but has recently been shown to be ineffective.

- Invisible condom is a non-toxic polymer-based gel that that serves as a barrier against viruses and bacteria.

- PMPA Gel works in the same way as some of the anti-retroviral drugs currently used for therapy: it interrupts the replication of the virus once it enters cells. The hope is that PMPA could be absorbed by cells in the vaginal epithelium and then stop the virus once it enters the outer cells of the vaginal wall. Many anti-retroviral drugs that were initially explored as potential AIDS therapies were later abandoned because they could not be absorbed easily into the bloodstream; these same compounds might be perfect candidates for a microbicide because they could be applied topically and not absorbed systemically.
It has been exactly eighteen months since an arson fire destroyed the building that housed Casa Segura/The Safe House, the harm reduction drop-in program that was the heart of the HIV Education and Prevention Program of Alameda County (HEPPAC) and the Alameda County Exchange (ACE), Oakland’s needle exchange program. It was also home to the Holistic Education and Access for Long-Term Health (HEALTH) project, which has been the source of the material readers have seen in the Witches Brew column for the past several years.

The HEALTH Project began back in 1997 as a small, volunteer and donation-only clinic that was located in Casa’s administrative offices, depending on borrowed desks and the generous cooperation of the staff. In April 2000, Casa Segura moved into a new space, and we herbalists, nutritionists and bodyworkers who staffed the HEALTH Project found ourselves in a ground-floor, wood paneled room with space, light and beautiful lovingly-restored furniture contributed by an herb clinic client. We had a full dispensary stocked with hundreds of herbs and supplements. We brought in art, antiques, and altar items. Some people from outside the program warned us against displaying valuable personal items and art objects in the center, but not one of those things ever disappeared from that space. Of course, we never imagined that arson would destroy our center and the things we brought in to beautify it for everyone who visited and worked there.

HEPPAC’s program participants felt welcome and respected. Herb clinic clients and staff used the HEALTH Project office as a peaceful refuge. Practitioners were able to spend time with each person who came in, do an evaluation and make individual formulations and recommendations to suit each client’s constitution and emotional/spiritual/physical condition. Community members came in for services, and clients brought family and friends for the services we provided, free of charge, to all who requested them. We had hours during needle exchange and also apart from the exchange. Herb clients came into the drop-in center and then into the herb office to access services. We generally saw 3-6 clients during our 2-hour shifts.

Although most herb clients left the office with custom-made formulas, just as they would if they’d visited an herbalist in private practice, HEALTH Project herbalists also made up some herbal teas and other formulas that became popular with the clientele.

One of the first teas we made, in response to client demand, was a tea for better sleep:

**SHUT-EYE TEA**

Used for insomnia, restlessness, and sleep deprivation that accompanies withdrawal or (recently) short-term methadone detox programs. This tea, and a similar tincture formula, have been among our most popular herbal remedies over the years (ED: See footnote 2 for instructions for making this tea.)

3 parts passionflower herb
2 parts skullcap herb
2 parts linden flower
1 part hops

After the fire, we temporarily suspended herb clinic. We never missed a day of needle exchange or wound care clinic, and within three weeks we began providing herbs, nutritional counseling and acupuncture offsite, in a borrowed private office in a medical building four blocks from Casa Segura. Few herb clients showed up for this service, even after we began to spread the word. The most marginalized program participants have well-justified fears of medical offices and space that hasn’t proved itself to be safe for them, so in general, only those herb clients who were in recovery or who felt at ease in “straight” surroundings came to see us in the alternate setting.

One evening at needle exchange, the herbalists brought some formulas to be used at the wound clinic. Exchange participants became aware that we had herbs in the trunk of the car and surrounded us, asking for herbs, vitamins and the healing skin salve we distribute.

**WOUND-HEAL TEA**

Speeds healing, improves circulation, reduces swelling.

3 parts gotu kola herb
2 parts cleavers herb
2 parts calendula flower
1 part yarrow leaf and flower
1 part gingko leaf
1 part horsetail

The following week we set up a three-sided tent in full view of the exchange, and we saw more clients that night than we ever had during the same time period indoors. Exchange participants felt that they could just walk over to check us out, and try the herb teas and healthy snacks we serve onsite. They could check us out before deciding to use our services. In most cases, they did stay for services and they came back again and again. We found that even asking folks to walk through a door could constitute barriers to accessing service. In the seventeen post-fire months that we provided service in parking lots and street corners we have seen many more herb clients than we did when we had a lovely office and full-service dispensary.

The nature of our services changed dramatically; we now have less time with each client, and we cannot do as much healing with each individual. We continue to offer herbal support using Donna’s formulas, as well as adding some Chinese herbal formulas to the mix. We have few individual herbs onsite, and we distribute herbs in formulas that we mix up offsite. These formulas change

by Donna Odierna
with the seasons, to address program changes and as we learn more from clients just what they need and want. We now also offer acupuncture as part of our wellness services. (Because we are space-limited, we are doing only chair acupuncture, utilizing mostly ear, face and hand acupuncture points to help relax clients and support their bodies, helping with any number of complaints, ie. detox support, insomnia, arthritis, stress, etc.) It is clear that we could use a permanent drop-in center.

Casa’s search for that site has been, and continues to be, ongoing. In January 2002 we purchased a building, and were about to close on it when the City Council stepped in and blocked the deal through some creative political maneuvers. Since then Casa has been negotiating with the City to find a solution. It does look hopeful that we will find something soon, however. We look forward to having a center where we can spend a little more time with each client, conducting indoor classes while further individualizing the care, and adding other much needed wellness services such as chiropRACTics and massage.

Even after we get access to a building for our drop-in center, we will continue to provide outdoor holistic health services at our needle exchange sites, because many of the people we see onsite don’t come to the center for services. Over the past 18 months, we’ve learned a lot about running a mobile herb clinic, and about how to tailor our services to the folks who come over to see us at the different exchange sites, each located in different parts of town and fulfilling different needs.

We have several tea mixes that we serve in the herb tent, and they are popular at all of our exchange sites. In hot weather, we serve them iced. Here are two:

**ENERGY TEA (makes 1 1/2 gallons)**

2 oz. nettle leaf
1 oz. lemon verbena leaf
1 oz. gotu kola herb
1 oz. Siberian ginseng root
½ oz. peppermint leaf, or more, to taste
½ oz. gingo leaf
1 12 oz. can frozen apple juice concentrate, preferably organic

Bring 1 ½ gallons of water to a simmer in a large, non-reactive pot. Turn off the heat, add the herbs, stir and cover. Let steep for at least 2 hours. Strain, add apple juice concentrate and water to bring level back to 1 ½ gallons (some will have been lost in cooking and straining). Let cool to room temperature or cooler, pour over ice and serve.

**SPICYHOT BURDOCK CHAI FOR LIVER AND IMMUNE SUPPORT**

We took a chance with this one, but people love it—it’s become the most popular beverage we serve at the outdoor clinic. Makes 1 ½ gallons. Serve hot or iced.

2 oz. burdock root
½ oz. dandelion root
½ oz. pau d'arco bark
½ oz. sinberian ginseng root
½ oz. dried ginger root, or 1-2 oz. thinly-sliced fresh ginger
½ oz. mixed spices: Cinnamon, star anise, cardamom, black peppercorns, all-spice, cloves, vanilla bean, etc. (We use mostly cinnamon in our mix)
2-3 quarts vanilla soymilk
Honey or raw sugar to taste

Place herbs and spices in a non-reactive pan with a gallon of cold water. Heat over a medium flame until the mixture just barely simmers. Lower heat, cook for 10 minutes, remove from flame. Cover and steep at least 4 hours. Strain, add sweetener, and soymilk to return total volume to 1 ½ gallons.

Donna Odierina is a herbalist, nutritionist and health educator. She no longer works at Casa, and currently balances her time between private practice in Oakland and the Public Health doctoral program at UC, Berkeley.

1 At Casa Segura, we refer to the people whom we serve as “participants,” acknowledging their active role in our program and in their own health. Herbalists in private practice refer to their customers as “clients,” and in this article the folks who come in to the holistic health clinic are referred to as clients as well.
2 All teas: Instructions make any quantity of dried tea mix. For personal use, 1 part might equal ½ ounce at each dry herb (so 3 parts = 1 ½ oz, 2 parts = 1 oz, etc.). To make a big batch for a clinic, 1 part might equal 4-8 ounces of dried herb. Tea may be brewed in cup-sized amounts or in larger quantities.
To make one cup: Place about a tablespoon of herbs in a mug or use a teaball, cover with boiling water, steep 1-5 minutes, strain and drink.
To make one quart: Place one ounce of herb mix into a quart jar. Fill the jar with boiling water, cover jar and let steep at least ½ hour or (better) 4 hours to overnight. Strain, and drink throughout the day. Good iced or hot.
To make a gallon, use 4 ounces of herb mix to a gallon of water.
3 We get our salve, Skin Salvation, from Matthew Perisco at Mother Tinctures, who supports harm reduction programs and sells his high-quality products to us at deep discount rates. He may be reached at www.mothertinctures.com or at 800-742-0848. Programs can also make their own salves; instructions will appear in a future article about herbal/nutritional support for treating wounds, abscesses, and skin problems. (ED: See “Witches Brew” in the Fall 1997 issue for Sara Kershnar’s recipe for a similar product, Junkie Cream.)
4 Readers who attended Casa Segura’s Fire Carnival and fundraiser on June 23, 2001, got to try our special “Damiana Hot-to-Trot Cha-Cha-Chai.” Ooh-la-la! Secret recipe only available at Casa fund raising events, so next time, c’m on down.
Taking Drug Users SERIOUSLY

1. Modality of working with individuals and communities to minimize adverse consequences of drug use. e.g. Overdose prevention, syringe access, healthcare especially for HIV, hepatitis and mental health needs, drug law reform including prison reform, housing, and drug treatment options. 2. A movement for social justice.

Keynote Speaker
Former US Surgeon General
Dr. Joycelyn Elders