REAL HARM REDUCTION: 
Underground Survival Strategies

by Donald Grove

What activists did, in the U.S. and elsewhere, when they established the first needle exchange programs was not so much to invent a novel concept as to give formal structure to a survival technique long used by injection drug users on the underground and among those "in the know." And today, right now, users are practicing forms of harm reduction that are still beyond the ken of the movement. Many aspects of harm reduction require deception on the part of the user, because revealing one's use entails massive social risk. I would contend that every time a user conceals her use in order to avoid losing her family, her home, or her job, that she is practicing harm reduction. Every time a needle exchange program participant ditches a used syringe to avoid arrest rather than bringing it back to the exchange, he is practicing harm reduction. Every time a methadone patient "beats" his urine to stay in the program, he is practicing harm reduction. And every time a dope injector or a pot smoker spends all day traveling around the city in search of good drugs, as inconvenient as this may be, she is practicing a form of harm reduction.

A television program I recently saw about the behavior of whales helped me to this insight. The program described how in the 1950s a marine biologist wrote a ground-breaking book about whale behavior based on several years' observation of the creatures from a boat in the ocean. This book established the dominant paradigm for understanding the behavior of whales for decades, until other researchers noticed that whales are near the surface of the ocean -- where they are observable to humans in boats -- for less than five percent of their lives. Many of the long-held assumptions about whale behavior that were based on the small part of the time they spent near the ocean's surface turned out to be wrong, and marine biologists were forced to re-evaluate their paradigms.

Our culture has developed a paradigm of condemnation as its primary way of understanding illicit drug use and for dealing with drug-related harm. This understanding of drug use is like the ocean that obscured marine biologists' ability to understand whales: just as marine biologists reduced the lives of whales to the sum of the creatures' behavior at the ocean's surface, our response to drug use and drug users is developed solely through the lens of condemnation. Under this scheme, any idea that is tolerant of drug use to even the slightest degree suffers an immediate challenge and dismissal. And just as we wouldn't know about the existence of whales if they always stayed under water, we detect the presence of drug use through behaviors our culture condemns. Concealment of one's drug use thus works to the user's advantage by controlling what other people can see.

Because the popular conception of drug use is so obscured by condemnation, a useful model for harm reduction is unlikely to come from anyone but a user.

Holding the Circle: 
Using a Contract for Group Work with Marginalized Young Adults

by Rod Sorge

There exists among many social service providers the perception that a harm reduction approach to drug use and drug users is one that posits a philosophy of "anything goes." But rules, regulations, policies, guidelines, and whatever else we might call them do, and in fact must, exist in harm reduction programs -- from "return policies" at needle exchange sites to not being allowed to punch your caseworker in the nose to the "absolutely no shooting up in the bathroom" sign one might come across in a harm reduction center storefront. As with any type of

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LETTER FROM THE EDITOR

As we teach harm reduction in our programs and on the street, and practice it in our lives, it becomes clear very quickly that there are not many guideposts out there to help us on our way. Some of us are lucky to have trusted friends and colleagues to whom we can turn for advice or validation; many more of us feel we have none. And in addition to those issues in harm reduction we’d eagerly discuss with someone if we had the chance, there are also those issues we are desperate to talk about because we feel we cannot.

Our goal is to make Harm Reduction Communication a regular and reliable guidepost on what is currently a poorly-marked path. Consistent with the Harm Reduction Coalition’s larger mission of supporting and facilitating harm reduction work, we want this newsletter to be a forum for practical, "how to" harm reduction information and techniques that can be put to immediate use by others — both other practitioners and other drug users; and a place where harm reduction ideas and questions can be aired honestly and openly.

This issue brings us closer to the goal we have set for ourselves. The article on using contracts in harm reduction work, for example, is a direct response to numerous requests for information on this topic received by the HRC office. Those of you who were interested in contracts should let us know if this article is helpful, and those of you who need information on some other issue should contact us and let us know. The other articles in this issue, while perhaps not offering "hands on" advice, are crucial in helping us understand the complex relationship between harm reduction workers and programs, drug users themselves (who may also be workers), and the larger world in which harm reduction takes place. Donald Grote, in his provocative way, reminds us that as workers and programs, our efforts should support — not work against — the harm reduction efforts that drug users already engaged in long before we came on the scene. And Ellen Fishman, Curtis Price, and Alan Greg all point out in different ways that harm reduction is about so much more than "drug policy reform," urging us to connect our movement to a larger, progressive social reform agenda.

We will do our best to make Harm Reduction Communication responsive to the movement’s needs, but we also need your help. As you will see, four out of the five articles are written by people who live in New York City. Unless we are set straight, those of us who live here will continue to think that New York is the center of the universe. Here’s your chance:

The next issue of the newsletter will deal with a topic that cuts across all geographical lines: occupational health for harm reduction workers. As a prelude to the First National Harm Reduction Conference in Oakland this September, where we hope this topic will be discussed in more depth, Harm Reduction Communication’s summer issue will be devoted to raising some of the emotionally painful, often very personal issues around how we take care of ourselves and others that nonetheless have huge implications for the survival of our movement. Occupational health has been one of those subjects I think we have been desperate to talk about but have been too scared to touch. We think the time has come. So please let us hear from you. See page 4 of this issue for a call for submissions to this special Harm Reduction Communication.

Finally, I would like to express my enthusiasm at being named editor of HRC’s newsletter. As someone with a longtime personal and political commitment to harm reduction, I bring with me a perspective developed before there was a harm reduction movement to speak of, but one that has evolved since I’ve been a member of HRC’s Harm Reduction Working Group and in response to all of the incredible work that is now happening — that you are making happen — in this arena. With HRC Program Director Sam Kershmar and Executive Director Allan Clear who are as responsible for the existence of this issue of Harm Reduction Communication as I am, I welcome you to this dispatch from the front lines of the U.S. harm reduction movement.

Rod Sorge

P.S. The next issue of Harm Reduction Communication will most likely be the last HRC will be able to mail out free-of-charge in such large numbers. In order to ensure that you continue to receive the newsletter, please subscribe (see details on page 23 of this issue) or become a member of the Harm Reduction Coalition, one of the benefits of which is a complimentary subscription to Harm Reduction Communication. Please support our work by subscribing today — and subscribe for a friend while you’re at it. Thank you.
HRC: Functions and Services

DEVELOPMENT
- Developing local, regional, and national networks of individuals and agencies working in harm reduction
- Coordinating and organizing local HRC affiliates
- Maintaining a diverse vision of comprehensive harm reduction

EDUCATION
- Creating and disseminating educational materials for drug users, providers, and the general public
- Providing public harm reduction education in the form of regional, local and national conferences, trainings, in-services and forums
- Communicating with the general public, policy makers, politicians, law enforcement, and funders about harm reduction
- Creating and maintaining a harm reduction library and database, including documents, articles, books, audio tapes, and videos

SUPPORT AND ADVOCACY
- Providing technical assistance to agencies and individuals working on harm reduction efforts, in the form of educational and material resources, financial management and support
- Supporting user self-organization and addressing the social and political barriers preventing users from voicing their needs and experiences.

Harm Reduction Coalition welcomes submissions and information in the following areas:

- FEATURE ARTICLES
- TERMS AND DEFINITIONS—with the intent of challenging standard orthodoxy and introducing new concepts and language
- POLICY AND POLITICS—significant events in policy affecting harm reduction theory and practice
- RESEARCH UPDATE—a briefing on significant research being done in the field
- CONFERENCE ANNOUNCEMENT—add conference information to our listings
- ARTS AND CULTURE—review of books, music, art and film which feature, or comment upon, drug use, drug users, or harm reduction
- CALLS FOR SPECIFIC HARM REDUCTION INFORMATION—i.e., info on harm reduction and child abuse, etc.
- TECHNICAL ASSISTANCE—practical information about organizational systems, management and infrastructure
- RESOURCE LISTINGS—on-line information, RFPs, job announcements.

Please call the HRC for more information on submitting articles.

EDITORIAL POLICY
Since a large part of harm reduction is about casting a critical eye toward the thoughts, feelings, and language we have learned to have and use about drugs and drug users, we assume that contributors choose their words as carefully as we would. Therefore, we do not change 'addict' to 'user' and so forth unless we feel that the author truly meant to use a different word, and contributors have last say.
The views of contributors to Harm Reduction Communication do not necessarily reflect those of the editorial staff or the Harm Reduction Coalition.

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

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A Call For Submissions:  
**OCCUPATIONAL HEALTH for HARM REDUCTION WORKERS**

- Why are needle exchange workers od-ing?
- What does it feel like to hide your drug use in a movement where it supposedly doesn't matter if you use or not? What does it feel like be an 'out' user? What would give you more support?
- How does working with people who use drugs all day affect your own drug use?
- What is it like being in recovery and working on the streets where you used to cop each day?
- How does the constant death, illness, and pain that harm reduction workers deal with affect us?

In preparation for the First National Harm Reduction Conference this September in Oakland where we hope occupational health for harm reduction workers will get the discussion it deserves and needs, we would like to put together an issue of *Harm Reduction Communication* that begins to explore this complex terrain. Doing so may be crucial to the survival of our movement.

In addition to addressing some of the issues mentioned above, we would also like submissions on what might be called more "traditional" occupational health issues such as infection control and prevention.

*Because of the nature of some of the topics, anonymous submissions will be considered.*

**Please have all submissions to the editor by June 1, 1996 at:**

*Harm Reduction Communication*  
c/o Rod Sorge, Editor  
526 West 138th Street, #19  
New York, NY 10031  
(212) 501-6146
Putting the Harm in Harm Reduction: Toward A New Social Policy

by Curtis Price

Although what we now call "harm reduction" was originally formulated in response to hepatitis outbreaks among Dutch injection drug users, the emergence of the AIDS epidemic in the early 1980s swiftly validated the tenets of this approach. Several Western European cities established needle exchange programs as a method of preventing the spread of HIV, and needle exchange quickly evolved as the primary, if not exclusive, public policy shift based on harm reduction principles. Logging behind, needle exchange did not "arrive" in the more reactionary social climate of the United States until the late 1980s and did not begin to be recognized as "legitimate" public health until well into the 1990s.

Needle exchange initiatives in the U.S. have so far faced formidable funding, policy, and legal obstacles. Typically, exchanges survive on shoe-string budgets and the copious use of volunteers; many began or still operate illegally. What activists once strategized as an interim step in the process of securing widespread, well-funded harm reduction initiatives -- setting up programs outside of official channels to demonstrate that they work, thereby causing bureaucratic and political roadblocks to needle exchange to disappear -- has instead veered dangerously close to becoming the permanent status quo. Most needle exchange programs are still poorly-funded and survive on the energy and dedication of a small core of unpaid workers. In fact, it often appears that state and local health departments are only too willing to let this status quo continue, reaping the benefits of needle exchange while steering clear of political controversy and fiscal responsibility. As a result, needle exchange advocates across the country still spend significant time and energy challenging this existing state of affairs at the most basic level. In city after city, activists are forced to "reinvent the wheel" by demonstrating the validity of needle exchange in their particular locale, reducing harm reduction to a narrow public health issue.

But a larger question remains: what does "harm reduction" mean in the context of the social and economic conditions of the United States? I would argue that models of harm reduction as developed in Europe cannot be imported here unchanged, and that to be truly successful in the U.S. the term 'harm reduction' itself must be expanded beyond its current apolitical public health focus.

The European harm reduction model was predicated, though perhaps not explicitly or consciously, on the existence of a strong welfare state. Harm reduction could be more easily applied in a country where people's basic needs -- such as an adequate income and accessible health care -- were met at an acceptable minimum level, and in a society with a strong political commitment to egalitarianism across the traditional political spectrum. This is not to say that every or even any European country meets the needs of every one of its citizens. But to be an unemployed heroin user in Amsterdam with a minimum monthly income of 25,000 Dutch guilders; to be housed in subsidized housing; and free health care is to be worlds away from an inner-city, very possibly homeless, heroin user with no income or health care in a decaying U.S. city. In fact, it is debatable whether the same concept of "reducing harm" can be appropriately applied in both of these cases without a significant expansion in meaning to encompass two radically different life situations and social contexts.

Ironically, public health policy and research paradigms have played a major role in limiting our conception of harm reduction. Part of the reason lies in the perception that public health, epidemiology, and related disciplines are, as all "good science" should be, politically neutral and concerned only with the abstract common good. But public health is and will continue to be shaped, as it has since its inception, by the larger political and economic priorities of the culture that supports it. This was true of public health a hundred years ago, when the growth of poor urban populations forced the state to pay attention to issues of sanitation and disease; and it is also true of public health today, when research grants are doled out to study AIDS and drug use while avoiding any discussion of the gross social and economic inequalities that exist between different U.S. populations. Because of its overwhelming dependence on the state, public health will probably never willingly assume this role, whatever the personal opinions of individual researchers may be.

This role must be played by harm reduction activists who are not tied to the state or mainstream institutions with an investment in the status quo. And people must roll up their sleeves and get involved in projects and issues beyond the usual needle exchanges and condom distributions. As worthwhile and important as these activities may be, they are not enough. Of course, bringing in "outside" issues, especially overly political ones, may result in some polarization within the harm reduction movement (as it did in the AIDS activist movement earlier in the decade). But doing so highlights the fact that "neutrality" is also a political position, one that for better or for worse accepts existing social and political arrangements. Such analysis should not be feared but welcomed, particularly if it leads to some clarification about the roles of both the harm reduction and drug policy reform movements.

When growing numbers of people are being marginalized and written off; as all pretense of a safety net is being scrapped; and as a whole litany of social problems -- from homelessness to mind-boggling incarceration rates -- are increasing in scope and severity, do not walk away after exchanging syringes. Get involved, discuss, and organize around these issues of growing misery and alienation with the people you serve on the street corners. You need to encourage and allow your program to become a hub of organizing activity for those who use it. It will make any harm reduction activity you do more effective and more meaningful.

Curtis Price is the Coordinator of STREET VOICE in Baltimore, on line at cans@igc.wtc.org.
Although the user's voice is the only voice capable of identifying the full extent of the damage created by current drug policy, it is also the voice given the least attention or credibility. Users are not generally heard if they cite their criminal record as an example of drug-related harm. Even HIV prevention is not understood as a social responsibility involving every single member of a community, but rather is seen as solely the responsibility of the user. Providers often ask, 'What role does the user have in harm reduction?' but posing such a question implies that harm reduction is something created away from drug users and then applied to them, and in fact many needle exchange programs are set up this way. Just as they are at the mercy of drug dealers, users must come to the programs on the programs' terms. This often is the context we create when we approach users to inquire about their needs, giving them no reason to trust us or our inquiries. You say you want to reduce harm, but you don't want to know about the harms you empower law enforcement or drug treatment programs or service providers to inflict.

The only way to hear the user's voice is to allow users to name the issues.

AIDS is a very hard reality for many heroin injectors, but so is the abysmal quality of the dope currently available in New York City. Some service providers understand that the quality of drugs is an urgent public health issue, but it is more than a health issue if you are dopesick and down to your last ten dollars. Public health is a convenient moral high ground, but most people do not live their lives or pursue their interests in order to fulfill an agenda of hygiene, prevention, and managed care.

The Big Three: Dope, dope & dope

My experience working with daily cocaine and heroin users has taught me there are three major day-to-day priorities for this population: quality of drugs, availability of drugs, and money for drugs. The quality and availability of a drug can determine whether a user is sick or well, and can even have life-and-death consequences. But while poison and law enforcement are serious threats, by far the biggest problem for users is the expense of their drugs. Despite their primacy in the lives of users, these issues are addressed only minimally, if at all, by harm reduction programs that focus on HIV prevention.

The user's experience should form the basis for all harm reduction. The user is the only person who knows why she uses, and ultimately decides when and how she will use. Users are intimately familiar with the problems associated with their use, but they are also intimately familiar with the benefits: the reason(s) they keep using. Most of all, they are familiar with the sheer normality of their use.

When not being subjected to the threat of imprisonment or the loss of their home or family, users turn out to be just like everyone else, and they love to talk about their lives and the things which matter to them. Many don't see their drug use as a component of their identity. Some are excited by their use, and others want to stop. But there is unanimous agreement among users about the importance of getting good drugs and avoiding law enforcement. Both of these user priorities are viewed by the public as pathological behaviors brought on by drug use rather than common sense -- something which drug users are not supposed to have. I don't mean to say that a person who doesn't use drugs can't make a difference. I mean that users by necessity are considering many more risks than simply whether they will get HIV from someone else's set, or whether they can get ibogaine. So think about it: can someone use what I offer them? Do I give users room to tell me if they can't? What are their priorities?

For heroin users, so much of the harm they face has nothing to do with clean syringes and everything to do with withdrawal, and people have very different strategies for coping. One woman I recently spoke with explained why she used so much heroin each day -- usually
The War on Drugs: Who says it is about winning or losing?

by Alan Greig

"The war on drugs is lost -- kill it," blared a recent cover of the National Review. In these Dole-ful times, the prominence given to drug policy reform by this libertarian mag may appear to be encouraging, but we should not be misled.

The drug war is a real war, and we in the harm reduction movement all have knowledge, and sometimes direct experience, of the "casualties" this war has produced. The "war is lost" theme has attracted a flurry of media attention lately with, in addition to the special National Review issue, a cover story in New York magazine and pieces on radio and television all arguing that the costs of the present drug policy outweigh the benefits to society. To those with jobs and jihads to pursue, however, this utilitarian calculus smacks of appeasement and resignation. For them, la lucha must continue, and so the prison camps keep getting built and military-style police offensives continue to be mounted.

But is winning or losing the real issue? The metaphors of war distract us from the realities of class and race; of poverty and disadvantage; of Third World communities in the midst of first world prosperity; and of social exclusion and isolation. In order to understand the way the War on Drugs has distorted the terms of the debate about drug-related harm, consider this passage from the recent New York magazine article arguing in favor of drug legalization:

It is easy to demonize junkies... They lie, steal, abuse their children, and sell themselves. I'm being purposely hyperbolic, but in the current full-throttle political backlash against the downtrodden, it's hard to generate any sympathy for drug abusers. Still, one can apply a kind of cold contemporary calculus to the drug war: Win it or end it.

But who says that it is sympathy that is required? And isn't the "current full-throttle political backlash" against the poor what this article should be addressing rather than the ease of demonizing drug users (as if anyone needed any help with that)? The War on Drugs debate isolates drug policy reform from wider issues of social policy reform, as if the two were somehow unconnected. We need to step out of that debate to ensure that harm reduction is not equated with losing the War on Drugs and to make explicit the connections between harm reduction and other movements for social change.

In so doing, we place people at the center of the analysis rather than at its margins, where they serve as objects of sympathy or stigma. Harm reduction services primarily deal with people and work in communities experiencing multiple social traumas. The drug users for whom harm reduction services are designed are not the snorters or chasers of the Beltway, ecstatic psychotherapists, or toking and tripping drug policy seminarists. They are the people bearing the brunt of the full-throttle political backlash. If there is a fight to win, it is to reverse this backlash.

Alan Greig is a freelance consultant on HIV and drugs issues and is a volunteer with the Harm Reduction Coalition in New York City.
three to five bags at a time, three to four times a day. She told me that she often cops five bags at a time because she knows a few will be good and a few will be beat, or mostly cut, and this way she gets straight and gets high. When I asked her why she didn’t just cop all the drugs she needed once a day, I assumed the answer would be that she didn’t want to carry around that much at once. But her reply was that as a sex worker, she preferred to cop and use after each date because going right from one date to another and making all her money at once is very stressful. Another problem is that if you cop several times in one night, you aren’t going to be able to use the same source each time and therefore won’t know what you’re getting each time. On the other hand, if you buy all your drugs at once from one person, you may get ripped off on a large scale. This woman has worked out how to get what she needs given the unreliable quality of drugs and the nature of how she earns her money. She is practicing harm reduction.

These are the real “givens.” If there is something you would like to change about how someone injects, you must recognize how the act of injection fits into that person’s larger concerns of earning money, coping, and using. If you want to change something about how someone cops, you must recognize how copping is related to that person’s need to get straight but also to get high. Each of these activities has its own harms with which each user copes and constantly tries to minimize. Real harm reduction in America today must be about how to get one’s money and drugs as much as HIV prevention.

Seeing the Forest through the Trees

Most needle exchange programs actually provide a valuable service to users beyond sterile injection equipment. They serve as sites of informal (and increasingly formal) organizing and coming together. A user might be able to do the networking needed to find good drugs in the half an hour he spends at a street-based needle exchange site -- networking that might otherwise have taken half a day.

Drug users are already organized on a lot of levels. The shooting gallery is one common form of user-based organization that promotes harm reduction. Many people think of this as part of the horrible underworld of drug use, but gallery owners provide a valuable service by giving a user a place to inject which isn’t an alley or a doorway, and where they don’t have to hurry. This is harm reduction, even if it was done exclusively by users without talking to any “experts.”

Harm reduction is also being practiced through the unstructured use of methadone as a day-to-day alternative to heroin. While not legally available to users unless they are a patient of an authorized clinic, there is an underground system for obtaining methadone that most commonly revolves around the sale of weekend pick-ups. Lovers, spouses, family members, and friends often share a single methadone prescription. Say what you will about methadone, but people want it and use it. A vast and complex web of pharmaceutical companies, hospitals, drug treatment agencies, public entitlement systems, community-based organizations, and legislators have all conspired to define the purpose and control the use of methadone, but once again, users have found what they needed and are practicing harm reduction whether we know it or not.

It may not be very glamorous or official looking, but harm reduction is being practiced and many users are already organized around their day-to-day needs. And when it works well, there’s nothing sweeter, but many users still have a hard time getting their needs met through connections that are often risky, precarious, and transient and a system that is far from foolproof. So, if service providers identify drug-related harms like HIV, they shouldn’t just identify users’ social networks as a potential mechanism for behavior change but actually facilitate them. Help users organize buyers’ groups. Publish information on where the good drugs are. Make all the day-to-day needs of users into common points of public dialogue.

It will be impossible to get any extensive user-based harm reduction going unless it comes out of what already exists out there on the street. What already exists is based on the genuine, normal, day-to-day issues of use, which is where most people are. Users are already using harm reduction, but we don’t necessarily want to know about it because it involves drug sales and getting high or beating a methadone program, instead of hygiene or political campaigning. Users are already doing what they can with what they have to reduce drug-related harm in their lives, based on their very real needs in a hostile environment. We need to make sure they can talk about how they are using, and not just how they ought to be using, in order to help people make this transition. Their voice has been there all along, naming the problems, naming the harms. Are we truly willing to listen?

Donald Grove is a needle exchange activist with the Lower East Side Harm Reduction Center and Needle Exchange Program in New York City. This article is based on a presentation given at the Harm Reduction Coalition’s “Sex, Drugs, and Harm Reduction” Conference in New York City in June 1995.
Membership:

(Subscription Form on page 23)

Purpose:
To demonstrate support for harm reduction and the Harm Reduction Coalition, to network with other people in the field, and to develop ongoing systems of support for harm reduction practice, policy and philosophy in your work.

Basic Benefits:
- membership card
- newsletter subscription
- discounts at conferences and trainings, including the upcoming national conference
- discounts on educational and training materials and merchandise

Fees:
$25 - Individual memberships
Agency memberships begin at $40
$50 or more - Benefits & National Conference T-shirt
$100 or more - Benefits, National Conference T-shirt & Special Edition Poster

Affiliates:

Purpose:
The purpose of the affiliates will be to provide support, networking, organizing, and education to individuals and agencies practicing or interested in harm reduction.

The functions of the affiliates will include:
- participation in harm reduction trainings
- coordinating harm reduction training and in-services to health workers and service providers throughout its particular region
- supporting people in integrating harm reduction into their work and agency
- providing harm reduction information—practical and theoretical—to service providers, drug users, communities and the general public
- participating in the planning and curriculum for national harm reduction conferences
- coordinating local harm reduction community meetings
- providing input into the Harm Reduction Coalition and the national Harm Reduction Working Group’s agenda for its national work and bringing that work to your region

Form:
Affiliates can take many forms. Below are examples of current and in-progress affiliates:

- **Regional working groups**: these have been started in various cities to create an umbrella organization to coordinate harm reduction in large cities or regions and potentially represent smaller affiliates within the locale.

- **By institution or agency**: these have developed in order to establish harm reduction policies and services within specific institutions or agencies (i.e., hospitals, drug treatment programs, health clinics, etc.)

- **By discipline**: these are designed to address and develop harm reduction practice and discourse within various fields (i.e., mental health professionals, legal defense, medical doctors, art and culture, nurses, etc.)

- **By representation**: coordinated to address harm reduction issues in particular populations (i.e., parents, youth, the black community, the Latino community, women, drug users, etc.)

Qualifications:
- Attendance at and/or coordination of 2 hours of harm reduction training for the affiliate
- Participation in working group meetings and activities
- Adoption of charter similar in content to the national working group charter

Please contact HRC for further information: 510-444-6969
A TRIBUTE TO JOHN K. WATTERS

AIDS researchers, harm reductionists and drug users everywhere have lost a relentless ally and formidable Bad Boy in the fight against HIV. John Watters died on November 20, 1995. He was 47 years old.

A distinguished maverick in AIDS prevention and research, John was one of the creators of community-based outreach, which became the national model for AIDS education and prevention among drug users. John conducted the first evaluations of street-based outreach and bleach distribution, debunking the myth that drug users would not take rational steps to protect themselves from disease. Back in 1985, long before Bleachman was born, he assigned me the task of finding a safe container for bleach that people could discreetly carry in their pockets. John went on to establish the first and longest-running street-based study of injection drug users, breaking the mold of traditional research by accessing drug users in their own communities — not at drug treatment programs. The Urban Health Study now sees over 1,500 drug users a year in six different communities.

John was notoriously intolerant of bureaucracies and bureaucrats and pretty much set the standard for creative disobedience and "pushing the envelope." There were two credos John taught us to work by: (1) It is better to beg forgiveness than to ask permission; and (2) Never confuse getting the money with doing the work.

John began studying Syringe Exchange back when it was illegal to do so, getting independent funding from AmFar and sharing it 50-50 with Prevention Point San Francisco. He is responsible for some of the best research proving the effectiveness of syringe exchange, including a landmark study published in JAMA in 1994. He also gave pivotal expert testimony in several needle exchange trials, submitted to dozens of press interviews and repeatedly called government officials on the carpet for not supporting these life-saving programs.

The circumstances of John's death are unclear. The coroner called it an accidental overdose, whether of prescribed or street drugs he couldn't say (although the press predictably jumped to the most "iconic" conclusion). To those of us who loved and admired John, the cause of death is immaterial compared to the magnitude of our loss. May his life inspire us to become fiercer and more creative in combating prejudice and inequity, and in fighting the good fight.

Postscript: Rumors that John was an ardently devoted father and that caring for his son Jake was the most important thing in the world to him, are all true.

-- Jennifer Lovick, Urban Health Study, San Francisco

BRIAN WEIL, 1954 ~ 1996

Brian Weil, an avant-garde iconoclast of the harm reduction movement and a photographer whose work took AIDS out of the shadows and into the mainstream, died in early February at his home in New York City. He was 41.

Weil's initial involvement with AIDS came in 1985 when he entered the "buddy" program of New York City's Gay Men's Health Crisis. In that context, he worked with a young HIV-affected family, and the relationship led to his first photographs of people struck by the epidemic.

He joined ACT UP/New York in the late 1980s, and in 1990 was one of a small group of activists who formed the Bronx-Harlem Needle Exchange Program. Bronx-Harlem was an illegal, underground operation at its inception, and during the guerrilla era, Weil and others were repeatedly arrested and jailed for distributing clean equipment to New York's large population of impoverished and disenfranchised inner-city drug users.

After working with Bronx-Harlem for five years, and ever frustrated by witnessing the unmet needs of injecting drug users — and in particular, those suffering from AIDS — Weil set out on his own and formed CitiWide Needle Exchange. Operating as a program of La Resurrección United Methodist Church, a tiny Latino congregation in the Bronx, CitiWide took needle exchange and harm reduction education directly to users in shooting galleries and New York City's single room occupancy (SRO) hotels, which now house in often dreadful conditions thousands of indigent people with AIDS.

CitiWide received a New York State syringe law waiver about three months before Weil's death.

"AIDS is something — like it or not, no matter how difficult it is — that we all have to deal with. It's here, and no matter where you go, there is no place on the planet where you can run away from it. So confronting and dealing with it is empowerment. Running away from it is not the solution."

Weil issued that warning in a 1991 interview that accompanied an exhibition of his work organized by the International Center for Photography (ICP), where he had also taught since 1988. The exhibition traveled to more than a dozen sites, and was the subject of a book, Every 17 Seconds (Aperture, 1992).

Weil is survived by his mother, Paula, of San Francisco; his father and stepmother, Jack and Marilyn Weil of Chicago; a sister, Nina, of Portland, OR; and two brothers, Kenneth of Denver, and Daniel of San Francisco.

-- Stephen Arrendell, New York City
**REMEMBERING GEORGE WILLIAMS...**

Born June 16, 1940 in Memphis, Tennessee to Mr. and Mrs. C. Dell Williams, George died peacefully in his sleep of natural causes on Thursday, February 15, 1996. George Williams was an AIDS prevention activist from early in the HIV epidemic in San Francisco and later in Chicago. He was a Community Health Outreach Worker (CHOW) in San Francisco where street-level HIV prevention outreach to injection drug users was first practiced. He returned to his native Chicago in 1987 and immediately began some of the first outreach to injection drug users in Chicago with the University of Illinois. George also worked for several years as a case manager for Erie Family Health Center, helping people with AIDS receive needed services and improve their quality of life.

In 1991, George founded the Chicago Recovery Alliance (CRA), an HIV prevention agency dedicated to reducing harm among drug users. CRA grew from one site of syringe exchange in January 1992 to its present 15 sites which now serve over 700 injectors and exchange more than 30,000 syringes a week. He worked for CRA at the time of his death, helping drug users avoid HIV seven days a week. Known for his hugs, George was frequently featured in the news and was a common sight at the Cook County Jail, drug treatment programs, and other social service agencies discussing HIV and training staff in HIV prevention outreach.

He leaves to mourn him his five children, his mother Pearl Mae, three brothers and two sisters, and a host of relatives and friends.

-- Dan Bigg, Chicago Recovery Alliance

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**MICHAEL LINKS**

Michael Links, who was a peer HIV/AIDS and harm reduction educator and outreach worker for the New York Peer AIDS Education Coalition and an outreach worker for the Lower East Side Harm Reduction Center/Community Family Planning Council youth project, will never be forgotten. He died December 23, 1995, suddenly and unexpectedly. Everyone knew Miss Tilling. He was on the board of Planned Parenthood, on Streetwork Projects Harm Reduction Advisory Board, a health department-certified HIV pre-and post-test counselor, and so much more.

Michael was full of a joyful energy, a natural curiosity and wonder, and a knowing innocence. He truly understood harm reduction as few people do — he taught it, he counseled it, he advocated for it, and he lived it.

Although it might sound corny or cliched, Michael brightened the lives of all the people he came in contact with. He had great compassion for those in pain, those ill, those broke, those homeless, those unloved. He understood entitlements and concrete services better than most social workers. He knew how to work the system for himself and for others.

Michael, we all miss you and feel you are still, and always will be, with us.

-- Edith Springer, Clinical Director
New York Peer AIDS Education Coalition, Inc.

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**In Loving Memory**

"better to hate than grieve. I sing in praise of hate and all its attendant energy. I sing a hymn to the death of love."

Matthew Bowman

April 18, 1970 – December 27th, 1995
The First National Harm Reduction Conference
Oakland, CA
September 18-21, 1996
Strategies Training Community Organizing Compassion Safer Sex Activism Support Alliances Respect Tools Safer Drug Use Sterile Injecting Equipment Information Discussion Exchange

The conference will support the expansion of the harm reduction movement in the United States and the development of strategies that reduce drug-related damage by giving service providers and people who use drugs with the tools they need to reduce the harm done to themselves and their communities.

The conference will encompass:
- Harm reduction practice: providing direct services to diverse populations including treatment, medical, social, health, HIV/AIDS and sterile equipment
- Putting in place harm reduction programs: issues surrounding starting new programs and incorporating harm reduction into existing programs
- Organizing communities: advocacy at the community level and involving the community in developing harm reduction strategies
- Networking: providing opportunities for service providers, outreach workers, active users, communities, and others to develop relationships and collaborations with other individuals and agencies working in the field or affected by drug use
- Harm reduction policy: history, politics, philosophy, ethics and theory
- Organizing user groups: getting users organized for peer education, politics and to inform policy development
- Expanding harm reduction beyond drugs, e.g., mental health, chronic illness, violence and abuse
- Intensive workshops: there will be a variety of intensive workshops offered on September 17 including but not limited to: 12-step and Harm Reduction, Harm Reduction 101, a Harm Reduction Approach to Domestic and Sexual Violence, Harm Reduction as Clinical Practice, Harm Reduction and Communities of Color

Location: The conference will take place at the Parc Oakland Hotel and Convention Center, centrally located in the heart of the San Francisco Bay Area, in a convenient downtown location, with easy access to San Francisco by public transportation in 12 minutes.

For more information and/or to receive a registration packet, please contact the Harm Reduction Coalition at (510) 444-6969 Ext.16
The contract is both a work agreement and a therapeutic tool.

Continued from page 1 Holding The Circle

Program, operational policies and procedures are necessary for the efficient delivery of services and in order to create an atmosphere in which everyone, participants and staff alike, feels safe and treated fairly. In short, rules and policies are necessary for the continued survival of the agency providing the service. What is distinctive about a harm reduction approach to service provision and policy, however, is that the rule-making process is as important as the rules and policies that result from that process.

At the New York Peer AIDS Education Coalition (NYPAEC) – a peer-driven HIV prevention and drug education outreach project that targets "street youth" – staff negotiate a written contract with the program’s adolescent and young adult peer health educators as the primary mechanism for setting policy. This article will briefly outline some of the nuts-and-bolts issues I have encountered as a group co-facilitator in using a contract as a policymaking tool, and show how this method of rulemaking is consistent with a harm reduction approach.

Because NYPAEC is a peer education project, our peer educators largely reflect the population the organization attempts to reach. Thus, many are homeless or unstably housed; use illicit drugs heavily and sometimes chaotically, especially crack; sell sex or drugs or engage in some other illegal activity to survive. Most left or were forced to leave their families of origin at a very young age, often because they were gay, lesbian, bisexual, and/or transgendered, and many are survivors of past emotional, physical, or sexual traumas. About half are also HIV+.

The peer educators are workers (but not employees) at NYPAEC since it is they who provide all of the organization’s outreach services in return for which they are paid a small weekly stipend. At the same time, because they typically have numerous immediate survival needs of their own, the peer educators also require (and receive) a lot of support from NYPAEC to help them do their outreach work effectively. In this sense they are recipients of services, mostly in the form of group counseling and therapy. The idea to use a contract grew out of NYPAEC’s dual need to (a) delineate some working standards for the peer educators in terms of providing quality outreach and recording data about it for funding and evaluation purposes; and (b) deal with the fact that the peer educators had a lot of their own needs which had the potential to conflict with their ability to do this work. Traditional service providers might view our peer educators as the classic "non-compliant" population; we view our peer educators as the only population able and willing to provide truly relevant and credible health information to other young sex workers, crack smokers, and homeless youth. The use of a contract allowed our project to establish some expectations around work while also giving the peer educators genuine control over their working conditions and empowering them to be able to take care of business. The contract is both a work agreement and a therapeutic tool.

How It Works

NYPAEC staff and peer educators negotiate their contract once a year. When NYPAEC was a tiny pilot project with seven or eight peer educators, two or three volunteer staff members, and borrowed space in a church basement, the whole group participated in hammering out the agreement. Now that we have two teams of 10 peer educators each, are recruiting a third 10-member team, and have a somewhat larger staff, each team of peer educators elects representatives to negotiate the contract on the group’s behalf – a process which requires the peer educators to put a great deal of trust in their negotiator and demands cooperation between all of the group’s members. Each team then discusses (with staff absent, if requested) what items it wants to bring to the table and charges its representatives with carrying them out.

After negotiations are complete and the final document is typed up, each peer educator signs his or her own copy of the contract which is counter-signed by a staff person, a tangible way for the staff to demonstrate that they also have a commitment to abide by and uphold the agreement. Finally, the contract is read aloud in each group so that those with literacy problems can be included with-out embarrassment, and to ensure that there is agreement of interpretation to prevent misunderstandings and confusion down the road. The negotiation, signing, counter-signing, and reading of the contract is a collective ritual that imbues the contract with authority.

What Goes In

The items in NYPAEC’s contract cover several areas: the work-related responsibilities peer educators must fulfill each week in order to receive their stipend (e.g., minimum number of outreach contacts to be made, turning in proper documentation of one’s work, and attending required supervision and support meetings); the work-related rights peer educators enjoy (e.g., the number of paid personal and late days the peer educators can take each year); and the way in which peer educators agree to comport themselves while “on the job” and in group with each other (e.g., maintaining the confidentiality of outreach contacts, not coming to group so high that meaningful participation is impossible).

Each rule spelled out in the contract is designed with one principle in mind: to foster participation and success in NYPAEC activities instead of promoting exclusion from them. Because the

It is important to point out that the contract as we use it works as well as it does because of our program’s overall commitment to and application of a harm reduction philosophy.
Drug use fades away as a non-issue instead of being problematized, and as a result it is extremely rare that a peer educator will come to group too high to participate.

Policies are crafted with the peer educators in mind—they are tailored to the exigencies of real-life situations. So instead of saying "drugs and weapons are not allowed in the office"—an unrealistic requirement for most of our peer educators—the contract reads "I agree not to display weapons or drugs at NYPAC meetings." Along these same lines, the contract does not attempt to set a drug-free workplace policy. Instead, it addresses drug use in terms of a peer educator's ability to function: we don't care if a peer educator has drugs in her body as long as she can participate appropriately in a group meeting without being disruptive or nodding off. Drug use fades away as a non-issue instead of being problematized, and as a result it is extremely rare that a peer educator will come to group too high to participate.

What Comes Out

We have experienced a number of benefits from using a contract at NYPAC. First, it helps get issues that could easily sidetrack the group out of the way at the beginning so that the outreach team can focus on more important work. Being clear about issues such as how late a peer educator can come to a meeting and still get paid prevents our groups from having to deal with this issue over and over. Items that at first may seem too mundane to put into the contract may in fact not be. While you do not want to create a long, laborious document, it is wise to have the group brainstorm about issues that have the potential to cause turmoil and figure out collective solutions to them at the beginning. In doing so, issues of justice and equality that understandably loom large for our peer educators (and others who are marginalized by mainstream culture) are addressed, and each participant is assured that they are being treated the same as everyone else. At the same time, the contract provides a rulemaking structure exterior to staff members' relationships with the peer educators (and peer educators' relationships with each other), leaving room for a therapeutic relationship to develop that is unencumbered by these types of concerns.

Secondly, the contract serves to minimize the traditional power imbalances between staff and "clients," or in this case the peer educators. Just as constructing the contract is a group process in which each "side" has equal power, the group also has collective responsibility for enforcing the contract. In the traditional social service model, staff always hold the power to make decisions for or apply rules to clients. At NYPAC, the contract—not any individual or class of individuals—is invested with this power, and the peer educators retain as much authority as staff in carrying it out. Because "clients" are so used to being told what to do or "what the policy is," at first we found that the peer educators would automatically turn to staff when a conflict or controversy arose. Staff refused to take decision-making power away from the group, and instead would focus the group's attention back onto the contract. The contract is useful in getting a group to govern itself instead of relying on or expecting direction from staff. On the other hand,

make a unilateral decision. The reply of a NYPAC staff person might be, "It's not up to me to make that decision," or "I don't have the power to make an exception for you." Sometimes it may seem easier for a staff person just to make a decision, and if an issue appears intractable enough to the group, the peer educators may implore the staff to "lay down the law." But we have found that if staff begin to make exceptions to the contract, peer educators lose both the belief that the contract will be consistently enforced in the future as well as the sense that they have the power and responsibility to enforce it. If an exception to the contract is to be made for any individual for whatever reason, the decision to do so should be made by the group. We have found that if the contract is consistently enforced, using a group process, the peer educators rarely breach it. The contract is our way of "holding the circle" that is our group, enabling us to do the important work that brought us together in the first place.

The Contract as Teaching Tool

The use of a contract is consistent with NYPAC's mission of helping its peer educators develop skills to better manage their drug use, conflict, and their lives in general. Through the act of creating the contract, peer educators learn how to negotiate and compromise, persuasively argue their positions, work with one another toward a common end.

see next page
mediate conflict without resorting to violence, and subjugate one's own desires to the desires of the group as a whole—skills that are frequently in short supply on the street. The peer educators also learn to postpone gratification long enough to sit through a meeting not stoned, and to take care of business before getting high. It is not NYPACEC's goal to entice its peer educators to square up and become members of straight society. But the skills peer educators absorb through the process of negotiating the contract in particular, and through their participation in NYPACEC's group experience in general, can help them manage some life situations more successfully. If a peer educator can learn to not come to group high, she can also learn not to go to her welfare face-to-face high. Interpersonal relationships may not involve as much violence in the future.

We have seen this skill development among those peer educators who have been with our organization for several years. NYPACEC's first contract was a modest document with only five items, but it took several months to negotiate. The peer educators had no idea how to go about it and would either refuse to compromise at any level or would throw up their hands in frustration and say "Fine, have it your way!" The staff refused to "have it our way," and instead worked with the group a little each week until a contract that was mutually agreeable to everyone was finally reached. This past year, NYPACEC's contract was several pages long and significantly more complex, reflecting the organization's transition from a tiny pilot program to an agency with its own office and expanded roles for the peer educators. Despite the more complicated delegate negotiation process, the contract was completed after only several short meetings. The peer educators' degree of sophistication in achieving their contract goals was impressive.

**Context Counts**

There is perhaps nothing inherently liberating or empowering about the contract as a form of human organization or communication. It is important to point out the contract as we use it at NYPACEC works as well as it does because of our program's overall commitment to and application of a harm reduction philosophy. The organization in general employs a non-hierarchical, feminist-inspired approach to governance, and support groups operate on a consensus model of decision-making. For a contract to actually have the effects I described, power-sharing is essential. Negotiation is by definition a two-way street and staff must be genuinely willing to listen and to compromise at the bargaining table. If not, the result is frequently an arbitrary and unrealistic set of rules which, when disobeyed or not followed successfully by those for whom they were designed, cause staff to see the rule-breakers as having problems of "discipline" or "motivation." It is okay to have some "non-negotiables" (one of ours is that violence against another peer educator or staff member is grounds for termination from the program). However, staff should then expect that peer educators will also have some non-negotiables, and a discussion should take place about these issues. If no violence is a non-negotiable policy, then the responsibility to prevent it falls on each group member to ensure that no one gets thrown out. If that means picking someone up and carrying them to the other side of the room until they cool off, so be it.

In addition, enforcement of the contract is done in a way that does not cause shame or embarrassment, or scare the person who breached it from returning. If someone comes to group too high, we might say, "It was obviously more important for you to get high tonight than to come to group, and that is totally okay! Go enjoy your high, and we'll see you next week."

Using a harm reduction approach does not mean having no expectations—or even high expectations—of the people who use your services. Rather, it is about constructing those expectations in a realistic and mutual way. A contract is one useful tool for operationalizing this principle.

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Rod Serge is a volunteer group co-facilitator at NYPACEC and the organization's former Administrative Director. Rod is also the editor of Harm Reduction Communication and a member of HRC's National Harm Reduction Working Group. The author would like to thank fellow group co-facilitator Kelly McGown and NYPACEC Founder and Clinical Director Edith Springer, MSW, for their comments on an earlier draft of this article and their continuing insight and inspiration.
by Ellen Fishman

Historically, discussions about drug policy -- in both the legal and medical treatment areas -- have neglected to include drug users themselves in any part of the dialogue. This glaring omission hit home to me as I listened to friends talk excitedly about how much they had learned at the Drug Policy Foundation's annual conference in Washington, D.C. in November 1994. I realized that critical discussions and decisions concerning drug use were being made without any input from the very people whose lives would be most affected: users themselves. It became clear to me then that users could complain to each other ad infinitum about how unjust the life of the user was, but that this would not change anything. Change that truly benefits users will come about only when users themselves insist on being involved in the dialogue at all levels -- and couple that with action.

Toward this end, the users' union ICARE (the International Coalition for Addicts' Resources and Enlightenment) was created. We are both advocates for the progressive reform of drug policies and laws, and activists who have established a self-help network for the using community. We hold our meetings in the Lower East Side Needle Exchange Program's storefront in New York City, and thus have daily, direct access to drug injectors. Our location gives us immediate and intimate contact with the needs and desires of the injection drug using community, as does our interaction with other programs similar to our own. For example, ICARE and JUSTUS (a users' union run out of St. Ann's Corner for Harm Reduction in the Bronx) have been collecting reports from users who were harassed by the police for having injection equipment they were legally allowed to possess and then acting as go-betweens for the complainers with local precincts in an effort to stop this harassment.

The most pervasive and popular view of illicit drug use and users -- internalized even by addicts -- is the familiar "gutter junkie" model which presents all users as dirty, unkempt, feebly-minded, unemployable individuals who are no good to themselves or their communities and who would hit you over the head and steal your money the moment your back was turned. This stereotype is just that -- a stereotype -- and the members of ICARE are determined to make this known. There are as many different kinds of drug users as there are people in any other arena of life. If you are an immoral person to begin with, chances are you are going to be an immoral drug user. On the other hand, if you have respect for yourself and others, you will carry this behavior over to your drug use as well. Some of us have never stolen or cheated to get drugs, but our stories do not make for good headlines or serve as ideal examples of the evils of drugs.

If the picture our society has of the drug-using population is so incorrect, how can we possibly establish sound public health policy or deal effectively with drug-related harm? It is equally important for users themselves to understand this and realize that they have a stake in speaking out about their needs to the people and institutions that create and effectuate policy. The time for telling war stories in back rooms and letting it go at that is over.

It is sad that it took a tragedy such as the AIDS epidemic for needle exchange to become a reality, especially when we have known for years about other blood-borne diseases, such as hepatitis, that can be transmitted through the use of unsterile injection equipment. The United States has lagged far behind other countries in taking a harm reduction approach to anything, even though this is often the most cost-effective -- not to mention most ethical -- approach to a problem. Spending a few cents to supply a clean syringe can save the government tens of thousands of dollars to treat a person who has contracted HIV. One of ICARE's "actions" is collecting petition signatures in support of New York State Senate bill number 02810, which would decriminalize the possession and distribution of needles and syringes.

In our country, moral judgment often takes precedence over common sense -- judgment that expresses itself particularly vehemently when it comes to the subject of injection drug users and which blinds policy makers to even considering options other than prohibition, treatment, and incarceration. But it is not just a narrow notion of what constitutes morality that prevents the development of truly
inclusive programs for drug users, programs that take into account the user’s myriad needs, including the need to be creatively satisfied, to have an interesting job, and to possess self-esteem. The tenacity with which the powers that be hold fast to their notions of the drug user is due in part to the fact that the treatment and incarceration of drug users is a major industry unto itself.

Drug prevention and education certainly have a role in harm reduction, but in order to be effective they must be presented in the context of a broad-based understanding of social issues, including the social inequalities that promise much to a few and little to most. If we can’t offer something children can say yes to, no drug prevention or education program is going to effect long-term positive change.

When asked, most users would not wish a drug habit on their worst enemy. But being that they already use; they would like to not have to constantly worry about being accosted and would prefer not to have to spend an entire day engaged in procuring their drug(s) of choice. If users could spend less time working at getting drugs, they could spend more time working at being productive, tax-paying folks. But this is not yet a reality. We do not yet live in a world where one can admit to previous or present drug use without the threat of sanction -- and this includes disclosing that one is on a legal methadone maintenance program – even though a person would be applauded for admitting to being in 12-step recovery for alcoholism. It is the job of users’ unions to encourage our constituents to believe that change is possible and convince users that they deserve to be treated like worthwhile human beings.

If our government is in earnest about wanting to reduce or eliminate the scourge of drug abuse from our cities, then it must be prepared to provide a “treatment on demand” approach to recovery. It is incomprehensible to have a war on drugs and then make available an insufficient number and variety of treatment options. Therefore, one of ICARE’s primary goals is to lobby for more comprehensive and patient-involved detox programs, as well as stepped-up funding and research efforts into presently-alternative treatments like ibogaine, buprenorphine and other drug substitution therapies, herbal remedies, and acupuncture. Since no one approach is going to work for everyone, there must be a wide array of choices. In an ideal world, private medical practitioners would be able to prescribe methadone or heroin to those who choose to use illicit drugs, and no one should have to run the risk of acquiring HIV out of fear of being discovered entering a needle exchange program.

In view of this strategy, ICARE members have been registering needle exchange participants to vote. And in the near future, we would like to be able to provide via the internet a basic medical and legal library capable of answering addicts’ inquiries and giving them information on current congressional actions related to drugs. A communication network like this would also enable us to keep in touch with the growing number of users’ unions nationally and internationally. It is only through direct involvement with society and each other that drug users can hope to change public opinion and the popular perception of who an addict is. Most importantly, this participation will increase drug users’ own self-worth and self-esteem.

Ellen Fishman is the Chairperson of ICARE. This article is based on a presentation given at the American Public Health Association Conference in San Diego, CA in November 1995.
It is the job of users' unions to encourage our constituents to believe that change is possible and convince users that they deserve to be treated like worthwhile human beings.

Manipulated illustration from The Making of a Fresco Showing the Building of a City by Diego Rivera.
Needle Exchange, Harm Reduction and HIV Prevention in the Second Decade

An ACLU AIDS Project Briefing Book
edited by
Ruth E. Harlow and Rod Sorge

The most comprehensive resource available for assisting activists and advocates in establishing needle exchange programs, advocating for public policy that supports harm reduction, and working toward the decriminalization of injection equipment. Also serves as a complete introduction to those new to this subject. Contains chapters on harm reduction theory, practical and legal aspects of providing needle exchange, scientific evidence supporting harm reduction, the politics of needle exchange, policy guidelines and suggestions, advocacy strategies in local communities, and legal and legislative advocacy strategies. 851 pages.

$40 per copy ($50 outside of the U.S.) from the American Civil Liberties Union AIDS Project, 132 West 43rd Street, New York, NY 10036; phone: (212) 944-9800 x 545; fax: (212) 869-9061. Make checks payable to "ACLU-F AIDS Project."

CHERYL SIMMONS
is a consultant and trainer.
She has developed models for healing and wellness specific to women who are chemically dependent.
Additionally, she has developed clinical incentives for women who have endured lives of trauma, violence, poor health, incarceration, spiritual despair.
Ms. Simmons has created holistic avenues for health and healing, concerning the African American community and she has incorporated these options with the philosophy of HRC.
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| Street Outreach Workers |
| Conference              |
| Radisson Hotel, Austin, TX |
| April 22-24, 1996        |
| Contact:                 |
| Texas HIV Connection at  |
| (512) 343-9595           |

| XI International Conference on AIDS |
| Vancouver, Canada                  |
| July 7-12, 1996                     |
| Contact:                            |
| Conference Secretariat at           |
| (800) 780-AIDS                      |

| Harm Reduction/Relapse Prevention Conference |
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| October 25, 1996                         |
| Contact:                                 |
| NSSR at 66 W. 12th St., NY, NY, 10011     |

| 1st National Harm Reduction Conference |
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| Contact:                                |
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| AIDS Housing of Washington              |
| phone: 206-443-3320                      |
| fax: 206-441-9485                        |

| Progressive Alliance of Alameda County Convention |
| County Plaza, Oakland, CA                    |
| May 31-June 2, 1996                          |
| Contact:                                    |
| Progressive Alliance at                     |
| (510) 419-0687                              |
The staff of the Harm Reduction Coalition would like to welcome to the Board of Trustees of the organization.

Carolyn Lee,
Director of Relationship Marketing at World Savings in Oakland, CA;

Donald Topping,
Director of the Social Science Research Institute at the University of Hawaii at Manoa;

Dennis DeLeon,
Executive Director of the Latino Commission on AIDS and an attorney in New York; and

Marsha Rosenbaum,
a sociologist/researcher in San Francisco who currently heads the Lindesmith Center West.

Congratulations from the staff of HRC to Joyce & Bart on the birth of Timothy Carlos Rivera Majoor born March 7, 2:30 a.m. May all your lives be filled with happiness.
Survey and Membership Form

We want to hear from you. Please fill out the enclosed form and return it with your membership. We want to know what you think are the most important priorities for the harm reduction movement. Even if you cannot contribute at this time, please return the survey.

1. Please rank the following programs. Which are most important for HRC to pursue?

- Sponsor national conference
- Publish a regular harm reduction newsletter
- Develop a training institute
- Develop a publishing center
- Provide technical assistance to community-based programs
- Expand participation through affiliates

2. What other programs should HRC be developing?


3. Would you be interested in forming a local affiliate of the Harm Reduction Coalition?  yes___ no___

4. In addition to providing financial support, are there other projects you want to work on with HRC?


Return form for newsletter and membership subscription:

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<td>INCLUDES SUBSCRIPTION &amp; CONFERENCE DISCOUNTS</td>
</tr>
<tr>
<td>$50 &amp; UP - ALL THE ABOVE &amp; CONFERENCE T-SHIRT</td>
</tr>
<tr>
<td>$100 &amp; UP - ALL THE ABOVE &amp; CONFERENCE POSTER</td>
</tr>
</tbody>
</table>
First National Harm Reduction Conference:
Abstract deadline extended to June 1, 1996