Sometimes life knocks you down. You just gotta get back up.
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The biggest barrier to HIV prevention for women in the AIDS epidemic is the absence of alternatives to the male condom. Yes, there is a female condom, but it’s not widely used. It fares no worse than the male condom, which isn’t used nearly as much as you would think, given the nearly two decades of condom jokes, condom posters, free condoms, condoms, bilingual condom messages and more. The virus is spreading, but no one challenges the absolute authority of the condom. We dispense a harsh social stigma to non-condom users, and we do not consider alternative.

Many women have no choice at all whether their partner puts on a condom. In the public dialog on AIDS prevention, these women are portrayed as victims. But the victimization is paradoxical, because they are also portrayed as unformed, as though the only reason they are a victim of male power is that they lack will-power. “If only they stood up for themselves, they wouldn’t have HIV.” The absolute power of the condom—the unused condom, the absent or unavailable condom—is not questioned. The woman, on the other hand, is stigmatized. They are branded victims, with the added stigma that they let themselves be victimized.

Yet another group of women do not see a condom as something appropriate to their sexual relations. Some women find a condom completely outside the realm of erotic appeal. Some may place high value on conception, include child rearing, money, division of labor, etc. Again, the absolute power of the condom—the desirable-but-unused condom, the commodified condom—is not questioned. The woman, on the other hand, is stigmatized. These women are branded as making foolish choices, as “not really understanding.” “You just don’t get it, do you?”

Yet another group of women do not see a condom as something appropriate to their sexual relations. Some women find a condom completely outside the realm of erotic appeal. Some may place high value on conception, include child rearing, money, division of labor, etc. Again, the absolute power of the condom—the interfering condom, the rejected condom, the unsexy condom, the meaningless condom—is not questioned. The woman, on the other hand, is stigmatized. These women are branded as willful. The ones who desire sex without a condom are sluts.

So we have women who are victims, who set themselves up to be victims, who make foolish choices, who just don’t understand, who are wilful, and who are sluts. There’s the explanation for the epidemic right there! (The same goes for MSMs and injectors.) The sacred pairing of condoms and abstinence is now bolstered by a third concept: according to the most recent prevention paradigms touted by public health institutions, preventing high-risk sexual activity is a all a matter of improving self-esteem. Undeniably, self esteem is a vital survival issue for many women, but there is no discussion from the Trinity of condom/abstinence/self esteem to address they ways in which women—especially women of color—are systematically devalued in the economy and by the dominant culture.

Which brings us to one more significant fact about women at high risk for HIV. They are almost always poor. The economic demographics of global AIDS are obvious, but the condom rules, absolute, serene, unquestioned. A cultural system of stigma and oppression of poor women on issues of HIV prevention is very convenient to a society where the only tool for sexual HIV prevention requires male consent and participation. (For many poor women, tools to anything require male consent and participation.)

“Use a condom.” This message is applied across the board to everyone, as though everyone has an equal degree of control in the dynamics of condom use.

In 2002, there is no reason why the condom should be the only barrier to HIV infection. In fact, there are several other tools, generally referred to as microbicides, which could be used even when a condom isn’t used. Some are topical gels that would block the virus by coating the vaginal or rectal wall. Some are materials that would enhance natural vaginal defenses, such as preserving vaginal pH. Some are straightforward anti-virals applied topically. None are available.

Safety and efficacy testing are underway for a handful, but significant funding is not available. The future purveyors, pharmaceutical companies, would rather buy the patents (or steal them) after someone else spent the research and development dollars.

It’s a matter of choice. A vaccine is the wished-for silver bullet of HIV prevention. But we don’t have it yet. In the meantime, we portray women at risk as lacking the moral fiber needed to stop the epidemic, so prevention is not worth our time. To the American public, AIDS is a crisis of morality that can only be ended with miraculous cures. Massive infection rates among women are a necessary backdrop to the heroic efforts of bio-tech companies seeking the silver bullet. The idea that women could actually have control over methods of prevention is a distraction, a side issue, an I-feel-your-pain issue, but not something that needs any real action or attention. At worst these women are wilful sluts who just don’t understand. At their best, they are helpless victims of a third world apocalypse, most easily understood in 90 second news segments between tuneful advertisements for life insurance and extra-strength aspirin.

Needless to say, many people disagree, and are fighting for funding, testing and availability of microbicides. There is a growing demand for microbicides, particularly from public health arenas of Africa, Asia and South America. I had the good fortune to attend an AIDS conference in Thailand last year, and everyone (largely from India, China and Southeast Asia) knew about microbicides. In the US, the term microbicides is virtually unknown. The need is here, but the dollars for testing and research are not. Bills exist both in the house and senate to increase funding for microbicides research and public awareness. Women-controlled HIV prevention tools are slowly becoming a reality, and the sooner we speak up about it, the sooner we can get them.

Senator Clinton is a woman representing the State with the most AIDS cases, including the most among women. She has not signed on. Ted Kennedy, boss of the Health Committee and darling of the AIDS funding advocates, has not signed on. You know where I am taking this. Write letters. No matter what state you are in, you should also write to Hillary Clinton and Ted Kennedy. Talk about it with your friends. Go to www.microbicide.org and www.global-campaign.org. Take the tools to prevent infection out of the man’s control and put it in the hands of the women, where it will be used!
PhotoVoice New Brunswick is a program of The Chai Project, New Brunswick NJ.

PhotoVoice New Brunswick, a program of the Chai Project, has enabled habitual users of illicit substances in New Brunswick, NJ, to create a photographic, oral and written archive of themselves and their community. The project documents their areas of concern, including their individual and community health as well as drug use and drug policy.

The photographs are a means for individual reflection on the meaning of community, race, class and health. They foster dialogue through group discussion, and they provide a way to communicate with policymakers and the public on drug-related health issues.

Oral and written testimonies are included to give voice — literally — to members of a community who are often spoken for or about, but who are rarely given a platform from which they can speak for themselves.

This project was supported with a grant from the Robert Wood Johnson Foundation.

The Chai Project has a 2003 Calendar using pieces from PhotoVoice New Brunswick, available for $20.00. Proceeds from the sale of the calendar help to support Chai Project, a not-for-profit organization.

To obtain a calendar, please contact:
Jay Petillo, Executive Director
Chai Project
PO Box 1470
New Brunswick, NJ 08903

Phone: 732/247-7014 x10
Email: j.petillo@verizon.net

PhotoVoice: A hand painted mural of yesterday’s and today’s New Brunswick.
PhotoVoice

Trees give off oxygen which is necessary for people to breath and live. Though I may fear others, places and things, trees are not a threat to me. They stand tall, majestic and their roots are embedded deep within the earth. Some even show beauty when their shed leaves reappear and their flowers blossom.

Sometimes tree branches get in the way of man. Some trees get in the way of power lines and keep having branches cut off. Probably these trees will be cut down when they become too much of a nuisance. But as long as trees still stand it gives me a feeling of hope for mankind.

PhotoVoice

Now look at the building. See the paint? No paint. Ain’t been painted in a hundred years. They let it deteriorate... nobody put any money in there... The apartments are all raggedy. When you come into it and you get a unit that’s raggedy and everything, what do you think people do? They feel “Why maintain? Nobody cares so why should I take care of it?” And so it keeps it raggedy.
Harm Reduction Drug Treatment: The Time Has Come

Edith Springer, A.C.S.W.

I write this article as an opinion piece. It is not a scholarly article, and I have done no research. Very few statistics will be provided. It is about my own experience as a former client of drug treatment, a former and current client of psychotherapy, and as a social worker who has struggled to find ways to help people with drug/alcohol and other problems of a similar nature. These are my feelings and beliefs about drug treatment in the era of HIV, based on my personal experiences. This article may not reflect other people’s experiences at all, and such is the beauty of life. I don’t intend to offend anyone’s sensibilities, nor negate another person’s potentially positive experiences where they were negative for me. I know that some people will personalize my remarks as an attack on their belief systems. I can only offer my views for what they are worth.

As a client/patient I have experienced multiple forms of drug treatment, all in New York City, from 1969 until the mid 1970’s; I’ve received in psychotherapy since the mid-1970’s and continue to receive it now. I have worked in four different drug treatment modalities since I became a counselor in 1979 and later a social worker in 1982. When I learned harm reduction in Western Europe in 1988, I finally began to feel somewhat competent to help people with drug problems.

The disease model
Before the HIV/AIDS pandemic, drug treatment modalities were assumed to be the state of the art. Most of them were based on a disease model of chemical dependency. According to the disease model, chemical dependency is a disease some people are born with. Substance use is not seen as a psycho-social phenomenon, and its cause is biological.

Although based on spurious and illogical theories, the disease model was seen as scientifically and morally correct, and effective with clients who were motivated. The model was sacred to those who worked in drug treatment and also to those who had conquered their drug problems through treatment. The erroneous belief was that treatments based on this model actually worked, and that they were the only way to help people.

Detox and rehab
The disease model indicated cessation of using/drinking as the only treatment, so the most prominent feature of treatment was detoxification, most commonly in a hospital or other institutional setting. The therapeutic goal was a drug-free patient, and indicating withdrawal symptoms was seen as counter-productive. People experienced full withdrawal syndrome without much symptom relief. Care was taken with “alcoholics” to avoid DTs by the use of B vitamins and sometimes Librium or other sedatives. In some cases weak and ineffective sleep medications were used. People who did not remain abstinent after detoxification were not motivated enough, weak or perhaps too morally corrupted by their disease. Many health care professionals working in detox units were themselves “in recovery” from this disease.

For those who had resources and access, “rehab” — short term (one month or so) institutional programs were the next step after detoxification. Often a client went right from the detox unit to the rehab. The rehabs used Twelve Step program philosophy as an institutional method, attempting to persuade clients to “buy into” the twelve step process. Some rehabs were kind and compassionate; others were harsh and sadistic, with every variation in-between. Even though programs published (untrue) high figures in their marketing brochures and literature, most had low success rates.

Rehab required money and was not available to everyone. Heroin use was very stigmatized and so was cocaine at first (before it became fashionable). In the early days, rehabs did not want clients whose drug use stereotyped them as “low-lifes”. Rehab was an upscale modality.

The Character Disorder Model: Therapeutic communities
For those who weren’t welcome or could not afford a rehab, Therapeutic Communities (TCs) were the next step after detoxification. TCs used a “character disorder” model, stating that a flaw in character was the cause of drug problems. Treatment meant breaking down one’s personality and adherence to drug culture, and rebuilding a new person who would be a good citizen for the right reasons. Far from being a disease model, some early TCs actually gave their graduates “drinking privileges”.

These long-term residential programs utilized milieu therapy, teaching people to clean up after themselves, make their beds, cook for the “house”, and achieve the socially acceptable structure to their lives which providers believed was missing. In addition, people had to conform to rules and obey the orders of the people above them in a rigid hierarchy. Much attention and therapeutic importance was placed on “learning experiences”, in which humiliation, exertion, toil and compliance with irrational orders would lead to a new understanding of life. The process would taught people “give

Many of us knew from our own experiences as clients and patients what a horrible failure the drug treatment system was, and how unkind it was in its treatment of people.
up guilt” which was believed to poison their souls and keep them going back to drugs and crime. Rewards and punishments showed residents the way to building the new character free from drugs.

When you look at the socio-economics of the drug war, and see who winds up in a TC, you can sum the model up this way: “Black men and women use drugs because they haven’t been shamed and yelled at enough yet”.

The dropout rate from this harsh system was approximately 80% to 90%. Few people actually graduated, but the belief was that these few people had a good chance of remaining abstinent. This turned out not to be the case when many went from “hard drug” problems to alcohol problems after treatment, and others relapsed once in the re-entry phase back to the community. The original TC, Synanon, did not have a re-entry phase. This weakness in TCs persists to this day.

**Drug Maintenance Model: Battles Over Methadone**

In the sixties came methadone maintenance, a medical intervention based on a “diabetic/insulin” theory. Drs. Dole and Nyswander believed that long-term opiate use caused a metabolic disorder that could be treated by medicating the patient with a long acting synthetic opioid that would reduce or eliminate the craving for opiates and eliminate withdrawal symptoms. A metabolic disorder was treated with chemotherapy in a medical context. The user was a patient, not a client or a customer.

Methadone programs were not the first opiate maintenance programs in the US, but they were new after 50 years of draconian laws that criminalized drug use, and they represent a significant turn of events. Maintenance is a model for working with users within the context of their use, rather than demanding abstinence. Along with the medical conditions behind the drug use, methadone providers began to see that people who came through their doors were poor, undereducated, underskilled, and often traumatized by their histories and environments. Counseling, groups and psychiatric interventions were added to the dispensing of medication.

What began as innovative and benign faced many setbacks as the result of drug war ideology. The Drug Enforcement Agency said methadone maintenance was “giving drugs to addicts”. By virtue of seeking therapeutic interventions for their illicit drug problems, patients were treated as criminal suspects requiring surveillance. Controlling and absurd regulations were promulgated which restricted program options, infantilized the patients, and replaced a therapeutic process with a system of reward and punishment. Urine toxicologies became the hallmark of progress or failure. In many programs, the regulations and attitudes meant that staff would treat people like “junkies”. Many people could not handle the level of monitoring and control, the absurdity of having to come daily or almost daily to take medication, or the attitudes of staff. Some people saw the opening of methadone programs in places like New York City as a form of social control (“keep them quiet and happy so they won’t make demands on the system”).

Advocates for strict abstinence have been successful in restricting access to methadone, and in restricting how it is delivered.
Methadone maintenance helped people to stabilize their lives and reduce their pain and personal hells. It’s benefits are documented with scientific accuracy... But this modality was and still is, to our shame, the most reviled and stigmatized form of drug treatment.

These restrictions are baseless, as the science justifying methadone is based on medical maintenance, rather than abstinence based. In some states, regulations restrict dispensing methadone in ways that negate its therapeutic basis. One such strategy is the “low dose bias” with patients deliberately undermedicated to the point where they are not maintained at all. Another strategy is to restrict the time a patient can be maintained—expecting patients to miraculously recover from their metabolic disorder after a year. In some states there is still no methadone maintenance, or access is so restricted that it is merely a token.

Methadone maintenance helped people to stabilize their lives and reduce their pain and personal hells. Its benefits are documented with scientific accuracy and as a result it has a foothold in the world of policy and public funding. But this modality was and still is, to our shame, the most reviled and stigmatized form of drug treatment. Methadone is attacked as counter to the nation’s crime-based drug policy and abstinence based treatment modalities. The drug-free modalities and disease models had control of the field, and they were terrified and furious that methadone maintenance was allowed to exist.

How All This Looked at the Time

Some of us who worked in drug treatment knew that these models not working for the majority of the people we served. Many of us knew from our own experiences as clients and patients what a horrible failure the drug treatment system was, and how unkind it was in its treatment of people.

There were many contradictions. It was especially upsetting to see that many workers who touted the disease model also showed a penchant for treating patients as though their condition was the result of a moral failure. Treatment policies were based more on criminal law enforcement than on scientific literature and therapeutic protocols. When workers pointed this out, the whole chemical dependency community came down on them with a furious and defensive response (and often still does). Treatment failure was the fault of the client/patient, and modalities with 90% failure rates did not require examination. Most of us eventually learned to keep our mouths shut or left the field.

It looked as if nothing was going to change. The Minnesota (rehab) model, the overcontrolling methadone maintenance model, and the S&M therapeutic community model were entrenched. Drug treatment as an institution adopted a paranoia about interacting with anyone outside the field. They didn’t want to share information with mental health, or social work, or child protection agencies. They didn’t want to collaborate, they couldn’t be questioned. Treatment providers even told clients that their primary care physicians were ignorant and disallowed prescriptions for “mood altering substances.” After repeatedly facing dismissal from drug treatment providers, many physicians gave up advocating for their patients with the drug treatment programs.

HIV/AIDS Causes A Revolution in Patient Advocacy

AIDS was unexpected, and as a result it exposed many flaws and inequalities in the American socio-economic system. The rampant spread of HIV among drug users forced open a community dialog on healthcare, drug treatment and housing for active users. Finally, people outside of drug treatment itself had a stake in its success. HIV people were public health oriented. They had a deadly infectious disease to deal with. In the eyes of HIV workers, issues of prevention and care shared equal priority with drug problems. Used to a new situation, they thought “outside the box.” They wanted practical, quick relief for their clients.

When drug users were hospitalized with HIV related illnesses, their drug dependencies typically were ignored. Many patients were left in full withdrawal or given insufficient doses of methadone. Many drug users were denied pain medication or under-medicated due to misinformation, judgements, and plain old meanness. Through the tremendous efforts of gay men actually living with AIDS and those who cared about them, advocacy for people with HIV/AIDS took new turns. People demanded that the health care system respond to the needs of gay men, rather than respond to the stigma of homophobia. Self-representation by people with AIDS brought enormous public attention and support to the plight of people with AIDS.

New advocacy was born in a long-standing movement for access to care in communities devastated by poverty, racism and the drug war. HIV advocates saw quickly that drug treatment was a closed system of ludicrous beliefs and “isms”; it was hardly serving anyone. People began to speak heresy. People outside (and inside) the system began to speak up, to break the law, to give out syringes illegally, and to advocate for drug using patients in the health care system. (Unfortunately even today drug users are cruelly treated in the health care system, with little improvement for anyone outside of AIDS care, and scarce improvement in AIDS care, depending where you live!)

The natural next step was to provide services in a new way—a way that later would be called harm reduction. Volunteers, many of them drug workers or people in recovery, went into shooting galleries to teach people about HIV and how to prevent it, how to find out if one had it, and how to access medical care. People from affected communities started illegal syringe exchange programs, working with their own money, out of their own homes. They began to confront drug treatment, which balked and put up moats and forts to keep things the way they were. Of course, this situation still obtains for the most part, but some breakthroughs are now apparent.

A New Way of Working with Drug Users

Harm Reduction in service delivery made great headway through two-fronts: needle exchange, and through AIDS supportive housing programs that staunchly insisted on housing active users. Harm reduction philosophies were born. Teasing out the process elements, people on the front lines began to put together harm reduction strategies for every service: case management, support groups, referrals, and later, acupuncture detoxification, counseling, and psychotherapy. Creative interventions, recreational interventions, groups of all kinds, vocational training programs, and peer interventions (outreach, counseling, etc.) were designed and implemented.
Abstinence isn’t wrong, and it is a deeply desired goal for many users, but there are changes a person can accomplish whether they stop using or not. And when a person chooses abstinence as a goal, it may still be years before she or he achieves it. The hallmark of harm reduction models is a combination of respect for the customer, non-judgmental stances, compassion, empathy, and practicality. In the new approach, abstinence from drugs is not on the agenda unless people chose that goal for themselves. Meeting people’s survival needs, their medical needs, their safety needs, their need for community and belonging, and respect for their autonomy replaced the knee jerk demand for “make them stop/punish them for using” philosophies, which prevailed even in HIV/AIDS organizations.

Finally, people working with drug users had applied clinical methods, a new theory and a new approach that could be used to critique the rigid methods of drug treatment. The need for drug treatment was not questioned, but the ideological basis for many treatment policies was challenged by practical alternatives. Turning a blind eye to a 90% treatment failure rate serves no functional purpose in AIDS services, housing drug users serves a purpose. HIV prevention through sterile syringes serves a purpose. Providing drug users with HIV medications regardless of their illicit drug use serves a purpose. HIV/AIDS workers began to realize that drug treatment programs were not the only place to treat drug problems; they could mount their own treatments outside of the traditional network of agencies.

**NEW FORMS OF TREATMENT FOR DRUG USERS**

**A Psychotherapeutic Model**

Workers sought new ways to help people which were individualized. They rejected “one size fits all” approaches, where everyone goes through the same steps to achieve the same goals. What intervention individualizes treatment plans and goals based on autonomy of the service consumer? Psychotherapy.

Some practitioners follow a particular school of psychotherapy (Gestalt, psychoanalysis, Jungian, etc.). Others today are eclectic, using different approaches based on the personality, issues and preferences of the customer. In good psychotherapy, goals are set by each customer and the therapist’s job is to help the customer reach his or her goals. Therapists also help people formulate their goals, but in good therapy, the customer makes the final decisions on what to pursue.

Before harm reduction was applied to psychotherapeutic practice, therapy was not generally available to people using drugs. Therapists often adopted the disease model and its assumptions, telling customers that they had to be drug free before they could enter therapy or reach their goals in therapy. Especially in high HIV incidence areas, many therapists today do not accept those constraints.

**HARM REDUCTION PSYCHOThERAPY**

Harm reduction psychotherapy is a modality developed by innovative therapists who saw that the old models were causing harm. Departing from systems which place an implicit stigma on drug use, the harm reduction psychotherapy approach does not identify drug problems as “a brain disease”, a biological imperative, nor a moral or character flaw. Drug problems can often be seen as coping mechanisms that perhaps once worked for the person, but now have gone awry and have become problems in and of themselves. Like all obsessive-compulsive coping styles (eating disorders, gambling problems, exercise mania, workaholism, religious fanaticism, etc.) the cure becomes a symptom. Elimination of the symptom alone does not result in a cure, and frequently the original problem, unmitigated, throws the person into crisis once again.

The model is not radical, except that it challenges the institutionalized rejection of active drug users from mental health support. It uses traditional and non-traditional

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PhotoVoice

A facility for showering and cleaning up is greatly needed for the homeless population in our city. The fountain on Main Street will have to do for now.
psychotherapy to work with drug users, but it differs substantially from standard methodology by not fixating on drug use, or demanding abstinence or a promise of eventual abstinence as a prerequisite to treatment. Traditional modalities objectify the patient through their diagnostic models, and require passive compliance with the diagnosis. Harm reduction psychotherapy, on the other hand, is interactive, and the patient is the agent of change.

But how is this drug treatment? If immediate, permanent abstinence is the only therapeutic goal, then harm reduction psychotherapy is not drug treatment. However, the success rates of standard modalities equally exclude them from viability as drug treatment. Harm reduction psychotherapy accepts that abstinence may be a viable goal, but locates abstinence within a range of potential objectives for client well-being, rather than the sole marker of treatment success. It addresses the cause of the chaos, the cause of abusive using patterns. It validates the authority of the client, rather than replacing it with the presumed authority of the therapist, working within the client’s capacity, and in a way that fits their life and experience. The coping mechanism is not removed abruptly or prematurely; rather, it is removed slowly, at the person’s comfort level, as its need becomes reduced by the psychotherapeutic work. (See Patt Denning’s Practicing Harm Reduction Psychotherapy for a more in depth exploration.)

The model began experimentally, and it hit pay dirt. Drug users began to feel better; many attended their group or individual sessions with unexpected regularity and motivation. New models were adopted such as the Prochaska DiClemente Stages of Change model and Motivational Interviewing, while existing models were used or adapted, such as Cognitive-Emotive Therapy. Traditional counseling models, typically not used with drug users, proved to work as well with them as with non-drug users. These therapists saw that we live in a drug using culture, although we chose to hide that by saying that some drugs are okay and others not.

A vast percentage of people with drug problems have histories of trauma (particularly childhood sexual abuse in women, but also physical violence and psychological abuse in both men and women). Many chronic users have also suffered the trauma of being a “junkie”, “crackhead”, “alcoholic” stigma society assigns to them based on their drug use. Others have untreated psychiatric problems or mental illness. Superficial symptom elimination through behavior modification is seen as ludicrous. It is the trauma, the depression, the anxiety, the pain, the stigma, the sense of worthlessness and “badness”, the agony, the loneliness, the sense of hopelessness that must be addressed. Behavior modification is the last step, not the first step.

Not all psychotherapists can do harm reduction psychotherapy. Ego-driven control-
The idea of having kick kits available came from Dimitre. His father was a physician and Dimitre knew quite a bit about pharmaceuticals. Dimitre carried around a kick kit. He explained to me the importance of it and what it might include. After doing some research about outpatient opiate detox I found out about the Haight Ashbury Clinic and other similar clinics, as well as their protocols. It seemed a bit rigorous that clinics expected clients to come into the clinic every day and get their meds. The folks I knew couldn’t make it to a clinic everyday, especially if they were also using some dope.

In the Olympia area there was a long wait for inpatient opiate detox. Access to detox sometimes required a two-week or longer wait, which is totally unrealistic. There are many barriers to inpatient detox as well:

- You have to provide verification of name
- Potential perception or link of identity to public assistance, law enforcement, probation, child protective services, etc. (Asking for medical services invites scrutiny, especially if it requires public funding)
- There’s nobody you know in the facility and it’s not very personal.
- You are not in control of medication management. The nurse tells folks when they will get what meds and how much.
- You can’t kick with a friend, lover, spouse (inpatient detox facilities prohibit this)

Syringe exchange participants were frustrated at having no access to detox and began researching outpatient detox models around the US. It turned out that a “community clinic” working out of a soup kitchen started providing some meds to opiate addicted individuals as a means to relieve their withdrawal symptoms. This created a push for something to change.

The timing was good for us. It was at the end of a budget cycle and there were detox funds left over (because people couldn’t get into inpatient detox!) We contracted with the community clinic to offer kick kits to heroin users.

This was in July of 1996. The clinic has changed a lot and has seen several different nurse practitioners and medical intake staff, as well as different clinics to operate it. We have learned the hard way how to save money. The clinic was charging the County $150 for medications on top of what it was charging us for the nurse practitioner, space, receptionist, phone, etc. It was a joke. Now we know how much a kit actually costs and how it should be provided in order to maximize public allocated detox funds.

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Community Planning is vital to HIV prevention efforts. We already see how poorly federal bureaucrats understand infectious disease. The people who are most qualified to decide how prevention dollars should be used live in the communities where the virus is spreading. But very often, these people don’t have the backgrounds to work on a Planning Group. Most of us aren’t even aware the Planning Groups exist.

What is a Community Planning Group (CPG)?

CDC money that is used for HIV prevention is mandated to have a community planning process. Many regions of the US have a Community Planning Group (CPG). This is a collection of qualified representatives from the communities most affected by HIV/AIDS that determines how the money is distributed. Diversity is the key, as HIV cuts across many social and ethnic lines. Community Planning Groups (CPGs) are required to demonstrate that there is adequate representation from affected groups. Because it is about public money, the process involves some complicated politics. But hard work and commitment can assure that people with histories of drug injection—including active users—can participate in this process, as members of the actual CPG.

Michael Wilson and Reginald Summerize developed a recruitment model to assure proper representation on the CPG. This model was originally created to recruit heterosexual African American men into the council. After using this model successfully and presenting it at the 1998 CDC HIV Prevention Conference, people in Chicago decided to use the model to bring drug injectors into the planning process. As a result, there are currently 7 active or former drug injectors participating in Chicago’s HIV Prevention Planning Group. 2 are voting members on the CPG, and several more serve on committees.

The Chicago Model

This recruitment process takes a year. This may seem like a long time, but there are some good reasons:

* Filling vacancies on CPGs takes time, and some political work
* People you have recruited need time to prepare. No matter how relevant their life experience may be, if their background is not in the field of HIV prevention, then the planning process will be foreign to them. Over the course of a year, they can learn the ropes, and learn the issues.
* People participating in the recruitment process also become more involved in their communities, promoting AIDS awareness and learning what others in their community need to prevent HIV. This gives recruits a strong background for their work on the CPG.

Phase One: Complete a Needs Assessment and Build Support

* Identify the number of members you will need on your CPG. There are a limited number of voting positions on the CPG, and every year there are some vacancies. Filling these vacancies may change the demographics of the CPG. You need to know how many vacancies may be appropriately filled by IDUs.

* Meet with the Membership Committee Chair and the CPG Co-Chairs, Make Presentation to Full CPG. You need the support of the CPG to get your recruits into vacancies. The membership committee is the group that oversees recruitment of new members. The Membership Committee Chair can let you know what vacancies will be opening on the group, and how these vacancies will affect the demographics of the CPG.

* Meet with the Co-Chairs of the CPG. The goal is to gain CPG support for your recruitment efforts. Be prepared to show the community co-chairs the need to maintain the necessary balance in representation on the Group (including IDUs). Your health department should have statistics available on rates of infection among IDUs and their sexual partners.

At this point, request to be placed on the agenda for the Executive Committee meeting to address the leadership of the CPG, requesting their support for the recruitment model. Ask the Executive Committee for permission to address the full CPG on the recruitment process.

Presenting to the full CPG will get support for the new recruits. It will also create an expectation that there will be IDU representation on the Group.

Phase Two: Reasonable Accommodations

After receiving support of the CPG, the search will begin for reasonable accommodations to host meetings of the recruits. Remember, this is a year long process intended to train community members with histories of drug use on CPG participation. This will require regular meetings with your recruits. Reasonable accommodations should include the following:

* Wheel chair accessibility
* Centralized locations
* Locations that are easily accessed by public transportation
* Communities that are reasonably safe to access
* You may need interpreters for recruits who don’t speak English (or who need Sign-Language)

Hopefully, you will find a church or community based organization with facilities that you can use. When you find a place, approach the ownership to give a presentation on what you propose to do at the location. Get a one-year, signed agreement that clearly states the times and dates of your activities and rights to access. (This space may be con-
It’s important to stress a central, easily accessed location. During the training process, people will be coming regularly. If people you are recruiting have to travel a long way, or if the public transportation takes too long for them, they will be less likely to participate. They also need to feel that they can come and go from the meeting place safely.

Phase Three: Recruiting Process and Community Relations

Identify the community or social venues as likely places to recruit. At this point you will start to reflect on what places Intravenous Drug Users (IDUs) frequently spend their business, social and spiritual time. Find places where an IDUs go regularly. That makes your work convenient to the people you are seeking out.

Identify the community gatekeepers and develop a strategic plan for how you will approach them as you identify the venues for recruitment. Share your plans with these gatekeepers and get them to take ownership in this process.

Examples of gatekeepers.

* Church leaders: you want them to know that you will be working in their area. Hopefully, you have already done some work with them in the past so they will be familiar with you and trust you.
* Local business owners: “Ma and Pa”, who own the corner store, know everyone in the neighborhood. If they support you, they will talk to others about what you are doing.
* Police: they need to know you will be working with IDUs in the area, and possibly bringing people in from other areas.
* Gangleaders: need to know that people will be coming in from other areas, and to leave them alone. Build supportive relations with gang members by providing services such as counseling, treatment access and case management.

You have to keep going back and doing ongoing education with the gatekeepers. Working with the gatekeepers is the easy part of the job, the hard part is getting recruits to the meetings on time on a consistent basis.

Phase Four: Orientation and Education for Recruited Members/Community Resources

There are two key elements to scheduling your meetings with your recruits:

1. Make it late in the day. Some people work, and people with no official job usually have business to attend to. Drug users or not, if you schedule your meetings early in the day, fewer people will come regularly.
2. Provide a meal! It’s guaranteed to make things easier for everyone, including staff and recruits. It also shows you don’t take people for granted.

Recruits need to know what will be expected of them on the CPG or on its committees. There will be expectations, what kind of work they will be in for, what kind of reading they are going to do. Recruits also need to know that a commitment is expected. Share with the recruits the benefits of being a member of the CPGs: education, being an asset to your community, helping prevent HIV and saving lives.

It is your responsibility to set the climate of the meetings. People need to know that they will be meeting with people from different backgrounds, including different education and class levels. Your recruits may range in backgrounds, from 8th grade drop-outs to PhDs. Be honest with your recruits. People who have a background of drugs, the streets or prison need to know what the environment of the CPG is like.

You must create ways to defuse negative stereotypes that exist between Intravenous Drug Users and Non-Intravenous Drug Users with respect to one another. Encourage people to understand how stigma works. Sensitivity training is also a process where you will identify the various sexual orientations of the planning group. Diversity will have a range of social implications. However, the responsibility of maintaining an even playing field ultimately falls upon you, the trainer. You don’t
want to come in a 3 piece suit with a name tag hanging off your coat. Be aware that your own actions may be alienating to the population you want to reach.

This goes both ways. It will also also be your responsibility to educate other CPG members and staff about stigma and hostility users face, and how to create an atmosphere where everyone feels safe, including people with histories of drug injection.

Community Resources
Assign the recruits to find community resources to listen to and share information with. Have the recruits going into community gathering places and listening to what’s going on. Methadone treatment centers, recovery houses, street corners, basketball courts, clubs, galleries, barber shops and beauty salons. Recruits will begin developing leadership skills through their participation in this process.

A community resource guide that consists of organizations and individuals that are supportive of the community planning process can be made, including local businesses, community based organizations, local churches, and civic offices. This guide will be distributed to new recruits and updated regularly.

The CPG has many committees, and people can participate on committee even if they don’t have a seat on the CPG. Suggest/require recruits to become active members on committee groups of the CPGs. In addition, recruits should attend all Community Planning Groups meetings. Recruits will begin to understand the relation between their outreach to community resources and the work of the CPG. They will begin to see on a whole new level why community planning is so important, and what their role in it can be.

Phase Five: Evaluation
The evaluation process is needed to validate the efforts of the recruitment of Intravenous Drug Users. Do not be afraid to make changes in the model during the implementation phases. Evaluation may be done on a quarterly basis, because the recruitment process is a year long. This evaluation gets presented to appropriate committees of the PPG to bring them up to date on the recruitment activities.

The evaluation should be on 3 levels
1. Effectiveness of community involvement
   * Was your community open to the process of recruitment?
   * Did your projected areas support the recruitment efforts?
2. Effectiveness of Information Exchange
   * Were the recruits actually sharing information with the community?
   * Were the recruits bringing back questions and concerns from the community?
3. Collect feedback on the process
   * Ask the recruits if there was anything that should be changed.

Michael Wilson works for Chicago Recovery Alliance. He can be reached by email at mnm1411@attglobal.net

Getting Drug Users Onto HIV Prevention and Care Planning Groups.

Michael Wilson and Reginal Summerize
Kicking at Home with Naltrexone

Kate McCoy, PhD

There are many good reasons to detox if you’ve got a heroin habit. Most people do it many times, especially if they use for several years. Only sometimes do people intend to stop using altogether. They run out of money, lose their connections, want to get their habits down to manageable levels, need a break from the hustle it takes to pay for their habit, need to take a break for health reasons, want to go on vacation without a habit, etc. Only a few people can afford to or even want to go to formal detox whenever they need to kick. Many people have to wait on a list for an opening, if they even want to go. It makes sense, then, that most heroin detox takes place outside of formal settings.

Unfortunately, researchers who study heroin use typically interview people primarily from treatment centers, jails, and prisons. As a result, there is very little public knowledge about how people detox at home and how they quit using heroin on their own. The few representations of at-home detox there are come from movies and books featuring heroin use, which often include scenes of kicking at home “cold turkey.” Think of Sinatra’s Frankie Machine in “The Man with the Golden Arm.” Or the more recent kids in “Trainspotting.” Gross-out pictures of the ravages of kicking heroin sell movie tickets, books, and video rentals, but they may not be so helpful for trying to understand how people might actually deal with these situations in a less harmful manner.

In May 1997, I began research with a group of around 20 mostly white and all middle-class men and women ranging in age from their mid-20s to early 50s. Seven of these people, all white and in their mid-30s, did rapid opiate detox at home. They provided support, advice, and supplies for one another. Most of them also kicked using other formal and informal methods. This article provides some cautious information about kicking at home with Naltrexone based on their experiences. First, I want to provide some background information on Naltrexone and briefly outline the context in which this alternative has emerged.

Background on Naltrexone and Rapid Opiate Detox

Naltrexone is an opiate antagonist, which means it counters the effects of opiates, in effect, pushing them out of your system. It is something like the well-known overdose remedy Narcan (Naloxone).

Naltrexone has been considered (and in some cases approved) for the treatment of numerous conditions, all of them thought to be caused by an underlying brain disorder relat-
ed to the body’s production of its own opiate-like chemicals. For example, it has been studied as a treatment for self-injury syndromes associated with mental retardation and autism, alcohol dependence, opiate dependence, and cocaine dependence.

Treatment researchers have experimented with “rapid opiate detox,” where Naltrexone is used to clear opiates from a patient’s body while under sedation. The protocol usually includes maintenance on Naltrexone to block future opiate use. There is debate about the safety of the procedure. The withdrawal symptoms are extremely severe and, when these are combined with general anesthesia or sedation, there is a risk for seizures and dangerous fluctuations in breathing and heart rate. Patients who are also dependent on alcohol or benzodiazepines (such as Valium or Xanax) face greater risk of dangerous complications with rapid opiate detox.

There is no detailed information available on the impact of Naltrexone on people who are HIV positive, except for a brief statement from an unpublished interview with a doctor who said that he had detoxed HIV positive people.

A striking example of the risks of rapid opiate detox can be found in the case of Lance Gooberman, a doctor in New Jersey, who is being sued for malpractice after 7 (out of 2,300) of his rapid opiate detox patients died over the course of 4 years. Dr. Gooberman did these procedures in his office because he couldn’t find a hospital that would let him do it there. It’s not clear exactly how the people died. Dr. Gooberman reports that autopsies revealed undetectable heart disease, which may have contributed to the patient deaths. One patient may have died from an overdose of opiates and other depressants shortly after being released.

Reports on the effectiveness of rapid opiate detox and maintenance are mixed; some studies indicate that the treatment is effective for highly motivated users, while other studies indicate that many people will not follow through on maintenance programs because they experience unpleasant side effects, including depression, anxiety, confusion, and hostility. No one that I have spoken with has been able to stick to a maintenance program for very long, but some did stop using heroin and have stayed off for a few years now. Others stopped for awhile and have gone back and forth.

Despite the risks and mixed reports on effectiveness, naltrexone has been approved for treatment of opiate dependence. It is aggressively marketed to upscale clientele, but is not widely available in publicly funded detox and treatment programs.

How Naltrexone Detox at Home Became Possible

Announcements of a heroin epidemic in the 1990s focused almost exclusively on the possibility (and fact) of white, middle-class people using heroin (as though this had never happened before) and generated scandal around the perceived spread of heroin use to gross-out pictures of the ravages of kicking heroin sell movie tickets, books, and video rentals, but they may not be so helpful for trying to understand how people might actually deal with these situations in a less harmful manner.

Continued on page 31
Particle Physics: Shooting Pills God Meant for You to Swallow

George Arlos

The media storm around OxyContin has done more to give that drug the gleam of forbidden fruit than all the drug-warriors could have. Perhaps the most dangerous non-fact repeated in the news is that OxyContin is comparable to heroin when injected. (Yes, of course: Heroin is an opioid; OxyContin is an opioid, therefore OxyContin is Heroin. It’s enough to make Aristotle hit the Pipe!)

This is a new twist on the old middle class nightmare that heroin has jumped the ghetto-wall and is stalking decent (read “white”) kids down the streets of decent (read “white”) neighborhoods. Only in Oxy version of the story, it’s not copped from a (black/Latino) dealer but prescribed by a (white) physician and purchased from a smiling (white) pharmacist. What could be more diabolical!!!

The real danger of the assertion that OxyContin is a substitute for heroin is that it increases the likelihood that more people will inject it. Oxy is not an injectable drug, or rather it wasn’t made to be injected. Of course, anything is injectable if there’s the will. In fact, Oxy is not all that easy to inject. First one must remove the coating, which is usually shaved or washed off. Then one is left with just another pill (like so many others) that doesn’t dissolve in water. This means patiently filtering it, if you don’t want to clog your veins and your syringe with crap.

Second, shooting pills that are not meant to be shot isn’t good for you. Those of you old enough might remember the Lou Reed song:

“all your two-bit friends, they shoot you up with pills, they say they’re good for you, that they will cure your ills, etc.”

(Oh Lou, he knew.)

OxyContin contains buffers and fillers that are common to many pharmaceutical medications. “Fillers” hold the pill together, and are also used to effect it appearance and consistency. The filler that probably causes the most trouble is talc (magnesium trisilicate). Yes, it’s talcum powder. It’s in lots of pills. When it gets in your bloodstream, this mineral can cause damage to blood vessels in your lungs, and also cause nodules and scarring in the lungs. Symptoms of lung disease associated with shooting pills cut with talc (pulmonary granulomas, interstitial lung disease, etc.) are difficulty breathing, which increases as the disease progresses, wheezing and persistent cough sometimes with blood present. Talc nodules may also show up in the liver, kidney, and spleen.

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PhotoVoice

I shot up in the bathroom of this [public place] and had an allergic reaction to the cut of the heroin. The doctors, nurses and staff treated me like shit. I was so humiliated. My bowels let loose and the [staff] were laughing at me and talking about me. I’ll never forget the humiliation.

A local public bathroom is as good a place as any to shoot up in. Until a more realistic outlook on IV drug users is set forth in NJ, this will be where we get high.
The storyline is familiar: A community impoverished by deindustrialization, meager and diminishing availability of low-paying and physically demanding jobs, a dearth of social outlets, and few opportunities for building social or economic capital. Drugs provide relief for unmet healthcare needs, an escape, and an economic resource. You are probably familiar with several communities that fit this description. You may live in one. The common assumption is that the community is urban, but it could also describe places like Washington County Maine, Nicholas County West Virginia, and Clay County Kentucky. Enter OxyContin, the time-released opioid analgesic marketed for the treatment of chronic pain.

The emergence of OxyContin abuse in non-urban communities of Appalachia and New England produced a recognizable pattern of response that typically includes little or no consideration of public or community health. Oxy media maestros have already led to a pronounced legal, rather than public health reaction. Maine is responding with intensified criminalization, increasing punishment for OxyContin specific offenses from misdemeanor to felony charges for larger quantities. Other states are considering comparable actions. While some localized crime related to an inflated drug market has resulted in more arrests, these are merely symptoms of a larger public health problem.

Media coverage of Oxy-related problems center on teenage overdose deaths, drugstore robberies, and tales of forced prostitution or senior citizens selling their prescriptions. Sensational and shocking to the uninformed, but such uncritical messages have become the norm: “Oxy is killing people,” conferring agency to the drug itself, or “Oxy is #1 drug of choice in our community.” It is no surprise that the most audible public response is equally exaggerated, providing incentive to for politicians to heat up the rhetoric even more. The result is that partial or inaccurate information is used to shape harmful policy remedies. Clearly there is a need for a more balanced picture of where OxyContin fits in the context of all opiate use, prescription diversion, and where all of this fits into drug policy.

“Hillbilly Heroin”

This expression tells us a lot about the driving social forces behind American drug policy. “Hillbilly” is a term that summons potent stereotypes of poor people living out their illiterate lives in squalid violence. These images have an irresistible appeal to media system that thrives on hostile images of urban communities of color, and images that place blame on victims.

The reality: Extreme Oxy abuse is most concentrated in small pockets of Appalachia, where mental health and substance abuse treatment budgets are minimal. Long-term
**What is Oxycodeone (OxyContin)?**
- Oxycodeone hydrochloride (HC1) is a semi-synthetic opiate derived from opium alkaloid: thebaine. It is similar to morphine and is sold under the brand names OxyR, Roxicodone and the popular OxyCon. Oxycodeone is in a class of drugs called narcotic analgesics and is prescribed for moderate-to-severe pain.
- OxyCon is sold in time-release tablets containing 10mg, 20mg, 40mg, 80mg and 160mg.
- Other brand names that contain the oxycodone component and aspirin or acetaminophen, but are NOT time-release tablets include Endocet, MS-Oxy, Percodan, Percocet, Percodone, Roxicet, Roxilox or Tylox.

**How is Oxycodeone Used?**
- Oxy’s are taken (swallowed whole) orally.
- Oxy’s are also broken, chewed, crushed or sucked to bypass the time-release feature so the effects can be felt immediately.

**What are the Effects?**
- Oxy’s are a controlled release tablet oxycodone for the management of moderate to severe pain when needed for continuous, around the clock pain relief.
- OxyCon is often reported feelings of warmth, well-being, euphoria, drowsiness and contentment.
- Since opiates are painkillers, OxyCon can reduce or eliminate pain. It can lead to unconsciousness.
- Negative side effects include constipation, nausea, nodding off or falling out, clumsiness or dizziness, vomiting, itchiness, headache, dry mouth, sweating, fatigue, pinpoint pupils, withdrawals and slowed breathing.

**What are the Risks?**
- When you use Oxy’s regularly you develop a tolerance, therefore you use more to get the same effect. The greater the amount and frequency of use, the faster you become more tolerant.

**Addiction is a risk of OxyCon use whether taken as prescribed or otherwise.**
- Because of individual tolerances, overdose and potential death is a risk.
- OxyCon is a Schedule II narcotic. Possession and sale of Oxy’s can carry stiff penalties including long prison terms.

**Be Sure of It!**
- Nearly all OxyCon related deaths involved another drug. OxyCon is especially dangerous when used with depressants including ALCOHOL, benzodiazepines like Xanax, Valium, Ativan, Klonopin, Halcion, Restoril or other drugs that have the same effect.
- It is possible to overdose on OxyCon by itself, although most drug overdoses occur when a person is using more than one substance or using after a period of abstinence.
- If you are using for the first time or after a break, use a small amount before using more and give yourself adequate time and wait before increasing dosage.
- If the person nods off or falls out, wake them, walk them around keeping them awake.
- If the person's breathing becomes shallow or slow, less than 1 breath every 6 seconds, has no pulse, or turns blue call 911 IMMEDIATELY. Tell the operator "someone has stopped breathing" and begin artificial breathing.
- Because there are antidotes to opiate overdoses, when the paramedics arrive tell them exactly what the person has used.
- The person has a 95% chance of survival as long as you can keep them breathing until help arrives. Doing this manually or artificially can be effective, but it's difficult to keep up over time. Calling 911 as quickly as possible is imperative for survival.
residential or opiate maintenance treatment is scarcely available. Despite the buzz that Oxy has taken the region by storm, a huge demand for drug treatment and appropriate interventions existed well before OxyContin became the media’s flavor-of-the-month. For years, rural states from Alaska to Arkansas report that addiction problems with methamphetamines, crack, and all forms of opiates have risen steadily, and that opioid addiction has long been fueled by prescription abuse regardless of OxyContin.

Regrettably, early perceptions about certain drugs are hard to overcome. The tendency to focus attention on Oxy for Oxy’s sake reminds us to gather practical information about Oxy and place it in the larger social, economic, and political context of drug abuse in the US. Then we may better understand the implications for the reduction of harm related to not only the drug itself, but also nearsighted policy responses.

Our project headed out into two communities, our own urban setting, and Washington County, Maine, conducting interviews and focus groups with active opioid users and sellers to find out what was going on from people with direct experience. We also examined available evidence of Oxy’s impact on overdose rates. Our main objective was to learn just how accurate popular understandings of OxyContin abuse are, and to determine what information could inform an effective public response. We offer a synopsis of the most apparent lessons we have learned as harm reduction advocates. To gain a larger perspective on Oxy diversion, addiction, ingestion practices, and risk for overdose, we must dispel some myths:

Lessons From The Past

“I don’t think it’s going to be a big rave. I think it’s a big hoopla, really, like anything else. When it’s new it’s a big deal, and then it’s not.” Karl - long time drug user and dealer

In fact, oxycodone is the opioid agent in at least 40 brand name prescription medications. Indications from most corners of the country are that abuse of pharmaceuticals like Vicodin or Dilaudid are far more problematic than OxyContin, but evidently less newsworthy.

Myth #1- Oxy Diversion: It’s an addict thing.

Myth #2- OxyContin is naturally attractive to heroin users.

NIDA indicated a base of at least 4 million prescription abusers (likely a low estimate) before Oxy ever hit the street, including those medications that contain the very same active ingredient oxycodone, like Percodan, Percocet, Tylox, Vicodin and Endocet.

Cincinnati is home to the only full-time drug diversion unit in the country. In 1999, thirty percent of the two hundred fifty felony drug arrests there involved health care professionals. We have also witnessed this in our home state of Connecticut in the arrest of a Bridgeport physician allegedly writing OxyContin and other prescriptions for cash. Similar occurrences around the country seem to be either rapidly emerging (not likely), or receiving much more attention.

Many of the pending diversion-related lawsuits around the country implicate medical and pharmacy personnel as accomplices. Diversion can be as much a profit issue as an addiction issue, especially with the help of free media promotion. Interviews with people in our local urban street drug scene revealed several other health care professionals willing to facilitate the distribution false prescriptions for a price.

Diversion has been going on for as long as prescriptions have been dispensed. New prescription monitoring systems should have been developed long ago, however not with prosecution in mind, but the protection of consumers against dangerous combinations of medications, which have been responsible for an estimated 20,000 deaths per year, long before Oxy was a household name.

Myth #2- OxyContin is naturally attractive to heroin users.

Every heroin user we have spoken with still prefers heroin. “Heroin, hands down. I would have to spend a lot more money for the Oxy high,” says Peter, echoing the words of practically everyone we spoke with. Most
indicate that they may take OxyContin if it is convenient for maintenance purposes, but the majority are unsatisfied with the effects, and find it far too expensive.

On the street, OxyContin is primarily an economic matter. "It’s awful strong, but it’s too expensive," says Lisa, a long time heroin user. With prices that often approach a dollar per milligram, regular heroin users are much more inclined to convert OxyContin into cash and buy a few bags of heroin.

So who is using OxyContin? In the rural reaches of the country the working class population is sustaining the diverted OxyContin market. In more urban areas, it is "professional people. People with shirt and ties," says Karl, a long time drug user and dealer. "That’s what most of the dudes I sell to look like." Or they can be working class. “These are working men, making good money. Sometimes the boss or foreman comes and buys them, sometimes they put their money together and cop on their way to the job. They take the Oxy to get through the day.” Oxy seems quite popular with people in heavy labor jobs, the time-released feature helps to endure the rigors of long days of intense physical work, whether building in the suburbs, or digging clams, picking blueberries or the other “stoop-labor” so common in Washington County. Law enforcement interventions that round up “the usual suspects” (i.e., heroin users) are looking in the wrong place.

**Myth #3 - OxyContin is an injection drug**

Much of the media reporting on Oxy either directly indicates or suggests that OxyContin injection is a preferred route of use, but injecting Oxy is not so viable, even for people who are accustomed to injection. The pill has several agents that don’t dissolve well (or at all). Of those regular urban injectors we interviewed who tried shooting OxyContin, the majority only did so once. “It’s just a pain in the ass. It takes too long to get the coating off, and it gets all gelled up. It’s just not good for injecting, like dilaudids used to be,” says Ken. “I only know one person who is injecting it regularly, he’s got a little chemistry set to break it down,” says Karl. In reality, people who don’t swallow the pills whole are mostly chewing, or crushing and sniffing. Those who start with Oxy may move to injection, but typically find more injection-friendly opiates soon thereafter.

For newer users who turn to other injection drugs when Oxy becomes less available, affordable, or desirable, less experience and fewer resources add up to increased risk and need for prevention interventions. In Washington County, for instance, Dilaudid injection has become a preferred choice, as inexpensive diverted prescriptions flow easily across the Canadian border. Not surprisingly, Hepatitis C infections have skyrocketed in Washington County.

**Myth #4 - OxyContin has lead to a huge increase in overdose deaths**

So far, there simply isn’t data to back these claims up although the potency of OxyContin is definitely a cause for concern. Most drugs containing oxycodone include 2.5 to 5 milligrams of the active ingredient, while OxyContin comes in 10, 20, 40, 80, and until mid-2001, 160 milligram strengths.

It’s prudent to use caution when talking about life and death. Consider the case of heroin. According to 1995 DEA statistics, a $10 bag of heroin on the street contained active opioids anywhere from 7.7mg in Atlanta, to 19.6mg in San Francisco, to 31.8mg in New York City. If anything, heroin is even cheaper now, since between 1988-1995 the price per mg of heroin has fallen by 3-4% per year. With OxyContin costing upwards, or more than $10 for 10mg, and with Oxy and heroin being pharmacologically equipotent, most people who inject heroin would get less “bang for their buck” using Oxy. This would reduce, not increase the overdose risk for Oxy injection.

Focusing purely on Oxy in overdose obscures the reality: as with most drug overdoses, the active ingredient oxycodone caused death in combination with other substances. ER reports we have received have shown poly-drug use associated with overdose, most including alcohol.
According to the Drug Abuse Warning Network, all oxycodone products combined don’t rank in the first 15 among the top 100 most frequently abused drugs. With current oxycodone figures in the low hundreds, almost all of which are poly-drug and alcohol cases, the impact of OxyContin is be slight compared to over 400,000 for tobacco, over 100,000 for alcohol, and 32,000 for adverse reactions to prescribed medications, and so on. Codeine (also an opiate) was mentioned at roughly ten times the rate of oxycodone in Medical Examiner reports: 1992 deaths in 1999.

There is consensus almost everywhere that problematic Oxy-abusers, as with all drugs, are over-represented by whites. During the period from January 1998 through June 2001, the Chief Medical Examiner’s office in Connecticut found that all 13 of the deaths involving oxycodone were white, with a mean age of 42 (50% male, 50% female), and that only two involved oxycodone alone, one accidental and one suicide. Media attention on possible Oxy overdose fatalities reveal substantial skin color bias. Alleged Oxy-related overdoses are tragedies, yet heroin or “street drug” overdoses remain stigmatized and contemptible.

“Increases in overdoses? No, that’s all bullshit,” says Karl, referring to the community of temptible. "I know everyone in this shit," says Karl, referring to the community of temptible.

**Myth #5: Oxy itself is the cause of drug abuse**

Media coverage increased the street price of OxyContin. The more it is covered, the higher the demand, the higher the price the market will sustain, and as availability declines, the price will escalate faster. “It’s big, big business,” say Karl. “Everybody I know is using it for monetary gain.” A rash of media coverage through the year has “really pushed the price up fast. It has more than doubled in price. You can get a dollar a milligram for Oxy, easy.”

As the demand and price are pushed higher, users have become more affluent, more suburban. “It’s not the poor man’s heroin, it’s the rich man’s heroin,” remarks Jimmy. “The way they got it in the paper is wrong. The people who are abusing it are people with jobs, good jobs, who can afford it. It’s people coming into the city from the outskirts. That’s the only people who can afford the stuff. For the man on the street, Oxy is just money to buy him some drugs and pay some bills. If they buy it on the street they’re going to buy it at a cheap price to sell it to somebody. As long as there’s people willing to pay that kind of price, they’re gonna be sold.”

Prescription consumers living with chronic pain are also finding the skyrocketing prof-

its hard to resist. Some people living with HIV, cancer, or other debilitating illnesses are inclined to bolster personal budgets by selling their pain medications. “The majority will sell them except for ten or so to keep it in their system for when they go back to the doctor, to show they have been taking them” says Terry. Indeed, many people will find other ways to remain comfortable and pain-free, including heroin injection.

**The Response: Purdue**

Popular reaction has blamed the manufacturer, Purdue Pharmaceuticals. Class action suits have been brought against Purdue typically charging over-aggressive marketing, and failure to warn about potential for abuse. The state of Kentucky’s suit against Purdue seeks a $300 million trust fund to provide rehabilitation services for Kentuckians harmed by Oxy. (Is it interesting to scale up such a precedent for harms created by beer, liquor, or tobacco consumption.)

Purdue has responded with tamper proof prescription pads, brochures with diversion prevention strategies, strong label warnings about the potential for addiction and death, and promoted prescription monitoring programs. They also pulled the 160mg version of OxyContin off the market. “I haven’t seen the 160s around since May (2001),” said Karl, who sells Oxy regularly.

Purdue’s has also designed a new “smart” drug, combining the opiate antagonist, naloxone, with OxyContin. Oxy is a time-released drug. Crushing the pill deactivates the time-release element, and allows you to experience the full dose immediately. The naloxone would be activated by crushing the tablet. Yet another attempt to fix a social problem with a chemical! The problem with this approach lies in the slow uptake of naloxone through the digestive system. Crushing and swallowing the pill still results in higher doses of oxycodone than the manufacturer intends, but the opiate blocker won’t kick in until you are already high. On top of this, Purdue doesn’t expect FDA approval for such a drug for another two-to-three years.

**The Greatest Harms**

We can expect, with OxyContin misuse, a familiar pattern we have seen with most other new drugs: First, a large spike in initial popularity characterized by cases of chaotic misuse and extreme examples of impact. This is followed by a leveling and stabilization period as people learn how to use the drug more safely (or become imprisoned), while supplies adjust to the market. Eventually, the historic pattern of the war on drugs indicates the burden will fall upon people of color in urban America. As sources dry up in rural areas and the suburbs, people will visit urban neighborhoods to purchase OxyContin, or if that isn’t available, some other substitute, such as heroin. And as the primary target of surveillance and repression, people residing in these neighborhoods will suffer.

In the meantime, chronic pain sufferers, especially older ones, are already feeling the effects. Nine states have restricted the number of physicians able to prescribe to Medicaid patients. A West Virginia senator went as far as attempting to ban oxycodone, taking over-reaction to its extreme limit. A few highly publicized cases have been brought against prescribing physicians. Officials have gone as far as fingerprint security for Oxy patients in Pulaski, VA for citizens who are unfortunate enough to suffer from chronic pain.

Current policies result in doctors less willing to prescribe Oxy to those who need it, pharmacists becoming disinclined to stock it, and chronic pain patients reluctant to seek medications. Sensational media finger pointing has obscured the need to treat chronic pain, portraying rational medical care as suspect. The criminalization of Oxy-related incidents drives a wedge in doctor-patient trust, and slows hard-won development in pain treatment at the expense of personal choice, the right to pain relief, and general public health. According to a New England Journal of Medicine editorial, approximately 56 percent of cancer patients and 82 percent of AIDS patients were under-treated for pain. Studies also show that minority patients are already more likely to be under-treated for pain. Further restrictions on Oxy prescription will only make these matters worse.

**Policy**

Public attention on OxyContin will no be used to justify opposition to drug policy reform. We can be sure that some will say that the OxyContin phenomenon argues against “legalization,” since a legal and controlled substance is “leading to all of these problems.” Cries to resist “legalization” are misplaced. The appropriate public health stance is that “all of these problems” are already pervasive, and have already long been placing people at harm.

To suggest that OxyContin is now the drug of choice in Middle America is grossly irresponsible. Like any abused drug, chaotic users are in the minority, but their stories that write policy. Limiting the potency and availability of OxyContin is shortsighted, since other drugs of comparable potency are cheaper and just as available. OxyContin is not more widely sold, and it is not more available than other forms of oxycodone. The isolated cases of Oxy overdose are not more frequent or more endemic than other drug related deaths. OxyContin is just more publicized.

**Response**

What is a reasonable response? Centralized
pharmacies, increased physician restrictions and certification programs, lawsuits against the manufacturer and physicians, reclassification and incarceration of offenders, using OxyContin profits to finance rehabilitation and treatment programs; All have been suggested, but none lead to a rational and sustainable drug policy. The proper response to “OxyMania” begins with placing Oxy-related problems in the larger context of the abuse and treatment of all opioids, the diversion of all pharmaceuticals, and overdoses of all kinds. We must understand and account for the different ways that this phenomenon is played out in different settings, creating different sets of service needs.

As long as stigma is a defining principle of policy, there is no difference in the public mind between drug use, drug treatment, jail and death. Oxy exposes the failed logic of the war on drugs. Drug policy has become more “up close and personal” with Oxy, as drug war targets and victims are no longer the anonymous faces of inner-city poor, but the family, friends and neighbors of middle America. But quite similarly, poverty fuels emerging economies, coalescing with increased drug abuse and increased incarceration for non-violent offenses. What was old is new again, or perhaps more accurately, as Karl puts it frankly, “It’s the same old shit.”

Oxy-Mania is both destructive and instructive. It exposes drug treatment gaps and deficiencies. Those of us working in urban settings may see one set of challenges characterized by an enhanced suburban network of use and markets. We see that users on the street are aware of the difference between media campaigns and the realities of their lives. Yet we also see that as a pharmacologically pure substance with a known potency, there is a lack of knowledge about purity and appropriate dosing for illicit drug users. The typical pattern of poly-drug use related overdoses points to need and opportunities for better awareness, education, and interventions for overdose fatalities.

In Washington County, Maine, we spoke with a handful of folks with the resources and incredible determination to make the daily five-hour pilgrimage (one-way) to Portland EVERY DAY for 90 days to participate in methadone treatment. Even after qualifying for take-homes, they take this trip once to three times per week to get their doses. Their desire to get treatment is only matched by the disruption in their daily living that they endure to get help. Of course, these folks represent a tiny sample of the people in need of services in Washington County, most of who can’t possibly get to Portland, keep their jobs, and raise their families. The dearth of treatment resources here is indeed desperate, and this is just one example of many.

While the media “reports” on the imaginary wave of Oxy injection, we know that some habitual users will eventually need sterile syringes, especially in places like Washington County, thanks to an opiate market gone crazy, where one 80mg Oxy routinely commands $120. The expense of daily habits with OxyContin is just not sustainable. As the availability of pharmaceuticals dries up, the heroin market ripens, and just as the demand for syringes is increasing, some pharmacies are becoming more reluctant to sell to non-prescribed customers. Conditions here are maturing for an injection-related public health nightmare. The opportunity for intervention is unmistakable.

In this backlash against the advancement of pain management, there is a synergistic relationship between the attention that Oxy gets, and the problems that become associated with it. If we could harness such synergy to educate more people about opiate abuse, proper treatment, and the harmful effects of our drug policies on individuals, families, and communities, that would be a news story.

Thanks to Robert Heimer for his comments on an earlier version of this article.
In April of 2001 in New York City, Harm Reduction Coalition convened a meeting of key African American harm reduction professionals and advocates to 1) identify methods for promoting harm reduction as a viable strategy and approach to drug use and HIV in African American communities 2) promote the visibility of African American leadership within the harm reduction movement and 3) develop a national network of harm reduction advocates and practitioners in African American communities.

This group became the African Americans in Harm Reduction Working Group (AAHRWG). In July of the same year another meeting was called in Oakland with the same goals. What resulted from this second meeting was the East Bay Chapter of AAHRWG.

The first fruit of this bi-coastal collaboration was a series of 3 day-long conferences (New York City, San Francisco, Los Angeles). Each conference offered a series of panels and workshops featuring a sample of the front-lines African American leaders in the harm reduction movement.

All told, almost 2000 people attended, many of them travelling from other states. All of this was made possible through the efforts of HRC National Policy Director, Amu Ptah, collaborating with people from all over the country.

We are proud to list the sessions and speakers.

CALIFORNIA

Welcome
Amu Ptah, Harm Reduction Coalition, New York, NY
Carrie Broadus, Harm Reduction Coalition

Award Presentation to Imani Woods

Plenary: Harm Reduction in African American Communities
Joy Rucker, Casa Segura/HEPPAC, Oakland CA
Harry Simpson
Lisa Moore, UCSF, San Francisco, CA

Plenary: Creating a Community Context for Harm Reduction
Cleo Manago, AMASSI, Inc, Inglewood, CA
Michael Northcutt, San Francisco, CA
Lateefah Simon, Center for Young Women’s Development, San Francisco, CA
Imani Woods, African-American Prevention Intervention Network, Seattle, WA

Harm Reduction 101
Carrie Broadus, Harm Reduction Coalition, Los Angeles, CA

Housing Active Drug Users
Lynn Lively, Bakers Places

Harm Reduction Strategies Working with Youth
Lateefah Simon, Center for Young Women’s Development, San Francisco, CA
Harold Atkins, AIDS Resources Info and Services

Community Organizing, Activism and Harm Reduction
Andre Robertson, Black Coalition on AIDS, San Francisco, CA

12 Steps and Harm Reduction
Imani Woods, African American Prevention Intervention Network, Seattle, WA

Harm Reduction and Faith
Rev. Edwin Sanders, Metropolitan Community Church, Nashville, TN
Rev. Yvette Flunder, Arc of Refuge, San Francisco, CA

Neddy Exchange Programs
Tina Jackson, Minority AIDS Project, Los Angeles, CA
James Hundley, Homeless Healthcare, Los Angeles, CA

Prison Industrial Complex
Rachel Herzig, Critical Resistance, Oakland, CA

Proposition 36
Robin Levi, Drug Policy Alliance, Oakland, CA

Living with HIV and Drug Use
Rachel Gipson, San Mateo County AIDS Program
Yvonne Reel, San Mateo County AIDS Program

Plenary: Prison Industrial Complex, Race and the War on Drugs
Deborah Small, Drug Policy Alliance, New York, NY
Dorsey Nunn, Critical Resistance, Oakland, CA
Van Jones, Ella Baker Center for Human Rights, San Francisco, CA

Welcome
Keith Cylar, Housing Works, New York, NY
Darrell Wheeler, Hunter College, New York, NY
Soraya Elcock, Harlem United, New York, NY
Nancy Margeson, Mount Sinai Medical Center, New York, NY
Amu Ptah, Harm Reduction Coalition, New York, NY

Plenary: Harm Reduction in African American Communities
Michael Bethea, Exponents, New York, NY
Fred Johnson, Prevention Works, Washington, D.C.
Divine Pryor, ADAPT, Brooklyn, NY
Amu Ptah, Harm Reduction Coalition, New York, NY
Howard Woods, Argus Community, Inc, New York, NY
Moderator: Keith Cylar, Housing Works, New York, NY

Plenary: HIV, AIDS and Harm Reduction
Rhon Reynolds, New York AIDS Coalition, New York, NY
M. Saidia McLaughlin, Bed-Stuy Legal Services, Brooklyn, NY
Marlene Taylor, North General Hospital, New York, NY
Donald Powell, Gay Men of African Descent, New York, NY
Moderator: Adrienne Brown, Harm Reduction Training Institute, New York, NY

Hepatitis — Stern Auditorium
Gloria Searson, NATAP, New York, NY
Damaris Carriero, North General Hospital, New York, NY
Housing — New York Academy of Medicine  
Luis Jones, Citivide Harm Reduction, Bronx, NY  
Joe Bostic, NY City AIDS Housing Network, Brooklyn, NY

Overdose  
Fred Johnson, Prevention Works, Washington DC

Prison/Rockefeller Law Reform (First Session)  
Sharda Sekaran, Lindesmith-Drug Policy Foundation, New York, NY  
Julie Mormando, JusticeWorks Community, New York, NY  
Shirley Curry, JusticeWorks Community, New York, NY  
Terrence Stevens, In Arms Reach, New York, NY

Expanded Syringe Access Demonstration Program  
Crystal Fuller, NY Academy of Medicine, Columbia University, New York, NY  
Tracie Gardner, Legal Action Center, New York, NY

Harm Reduction and Faith  
Rev. Edwin Sanders, Metropolitan Interdenominational Church, Nashville, TN

HIV Meds Access and Treatment  
Sharon Rascoe, Agouron Pharmaceuticals, New York, NY

Women and HIV  
M. Saidia McLaughlin, Bedford-Stuyvesant Legal Services, Brooklyn, NY

Working with Youth  
Maria Alvarez, Centers for Disease Control and Prevention, Atlanta, GA  
Douglas Manigault, Streetwork Project, New York, NY

Needle Exchange Programs  
Rochelle Baerga, Philadelphia, PA  
Thelma Wright, The Wright Cycle, Jamestown, NC  
Larry Gray & Calvin Cleveland, Lower East Side Harm Reduction Center, New York, NY

Plenary: Race and the War on Drugs  
Debra Small, Lindesmith-Drug Policy Foundation, New York, NY  
Alicia Young, American Civil Liberties Union, Hartford, Ct  
Mike Bethea, Exponents, New York, NY  
Julie Mormando, JusticeWorks Community, New York, NY  
Shirley Curry, JusticeWorks Community, New York, NY  
Moderator: Carmen J. Neely Crucial Arts Productions, New York, NY

Closing/Benediction  
Amu Ptah, Harm Reduction Coalition, New York, NY  
Rev. Edwin Sanders, II, Metropolitan Interdenominational Church, Nashville, TN

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PhotoVoice  
Sometimes when you’re in the worst slump, something good happens, ya know? Thank God.
ling therapists who do not see themselves as equal to their “clients” are to be avoided. In my personal experience, this describes a large proportion of psychotherapists in practice today. Harm reduction psychotherapists are a unique group: they know whom they work for, and they do not set the goals, rules, and timeframes of the relationship. Put simply, they don’t tell people what to do, how to feel, and where they should be going. There is also a real understanding of cultural diversity and ability to work from within the customer’s culture.

I admit to a bias toward the psychotherapeutic approach because it was my first training as a clinician and because it is the approach that worked for me in my personal struggles with addictions. Where drug treatment failed me repeatedly with superficial attempts to change my behavior (along with put downs and judgements) psychotherapy helped me make sense of my emotional life and realize that I could change the way I viewed my past, my present and my future. Once things were in perspective, the behavior change part was finally possible; previously, it was a series of failures which created additional negative emotions.

However, even if we adapt this approach to try to make it comfortable and appealing for people from classes and lifestyles other than middle class/mainstream, some customers are not going to be interested in it, especially because the process is often only effective over a long period of time. It usually requires a structured approach over time, with commitment to follow up on a regular basis. With the chaos in many customers’ lives, it may not be a good fit at all. A significant difference between this method and traditional treatment methods is the willingness to admit that it is not the fault of the client if the treatment is not appropriate!

SOLUTION-FOCUSED TREATMENT

Solution-Focused Treatment models, developed by Insoo Kim Berg and Norman Reuss of the Brief Family Therapy Center in Milwaukee, Wisconsin, are non-psychotherapeutic models that fit into a harm reduction perspective and work for people who cannot or are not interested in long term, intrapsychic work. The model’s underlying rationale is that providers cannot possible create solutions for their customers, only customers can solve their own problems. When one thinks of the class, racial/ethnic, cultural and lifestyle differences between providers and customers, it makes perfect sense. Providers come up with solutions that fit their own culture, class and lifestyle: often these are a poor fit for the service consumers.

While consulting at a New York harm reduction agency, a situation occurred which elucidates why provider solutions don’t work. A customer with HIV disease had severe gastrointestinal problems. He was a homeless active drug user and was losing weight rapidly. His doctor referred him to a nutritionist. His case manager encouraged the customer to be very clear with the nutritionist that he was homeless and could not cook his own meals, but ate at soup kitchens and other feeding programs. The customer returned from the nutritionist with a pre-printed diet of salt-free rice and steamed vegetables with broiled meats without fats and spices. With tears in his eyes, the customer asked his case manager how he could possibly use this diet when he had no ability to cook his own food (much less pay for the groceries.) The nutritionist completely ig-
nored what he had told her about his situation, lifestyle, etc. She solved her own problem and acted as if the customer lived in her house, had her facilities, her income and her abilities. She also told him to give up drugs. Provider solutions only work for providers. I’m sure that everyone has stories like that.

With any person’s history of chronic use, there are times when the problem isn’t such a problem or the person is able to stop the behavior for a time. These are called exceptions to the problem. Because of the cultural prevalence of the disease model, many people deny that they have ever done a single thing to reduce the harm of their drug use. They tell stories of how completely self-destructive and crazy they were in their use. This type of “splitting” or “black and white thinking” is a hallmark of the disease model. There is nothing in life which is all this or all that. The symbol of Yin and Yang is a far more accurate description of the universe. It is possible to question the validity of their customary beliefs, and offer clients a new way to look at themselves and their drug histories. And if you can get a person to look closely at their histories of use, there are always exceptions.

There are exceptions that are thrust upon people without their volition, such as being incarcerated or hospitalized when one doesn’t have control of what one does. These exceptions are not terribly helpful because the customer doesn’t “own” them. (Of course one can make a case that while incarcerated there are certainly many drugs available and many people use drugs in jail—same is true for hospitals, but many people choose not to struggle to get them and decide that they have to stop during these periods of institutionalization.) Other exceptions may involve the crimes one did not commit to get the money for drugs and the withdrawal that one suffered, rather than hit someone over the head and take their wallet. Or the times people tried to stop and had periods of success in not using. These can be owned and explored.

The exceptions that matter are those where the customer voluntarily did not do drugs for his/her own reasons—no matter how short the timeframe. This applies to working addicts who control their use for work periods, either not using or using just enough to avoid withdrawal until the workday ends. This applies to the person who did not drink during the Mass at church. This applies to the person who went to a funeral in another state and stood in withdrawal so their family did not find out they were addicted. This applies to the woman who stopped using during her pregnancy. This applies to customers who have tried to stop on their own and manage to do so for some time period—whether an hour, a day, a week, a month or a year. Since we are trained to think in all or nothing terms, they assume that since they used again later, none of it counts.

If the customer can recall such an exception, the worker helps the customer “mine the exception for details”. How did you do it? How did you not drink all day at work? How did you stop smoking for one day? How did you put the crack down for three weeks when you were on a vacation? What strategies did you use when you had cravings? How did you cope with feelings of withdrawal? How did other people react? Who saw a difference in you? What do you think they thought about what you did? And so on.

Whatever the customer did and whatever strategies were used become the building blocks of a solution. If a person can manage to stay off drugs for an hour, it can be lengthened into a day; if for a day, it can be stretched to two days, and so on. The job of the worker is to help the person figure out what he or she did in great detail, and then encourage the person to try it again—this time, with the worker’s support. “How can I support you in doing that again?” The solution focused worker is clear that customers heal themselves. Healing begins when the person decides to do something about their problem, not when they actually eliminate it. This must be made conscious. It does count, even if it does not result in the total achievement of goals.

In harm reduction, process is everything. We focus on process and not on outcome. Outcomes and goals are a natural reality, but there is a cultural tendency to ignore process, and focus purely on outcomes. When pre-defined outcomes are not met, the character of the client is stigmatized, or they are labeled as diseased, with no examination of the process. This pattern is often reinforced in parenting! Parents frequently do not reward process, and only praise outcomes. You studied hard for a test but did not get a high mark, then your parents expressed disappointment rather than praising your effort. “It’s not where you start, but where you finish” is impossible logic. Both matter. Both are a normal part of attaining any goal. Except, of course, in standard drug treatment modalities, where failure results in automatic judgement on the character, will and intentions of the patient. In standard treatment modality, examining or questioning process is taboo.

For people who cannot come up with such exceptions, we ask the person, “If you’ve never had an exception to the problem why isn’t it worse? Why aren’t you dead now?” Every drug user struggles to stay alive, healthy, and have some quality of life. The old models disregard these efforts, giving no credit for them. Or worse yet, positive action is interpreted as manifestation of the “disease”, i.e. “doing your laundry is just hiding your dirty life.” Solution-focused workers stress the times when the person managed to struggle. It is the constantly recurring struggle that is important, not the achievement or non-achievement of the goal. While the disease model would have a negative view of a person with an alcohol problem calling in sick after a bender, the solution focused model would applaud the effort to save the job and maintain employment despite a problem with alcohol that sometimes gets out of hand. This is strength-based work, not a focus on weakness. This is about the real world people live in, not a fantasy world.

When people are able to own the times their actions had a positive impact on their problem, the building blocks for a longer-term solution are identified.

Of course, there is a lot more to this model than this brief explanation. But the gist of it is that people can and do solve their own problems, and in fact, those are the most valuable solutions. For one thing, they can be reproduced again without going to a provider. For another thing, they create a sense of power over the problem. Models that tell people they are powerless can be counterproductive, especially for people who are already facing extreme hardships due to racism, sexism, homophobia, poverty and other power systems that thrive on disenfranchisement.
Drug problems can often be seen as coping mechanisms that perhaps once worked for the person, but now have gone awry and have become problems in and of themselves.

There’s a house disco song where a woman sings “I’ve got the power.” Yes, you’ve got the power, I’ve got the power, everyone’s got the power! But sometimes we don’t know how or when we are really using it. It is a conscious decision to use a drug each time it is used. Harm reduction models help people see that they’ve got the power and they can use it. The provider doesn’t have the power to “fix” people. The provider serves as a guide, a facilitator, a consultant. The power must be acknowledged if one is to stop using or reduce or change the use patterns. Although it may be a core belief for some, insisting that the source of control is external to the individual—a “higher power”—is counterproductive for others.

Some people may find the concept intolerable, but for drug users seeking change it is important for people to love the drug user in themselves; splitting that part off as the bad part keeps the personally divided. An integrated person loves and values all the parts of herself. One must learn to love oneself unconditionally, that is—warts and all! A problem with traditional models is that they don’t make a space for people to love the junkie in themselves with compassion. One must learn to accept, if not appreciate, all the parts of oneself to be a healthy person. Then behavior change is an act of self care, not self amputation.

New York Harm Reduction Educators, uses the solution-focused model in an intervention known as “Sidewalk Psychotherapy.” All services of this program are provided during street based outreach, in tents at specific locations in drug using neighborhoods, five days a week. The sidewalk psychotherapist sets up two chairs in the street. No appointments are necessary. Customers come and sit down and engage in solution focused explorations for whatever time period suits them. It doesn’t have to be fancy or highly structured, or cost a lot of money. It does have to be adapted to the preferences and lifestyles of the customers.

Catholic Charities’ Chemical Health Program in Minneapolis uses solution-focused models to deal with the multiple problems of poor, drug using women. Insoo Kim Berg and Norman Reuss use the model in a family agency in Milwaukee. They make the claim that they have helped people overcome alcohol problems in one session! Treatment does not always have to be long-term, expensive, and complicated.

Many harm reduction programs, particularly syringe exchange programs, have groups or individual interventions that address “drug use management” or “safer drug use.” These sessions focus on how drug users can use drugs in less chaotic ways and take care of their life’s business. They look at when people use, how they use, dosages, frequency of use, who they use with, where they use, how to prevent overdose, and drug purchasing situations. They strive for the maximum safety for the drug user, the minimum negative effect of the person’s use on life tasks, other people and the community itself. But the main focus is on getting consciousness and control over one’s drug use.

When people make small changes in their drug use (or big changes) it lets them see that they do have control and that control can extend all the way to becoming abstinent for those who choose that path. Cutting down is a very helpful strategy for reducing chaos. In my own life, I’ve learned to minimize the dosage and frequency of use, which allows me to take care of all the work and personal tasks in my life, allows me to socialize freely with friends, to be of service to my family when they need me, yet still enjoy the benefits of drug use.

I’ve learned what the triggers are that put my use out of my control, and who in my life will support me when I need help. I have a core group of nonjudgmental people who are not negative about drugs and who will discuss the tiny details of drug use with me, allowing me to ventilate my feelings and process things when I need to. I’ve used the literature, particularly from the Harm Reduction Coalition, to look up information on what is safer and what is not safe. I’ve also learned which people not to talk about my drug use with, so I don’t have to experience narcissistic injuries which make me feel bad about myself.

It’s hard to do this, but what has helped me is a refusal to be on the defensive. I am a drug user, but I don’t need everyone to use drugs in order for me to feel comfortable. I don’t need to be “right.” People who are not drug users, or who are ex-users are sometimes insecure because they haven’t resolved their ambivalence about drugs. Many of these people exert serious personal effort to stay drug free: it is extremely important for them and they deserve support for taking care of themselves in that way. Yet, some people practicing abstinence still envy those
Outcomes and goals are a natural reality, but there is a cultural tendency to ignore process, and focus purely on outcomes... “It’s not where you start, but where you finish” is impossible logic. Both matter.

who continue to use, and must devalue users in order to feel superior and “right.”

Of course, there are many non drug-users, ex-drug users and folks in recovery who are developed and don’t need to put users down in order to maintain their own comfort. These are folks who went beyond the splitting of the “good/bad” morality model of abstinence models.

**Basic Unconditional Support**
Abstinence is the choice of many users who have been struggling and suffering for years, even if it is a choice they do not always succeed in maintaining. Lifelong, perfect abstinence may not be a realistic short term goal. It takes time, effort and support. Many harm reduction programs are helping people become abstinent, either by supporting them in going to traditional drug treatment programs, or by using harm reduction counseling models plus the provision of alternative treatments or complementary treatments such as ear acupuncture, Reiki, herbology, etc. Using holistic healing methods to reduce withdrawal, increase and balance neurotransmitters, and center people, along with counseling and other interventions, reduces the misery of trying to stop. Lapses or “relapses” are not met with disappointment, criticism or shaming; rather, they are seen as part of a process.

Natural interventions that allow customers to achieve their goals without having to reconstruct themselves work best, especially for those who have responsibilities in their lives, such as working or caring for children. Removing people from their communities, their families, their jobs in order to feel superior and “right.”

There are ways to help people become abstinent from drugs (or cut down or just feel better about themselves) without all the judgment, control, sadness and discomfort that traditional treatments may involve. In fact, the old models don’t offer much hope to people who have tried them many times without success. It isn’t the willingness of the client’s which is lacking. What is lacking are clinical models that accept the realities of how behavior changes over time. Change is slow and incremental, to allow coping mechanisms to be constructed, or strengthened. Rushing through 4 day detoxes, 21 day rehabs and the time constraints in managed care, is counter-productive. People don’t change according to a prescription written by someone else; people change in their own timeframes.

**Recent Programming**
In recent years, drug treatment programs have taken a look at harm reduction to see if they can utilize some or all of its strategies to improve treatment outcomes. One Los Angeles area program I visited has a TC resident model and a rehab, but they have added a harm reduction outpatient program and a harm reduction outreach program. When I asked them why they had added harm reduction components, their response was that the “customers were coming in here and demanding it.” A well known rehab in New York, has integrated harm reduction principles into most of its treatment offerings. With the backlash that followed Smithers’ attempts to move toward harm reduction, some programs are doing harm reduction work but they aren’t talking about it or aren’t calling it harm reduction. Two San Francisco based psychotherapists, Patt Demning and Jeannie Little, have opened a new harm reduction drug treatment program.

Some managed care companies are declining payment for drug treatment on the basis that success is too low. This should encourage some of the rehabs to think about changing their models. One can only hope. San Francisco’s new “treatment on demand” initiative, while fraught with problems, seeks to create a continuum of care that incorporates harm reduction philosophies. Dr. Ernest Drucker, a NYC epidemiologist, is working on a study to show that methadone can be moved out of methadone programs and placed in the hands of primary care physicians.

We have come to a place where drug treatment’s flaws have been uncovered, where creative people are looking for new ways to help drug users—both those who want to continue using and those who want to stop using—and where services are integrative and holistic rather than reductive and fragmented. The enthusiasm and dedication of providers and customers in developing effective interventions is heartwarming.

**Political and Economic Realities**
For any treatment effort to succeed, we need a national healthcare plan that covers every single individual and provides all the care that is needed. Drug treatment must be accessible on demand, not fee-for-service and available only to those who can pay. Mental health care medical care must be similarly available to all people. Insurance companies must be barred from excluding drug treatment and giving less coverage for mental health and drug treatment than for medical care. As it is, “managed” care is a series of barriers to care, driven by sheer greed.

Americans must confront their own hatred of poor people. We tolerate homelessness, untreated mental illness, untreated drug problems, wretched schools, lack of parental supports and childcare. One out of five New Yorkers attended food programs last year. Working mothers can’t get medication for their children unless she wants to quit her job and go on Medicaid. While the economic roots of poverty and racism thrive, harm reduction can only put band-aids on gaping social problems. We have to start addressing those social problems directly so we won’t have generation after generation of traumatized, neglected, disenfranchised people. It is a choice tolerate disaster, and it is a choice to reverse it.

What do politics and economics have to do with drug treatment? Everything. Rich people can always get what they need. But poor, working class and middle class folks are suffering. This suffering will result in more drug use, more attempts to cope, and less access to drug treatment. It really isn’t surprising that our society has developed systems that punish poor people for using drugs. It also isn’t surprising that the new models for drug treatment don’t come from the top end of the system. But the work is happening!

**Need Bio**
All responses go to: Paul Cherashore pcherash@harmreduction.org

THE ANONYMOUS ISSUE

Against incredible odds, we users have managed to survive in a country which seeks to control us by violence, deadly infections and social isolation. We want to hear your stories: how you manage to live in the face of such adversity.

Announcing the anonymous issue, a forum for drug users to talk about the issues that matter to them, in anonymity. We are making the issue anonymous for two reasons: 1) To protect the identities of the authors and any individuals or agencies that may be mentioned in the writings, thereby reducing the risk inherent in writing about drug-related activities and 2) To highlight the realities that users live with everyday. We will also alter the names/locations of programs and individuals mentioned in articles.

We want to examine what it’s like living in a society that’s at war with us. What it means to be a user dealing with housing, employment, doctors, therapists, the legal system, insurance, welfare and social security. And what about the drug treatment system?

We are especially interested in topics related to user involvement in the harm reduction movement—whether it be as paid employees, volunteers or participants. The harm reduction movement faces contradictions as it seeks the involvement of ACTIVE drug users. Users involved in the harm reduction movement are caught in the middle of a struggle that involves the drug war, public funding, employment policies and plain old-fashioned hatred. How do you manage?

All these issues require a new language and way of thinking. We want to generate a dialogue. Not solely to criticize, but to generate creative solutions—and develop a vision where harm reduction can live up to its initial promise.

HOW

We are actively seeking commentary, personal accounts, “how to” pieces, interviews, research reports and whatever else that comes to mind (excluding poetry), up to 4000 words in length. We are also seeking artwork.

DEADLINE

Our deadline for submissions is January 31, 2003.

Do you need technical assistance? We will help. Just email Paul Cherashore and say you need help with an article.

SEND TO

Please send your electronic submissions to:

e-mail: pcherash@harmreduction.org with the article (double-spaced, MS Word or Corel WordPerfect file) or artwork (Photoshop, illustrator EPS or Quark XPress/Adobe Pagemaker file) as an attachment.

snail mail:

There are ads in the Village Voice and websites offering luxury detox. Promotional materials claim that you will wake up from sedation tired and shaky, but completely detoxed.

Do you have a place to stay? You must have a place with somewhat to lie down and a bathroom with running water and a toilet. You will need this during the approximately 8 hours of intense detox, and for 3 to 5 days afterward to rest and recover.

Do you have someone who will stay with you? You need at least one person who will stay with you at the very least through the detox experience and preferably also for awhile afterward because you will be very weak and tired. If you have a few friends who can be with you in shifts, even better. Remember, this is a potentially dangerous mode of detox; you need someone there in case something goes wrong and, even if nothing goes wrong, you will need help.

Your helpers must be able to dole out sedatives gradually based on your discomfort level, pulse rate, and breathing. Even better if they know CPR or Rescue Breathing. These need to be people you can trust to use good judgment and get you to a hospital if things go very wrong. You don’t need someone who’s going to bug out. You will either be incapacitated or bugging out enough for everyone. You need people who can help keep you calm. You also need someone to keep track of the time and tell you that it will be over soon.

What supplies do you need?
- One dose of Naltrexone (a 50 mg tablet) is sufficient to induce detox.
- You may want to get a bigger supply to take for awhile afterward to block a heroin high. Remember that not many people stay with the blocking maintenance, which they say has difficult side effects such as anxiety, depression, and hostility. Many people say that the side effects are precisely the sorts of things they take heroin to medicate in the first place.
- Sedatives like Valium, Xanax, or other benzodiazepines can help you get through the extreme discomfort and the increased heart rate you will experience. Clonipin or Clonidine may also be useful. In any case, you do need to be careful that you don’t take too much. Someone you trust should monitor your gradual use of sedatives and your breathing and heart rate to make sure that you don’t overdose.
- Diarrhea medication may be helpful,
What are the ingredients of a kick kit?

The clinic practitioner prescribes and dispenses the following medications to our patients for free at varying doses depending on drug history, drug use and body weight (This is one example and sometimes patients need other medications depending on the case.).

1) Clonidine pills 0.1 mg: 13 pills total. To treat anxiety, insomnia, restlessness; it also lowers blood pressure and heart rate (most people detoxing from opiates have increased blood pressure and heart rates).

- **Day 1:** take 1 pill every 8-12 hours.
- **Day 2:** take 1 clonidine pill every 8-12 hours.
- **Day 3:** take 1 clonidine pill every 10-12 hours.
- **Day 4:** take 1 clonidine pill every 8-12 hours.
- **Day 5:** take 1 clonidine pill every 12 hours.

2) Trazodone 100 mg: 18 pills total. Take 1 pill every 6 hours for abdominal cramps.

3) Robaxin (Methocarbamol) 750 mg: 28 pills total. Take 1 pill every 6 hours for muscle cramps.

4) Bentyl (Dicyclomine) 20mg: 20 pills total. Take 1 pill every 6 hours for abdominal cramps.

5) Hydroxyzine (Vistaril) 25 mg: 30 pills total. Take 1 or 2 pills every 6 hours for anxiety, cold symptoms (runny nose, stuffy head, watery eyes), nausea and vomiting.

Costs of the Clinic

The kick kit meds costs around $15 and last for 5 days if taken as directed. Nurse practitioner cost around $30 an hour.

Our little clinic opened on Tuesday afternoons had 253 client visits in 2000. Some of these visits were follow-ups and repeats. There were no limitations as to how many kits a person can get or how many times they can come to the clinic for services. Other services include harm reduction counseling/education, abscess treatment, access to other health services like dental, etc.

The project has done some statistical evaluation information:

- **Self-report outcome data compiled by harm reduction case manager (n=253):**
  - 16.5% abstained from heroin for one month following intervention (No recent follow up contact has been made to determine ongoing status)
  - 67.3% of patients decreased their HIV risk
  - 40.8% of patients participated in 12 step program
  - 73.5% of patients decreased their drug use
  - 22.4% of all opiate clients entered inpatient drug treatment
  - 32.6% of patients improved their job status

The data has a few limitations. All data is self-reported, and the follow up was usually short-term (30-90 days) and sometimes inconsistent. Given the needs of the population, this isn’t surprising. The people that we continuously see are the folks that need more kick kits for a variety of reasons. The people who are potentially doing well don’t come to see us at the clinic anymore. But the statistics clearly show that there are great benefits to providing support in self-detox.

Another condition resulting from injecting talc is “talc retinopathy”. This condition is usually discovered by eye doctors who notice tiny foreign bodies during eye exams. This condition, if severe, can lead to detached retinas, but seems not to be harmful in most cases. It was first found by eye doctors in patients who were shooting Ritalin tablets.

When injected, the fillers in pills can also lead to complications due to blocked blood vessels, like varicose ulcers and gangrene. Irritation caused by the build-up of insoluble binders behind heart valves can lead to endocarditis.

An old friend of mine once hit an artery in his arm while shooting Seconal, which still had a ton of fillers in the shot. Well the particles lodged in the capillaries throughout his arm and he had to have the limb amputated. He said the pain from this unfortunate hit was almost unbearable. I tell this to point out that while hitting an artery is bad news, and hitting one with a shot containing pill-binders is that much worse. When in doubt pull out.

All in all not a pretty picture.

What is to be done? Well, first off, remember most drugs formulated for oral use are better if used that way. OxyContin is a case in point. Orally it lasts longer and the effect is much more even. There’s also less of a blood-level rollercoaster than you get with repeated injection. The reason it was formulated as a sustained release medication is that it works BETTER that way!!

If all of this doesn’t repel you and you must use oral medications by injection, there are serious risks you can reduce. Reduce is the operative word here. Injecting drugs contained in pills means risking injecting the other stuff that comes in them as well, and eliminating those other substances is a complex, imperfect process. You may be reducing risk, but you are still taking a risk.

It is best to use a 3cc syringe with a removable point. Such a big syringe has stronger suction than the more common 1 or 1/2cc syringe, so it’s easier to draw a pill and mixture through a large cotton filter. A syringe of this size will also hold more water so that water lost in the filtering process isn’t such a big deal. Using too much water is going to make it hard to maneuver, though. The best removable point is the “lier lock” which screws onto the syringe.

Drop a large cotton into a cooker containing a thin pill and water mixture. Trying to filter through the point will take forever and possibly clog the point, so take the point off your syringe and lay the hub of the syringe straight down onto the cotton with gentle, even pressure. The solution shouldn’t rise much above the cotton. (It helps is the cooker is flat and shallow, like a tablespoon.) The solution should then be filtered through the cotton by drawing up on the plunger slowly and evenly. Never draw up faster than the liquid is coming into the syringe.

No matter how patient and careful you are with the first filtering of the solution, there will still be particles in the syringe. It will still appear somewhat cloudy. This process should be repeated at least two more times. The clearer the end product is lower the risk.

Isn’t it easier to just pop a couple of 40mg. Oxs and wash ‘em down with your favorite beverage? I leave the answer to you, Gentle Reader.

The real danger of the assertion that OxyContin is a substitute for heroin is that it increases the likelihood that more people will inject it. Oxy is not an injectable drug, or rather it wasn’t made to be injected.
In December 2002, HRC is holding the biggest conference in the world on harm reduction. It will be over by the time most people read this. More than a thousand people will have come and gone, having attended over 300 presentations and workshops on services, community organizing, drug user rights. Though many of us work in relative isolation in our own communities, the work of harm reduction is happening everywhere! How do you get the word out? Well, our mailing list for this newsletter is now at 10,000 names.

This newsletter is a product of the harm reduction movement. Those of us working on the ground know that at the high levels of funding, law and politics, there is very little going on with harm reduction. The foundation of harm reduction was laid in communities, at the grass roots. What we print comes from people who are living and working on the front lines: drug users and sex workers, incarcerated people, people living with the virus (any or all of them...), and the providers and advocates who are building a community with them. This community is the source for the articles we publish here.

If harm reduction is a part of your life and your well-being, whether as a drug user, a program client, a community member or a professional, your voice can be part of this newsletter. If you haven’t ever written something, why not give it a try? Seriously! Are you a client who is making change at your program? Are you someone who created methods to make life safer and healthier for drug users in your community? Have you created a community? What is your struggle? What is your triumph? That’s what we’re here for.

A lot of what we publish is about programs for drug users and their loved ones, AIDS services, drug treatment, legal advocacy and housing. If you have something about your program you want to share, there is growing list of names your message can go to. But that’s not all. Programs are only part of the picture. Writing requests for articles is tricky, because we don’t want to devalue lifesaving programs, but no matter what is going on with programs, the program only works because drug users come to it and use it. To keep the issues alive, we need both things. We want to hear from programs AND we want to hear from users, active or abstinent, men and women, young and not-so-young, in and out of programs, in or out of the joint, by name or anonymously.

We also take artwork and photography!

Some of the issues we publish have a special angle or topic. Below are requests for articles for two newsletters we are planning. Let them be your inspiration, or go ahead and send us something on a topic you choose. Just remember: this newsletter isn’t written by HRC. It’s written by the people on the ground making harm reduction happen. You are the experts. Represent!

**SPECIAL PRISON ISSUE**

**SUBMISSIONS INFO**

**ABOUT**

For a special issue of Harm Reduction Communication, we are actively seeking essays, interviews, reviews, fiction and poetry, up to 4000 words in length. The focus will be on the drug-user’s experience and knowledge regarding the criminal justice system.

**ISSUE TOPICS**

We invite drug users and others to submit pieces based on experience: personal and political. We are interested in hearing from women and men who have been incarcerated; are incarcerated, on parole, probation, or in some way entangled in the criminal justice system. We’d like to hear from those who work in prison systems as well. Creative and provocative explorations on the prison-industrial complex, drug policy and communities of color, prostitution and the law, coerced drug treatment, realities of life post-incarceration, prison health care, harm reduction behind the wall (and whatever else is on your mind) are encouraged. We are also seeking artwork.

**DEADLINE**

Our deadline for submissions is _________. Do you need technical assistance? We will help. Just email Ellen Miller-Mack and say you need help with an article.

**SEND TO**

Please send your electronic submissions to:

e-mail:  ellenmm@attbi.com with the article (double-spaced, MS Word or Corel WordPerfect file) or artwork (Photoshop, EPS or Quark XPress/Adobe Pagemaker file) as an attachment.

snail mail:  Ellen Miller-Mack  
Brightwood Health Center  
380 Plainfield Street  
Springfield, Ma 01107
Most heroin detox takes place outside of formal settings.

though most people say it doesn’t work very well. Some people have used charcoal capsules to control diarrhea. A doctor may be able to prescribe a prescription-strength anti-diarrhea medication that will work better than the over-the-counter stuff. Also along those lines, adult diapers may be useful. You may be embarrassed to use these, but be aware that you can’t always make it to the toilet when the diarrhea comes.

* Have a bucket, trash can, or other container handy for vomiting.
* Have a warm blanket on hand should you get the chills.
* A cool, wet washcloth or towel will be useful if you feel very hot.
* Plenty of water to drink and Gatorade or some other sports drink with minerals should be on hand. You may not be able to drink much during the most intense period of the detox, but as your symptoms ease, you will need plenty of liquids. Vomiting and diarrhea will make you extremely dehydrated and that can be dangerous.

What about using heroin or methadone up until taking Naltrexone?

Different people have different approaches to this. Of the people I studied, some used heavily up until detoxing, while others did a reduction plan with either heroin or methadone to get their habits down beforehand. It seems that the ones who reduced their habits suffered a little bit less.

Conclusion

In closing, I just want to repeat a few important points. I’m not a medical professional, and I don’t personally recommend this form of detox. It is risky, especially for people in poor health or who have multiple addictions. The risk for overdose after this kind of detox is particularly high.

If you are considering doing rapid opiate detox, it is best to consult a doctor. If that isn’t possible, at least be realistic about your health and the potentially dangerous health risks. And, finally, don’t do this alone.

FOOTNOTES

1. Earlier versions of this paper were presented at the National Harm Reduction meeting in Miami, FL, October, 2000, and the annual meeting of the American Anthropological Association, San Francisco, November 2000.


3. Other opiate antagonists go by the name of Nalorphine and Naloxone, but Naltrexone is the most likely to be encountered on the street.


13. This finding is consistent with other studies that indicate that non-compliance with maintenance programs does not necessarily mean that a patient has relapsed. See Rabinowitz, J., Cohen, H., Tarrasch, R., Kofer, M. (1997). Compliance to naltrexone treatment after ultra-rapid opiate detoxification: An open label naturalistic study. Drug and Alcohol Dependence, 47(2):77-86.


16. One study found that people detoxing from methadone maintenance programs had more withdrawal symptoms under rapid opiate detox than people who were detoxing from other opiates such as heroin, codeine, and morphine. See Hansel, M., Kox, W.J. (2000), note 6.

17. This is the dosage taken by the people I studied. 50 mg tablets seems to be the most common dosage of Naltrexone prescribed for maintenance purposes. I don’t know whether a smaller dose would be sufficient. I also don’t know about using other opiate antagonists in pill or injectable form.
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 como evitarla, y los pasos a tomar que pueden salvarla 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 para 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 11-50 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.

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