HARM REDUCTION COMMUNICATION

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

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

Editorial Policy
Harm Reduction Communication provides a forum for the exchange of practical, “hands on” harm reduction techniques and information; promotes open discussion of theoretical and political issues of importance to harm reduction and the movement; and informs the community through resource listings and announcements of relevant events. Harm Reduction Communication is committed to presenting the views and opinions of drug users, drug substitution therapy consumers, former users and people in recovery, outreach and front-line workers, and others whose voices have traditionally been ignored, and to exploring harm reduction issues in the unique and complicated context of American life. Since a large part of harm reduction is about casting a critical eye toward the thoughts, feelings, and language we have learned to have and use about drugs and drug users, Harm Reduction Communication assumes that contributors choose their words as carefully as we would. Therefore, we do not change “addict” to “user” and so forth unless we feel that the author truly meant to use a different word, and contributors always have last say.

The views of contributors to Harm Reduction Communication do not necessarily reflect those of the editorial staff or of the Harm Reduction Coalition.

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IN THIS ISSUE...

Letter from the Editor ................. 3

Conference Report: Women and Harm Reduction
Highlights by Julie Hantman ............ 4
It’s About Respect by Evelyn Milan ... 5
Look in the Mirror! by Rose Lease ... 6
Applying Harm Reduction to Services for Substance Using Women in Violent Relationships by Amy H ill ... 7

Got Works?
Shalala’s Lack of Determination by Chris Lanier and Alan Greg ... 10
Do What Works For You by Joey Tranchina ................. 11
One-for-one Exchange Is Not Harm Reduction by Corinne Carey ... 12
Hygiene vs. Politics by Donald Grove ................. 13
There Is No “Must” in One-for-One by Marla Stevens ................. 14

What Works in Canada?
The Politics of Needles and AIDS by Julie Brunau and Martin T. Schechter ................. 15

Working With Lives and Not Just Veins by Walter Cavalieri ................. 15
Vancouver Story by Judy McGuire ....... 16

Global Voice by Alan Clear ................. 17

Hepatitis
What We Know... .................. 18
On Snorting by Dan Bigg ................. 19
Hep C and Me by Vicki Patterson ....... 20
Dealing with Hepatitis: Some Facts forInjectors .......... 21
The Hepatitis C Epidemic by Joey Tranchina and Tom O’Connell .......... 22
Witches’ Brew by Sara Kershner .......... 24

Hepatitis Counseling and Testing: Practical Guidelines for Providers by Kristen Ochoa, Paula Lum, M.D., M.P.H. and Andrew Moss, PhD .......... 26

Mental Health
Peers and the Possibility of Change by Ana Olivera ................. 30
Making Choices Is Good For Your Health by Fred Rotgers .......... 32

Harm Reduction Psychotherapy With Active Substance Users by Andrew Tatarsky ................. 33

Please write in with your comments, feelings, responses—we want to hear from you. Send them to: The Editor, Harm Reduction Coalition, 22 West 27th Street, 9th Floor, New York, NY 10001

DRUG CRAZY

“Exposes the insanity of American drug policy—essential reading” — Robert Field

Look into the madness of the drug war in Mike Gray’s Drug Crazy (published by Random House). Order from your bookstore now.
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Rod Sorge, the soul of Janis, the blue light of Billie, the beautiful tone and grace of Billy has left the staff of HRC. Hopefully, we’ll work on projects together in the future because revolutions need poets to turn the mundane into the magical. We all miss him dearly in the office.

Lee Tech Artist, visionary, shining star, speaker at both the North-East Conference and the National, drug user activist, member of ICARE, bastard child of Artaud, preferred art to life but died this March 1998.
CONFERENCE REPORT: WOM

HIGHLIGHTS

BY JULIE HANTMAN

The meaning of harm reduction for women was the theme of a day-long conference held on October 17th last year at the Mt. Sinai School of Medicine in New York City. Two hundred people, 90% of them women, attended this first U.S. conference to exclusively focus on harm reduction in the context of the lives of women and their families. Bringing together drug users, program participants, advocates, administrators and social and health service providers, the day-long conference created a space to discuss the drug-related health, psycho-social and legal issues relevant to women and to make programmatic and policy recommendations for further action.

Significantly, the conference was also about harm reduction philosophy in practice. In the morning, each woman received a long-stemmed iris, the purple blooms symbolizing power, and a ‘healing’ stone. The energy, creativity and caring of all women was evident throughout the day. Some 40 women literally raised energy at a hands-on wellness workshop that turned into a huge group Reiki circle, and acupuncture and yoga sessions were also offered. The inclusivity of experience, personal as well as professional, was a crucial inspiration for the conference, with users and program participants numbering about half of those attending. In the keynotes, advocates shared their experiences, strategies and personal transformations (see the articles by Evelyn Milan and Rose Lease). Participants from the Lower East Side Harm Reduction Center and Positive Health Project took active roles in conference planning, and women users took major leadership roles at the conference. They co-led workshops, along with a provider or other advocate, and women users led and spoke at the community forum, “HIV-Positive Women and Drug Use,” organized by the Users’ Advocacy Project, which took place over lunch.

The conference was planned by the Women and Harm Reduction Working Group (WHRWG), and sponsored by HRC and five co-sponsors, with twenty-two participating agencies. Formed in

CONFERENCE RECOMMENDATIONS

Some of the main recommendations made at individual workshops are summarized here.*

Youth

Homeless drug-using youth, whether female, male or transgendered, need basic access to housing and health care. To get a safe bed for the night, youth in NYC currently have to sign in to Covenant House or a treatment center. Harm reduction-oriented emergency housing open to drug-using youth is urgently needed. Youth also need accessible, non-judgmental health care, which is sensitive to gender issues in its service delivery and philosophy, with coverage extended to older teens, who are currently overlooked. Drug-using youth must be involved in planning, delivering and evaluating services.

Sex workers

Double or triple stigma, discrimination, and chronic risk for arrest make it all the more important to deliver client-centered care to sex workers where, when and how they want it. Sex workers who are representative of the population to be served must be directly involved in crafting, operating and evaluating outreach and services, especially since their awareness of changing drug use, sexual practices, and work sites is essential to effective service responses. Programs should both serve, and recruit staff from among, male and transgendered as well as female sex workers. Advocacy is required to challenge and reform current laws on prostitution.

Mothers & children

Many women users at some point lose their children to foster care, which causes continuing grief and shame. Child removal may be the start of a downward spiral involving loss of entitlements, home, self-respect and sometimes liberty. Within the context of the child care debate over family preservation vs. permanent placement, a recommended harm reduction response is ‘foster care prevention,’ providing legal advocacy, education and empowering women about their rights with regard to the child welfare system. Among the recommendations on pregnancy are the need to: train providers to deliver respectful and informed prenatal and birthing care to women users; establish birthing centers for users; and create peer-led support groups where women can talk honestly about their drug use and parenting.

HIV-positive mothers

Existing ways to prevent child removal during temporary periods of mothers’ illness include the legal measure of assigning temporary ‘stand-by guardianship’ to someone, and also emergency family housing and care. Women need to hear about these services, and it is recommended that more emergency programs be established. Women need education about their rights of parental consent regarding care and medications for their HIV-positive children.

Sentencing and Incarceration

High rates of custodial sentencing for drug-related offences impacts many women. Sentencing reform is urgently needed to reduce the number of women going to prison and the length of time served in prison. Women in prison require timely and high quality discharge planning and incarcerated women living with HIV also need comprehensive AIDS care and accurate treatment education as well as access to medical parole.

Policy advocacy

The trend toward punitive social and welfare policies threatens the physical safety, rights and reproductive freedom of women and the well-being of their families. Mandatory HIV tests of infants and pregnant women, and mandatory reporting and partner notification, are happening already in some places. Vigorous advocacy is needed to reverse this trend toward mandatory testing, and to preserve and extend comprehensive, voluntary testing policies. ‘Welfare reform’, and its efforts to restrict benefits to drug users, threatens women and their families in terms of access to food, shelter, drug treatment and health care. Advocacy to minimize the impact on drug users is necessary as states continue to implement their welfare reforms.

Methadone & other substitution treatments

Women would greatly benefit from greater options in pharmacological treatments for heroin addiction; the deregulation of methadone delivery; and the option of comprehensive services. Methadone providers need training on the existing standard of care for pregnant women, and also training in treating clients with HIV, hepatitis C and other conditions.

* Please note that the agenda for action, to be produced by the WHRWG later in the year, will be broader than these conference highlights. The summary presented here omits some recommendations made and does not cover some workshop topics, especially Violence which was scheduled outside of the conference’s seven tracks.
New York City in 1996, the WHRWG is coordinated and supported by HRC with representation from women working with and/or affected by issues of drug use. The conference featured fourteen workshops covering seven tracks, focusing on a range of topics as they relate to women, including: effective street outreach and harm reduction programs, methadone and other substitution treatments, violence, HIV-positive mothers, parenting grandmothers, child care and drug treatment, child custody, shelter and HIV treatments for youth, incarcerated women and welfare reform. Limited time and space meant that other topics like sexual minority issues, pregnancy and needle exchange were not explicitly addressed, although they were raised during workshop discussions.

Each workshop was asked to make recommendations, and these were presented by the track coordinators at the closing session. Later this year, and building on these recommendations, the WHRWG will issue an agenda for action—a document of wide-ranging programmatic and policy recommendations to address, within a framework of harm reduction philosophy and practice, the drug-related issues facing women. In addition, the Second National Conference on Harm Reduction, to be held in Cleveland, Ohio, October 7-10, will continue the work and spirit of this conference through centering discussions of women and harm reduction at the heart of its agenda.

Julie Hantman is a writer and policy analyst, and a member of the Women & Harm Reduction Working Group. This article is based on input by track coordinators (the author, Stacey Rubin, Evelyn Milan, Kelly McGowan, Jennifer Flynn, M. Saidia McLaughlin and Paula Santiago, and by the rest of the working group and the conference. For more information on the Women & Harm Reduction Working Group, contact Paula Santiago at santiago@harmreduction.org.

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SECOND NATIONAL HARM REDUCTION CONFERENCE

Focus on Issues Affecting Women

In addition to integrating issues affecting women throughout the conference agenda, HRC are seeking agencies and networks to collaborate on a Women’s Policy Caucus luncheon to share information and organize around the following issues (this is a preliminary list, we encourage the addition of other items):

* the criminalization of women who are pregnant and are using drugs
* the criminalization of women who are mothers and are using drugs
* the mandatory HIV testing of pregnant women
* the movement away from family reunification towards permanent placement
* welfare reform issues
* the criminalization of sex workers
* incarceration of drug using women
* lack of access to and availability of drug treatment services for women

Contact Christy Robb, Conference Coordinator, 212.213.6376 x 31
LOOK IN THE MIRROR!

BY ROSE LEASE

I hope that this conference is the beginning of a long beautiful relationship between you and harm reduction, because harm reduction means understanding for us all, no matter whether we’re black or white, gay or straight, junkie or no junkie, alcoholic or no alcoholic, crack smoker, whatever. Harm reduction is for all of us.

I don’t want to explain to you what harm reduction is, I don’t want to preach to you about what it is but I can tell you it fucking works. I mean I’ve been there, I’m still there, I’m still fighting for my own sanity, and with the help of my friends I am incorporating this thing called harm reduction in my life and without it, I wouldn’t be able to stand here and talk to you. Without it I probably wouldn’t be standing anywhere.

I’m not going to pull any punches with you and if I offend you please forgive me, but AIDS is a very offending thing. I am HIV positive. I am a recovering junkie, and I still drink and I still smoke pot, so you know what, two out of three ain’t bad. I don’t want to spend a lot of time talking about the shit in our lives, and there’s a lot of it. You know the kind of things, like coping, like praying that you don’t get busted by anybody. Praying on your way to get the drugs. Praying on the way back home and praying the kids aren’t there so you can get high. Then you got your relationships, whether it’s your boyfriend or your girlfriend, or your insincere friends, you know, people that like to try to keep you down there, instead of building you up. Then you got family and friends who are “worried about you” but all they can do is talk about you like a damn dog and put you down. And after you went through all that stuff about the relationships and your boyfriend or your girl-

friend and your family, and you’re worried about everything, you get in the bathroom and you either blow your damn shot or you got beat. It’s like a merry-go-round that’s not fun to ride anymore.

You know what I tell my so-called friends, “You kiss my ass, because I’m not here to prove myself to anyone but my God and myself, and then you people come next.” I have a 24-year-old son, and I look at it like this. He can’t live for me, he can’t die for me, and I can’t do it for him either, so if he doesn’t like the way I going to respect me. I can now walk up the street with my head held high, and it’s not because I quit getting high. I think what helped me the most was that I realized that Rose is worth loving, and if Rose doesn’t love Rose then I can’t ask anybody out there to give me anything. And as a woman, that’s the hardest thing. We can give our love to everybody else but ourselves. So you have to stop doing that, because if we don’t love us first, then we can’t expect our boyfriend or our girlfriend to love us. We can’t expect them to respect us because we’re not giving it here first. You can’t give something out there that you’re not giving in here. That’s what harm reduction does. I hear politicians ask, “what the hell is harm reduction?” Look in the mirror. It’s you. It’s how you treat yourself. It’s how you wake up in morning, even if you’re dope sick, even if you have AIDS, even if you don’t think you want to finish the rest of that damn day, you got to wake up and go, “hell yeah, I’m here and I want to do the best that I can.” And it doesn’t matter if you’re getting high or not, it’s just doing the best that you can for you to protect yourself, because nobody’s going to do it for you.

I’m hoping that today will be one that will always be in our memories, that every time that you start getting down on yourselves or you get down on your clients or your participants, that you remember that we’re all one step away from death and that doesn’t matter if we’re getting high or we have the virus or what, we’re just one step away from dying and the point is, that if we don’t start loving and caring, ain’t nobody going to give a shit whether you’re dead or not. Like I said, if I offended you, too bad. Life can be very offending, AIDS can be a very viciouss thing. I hope we can learn to stop hurting people, stop judging people and start showing what harm reduction is about. May the Lord bless you all and keep you safe no matter what you perceive him or her to be.

This text is based on Rose Lease’s keynote speech at the conference. Rose Lease is 38 and hoping for a miracle.
Applying Harm Reduction to Services for Substance Using Women in Violent Relationships

BY AMY HILL

From its origins as a way of addressing the negative consequences of drug use, the harm reduction movement has grown considerably in recent years. It has come to attract the attention and support of an array of providers and advocates with a history of and ongoing interest in designing successful, relevant and life-enhancing services and policies. Harm reduction strategies are promoted for active drug users, individuals who are seeking to end their dependency or addiction, and non-drug users who engage in a range of potentially risky behaviors or live in environments which pose a threat to their health and well-being.

Harm reduction practitioners value and strive for an egalitarian relationship between worker and client. The philosophy of harm reduction requires health care/ service providers to set aside their judgements in order to address problems and crises on the client’s terms. The worker becomes a consultant who assessments the client’s needs, provides information and options, and allows the client to set her/ his own goals. Services based on a harm reduction model are user-friendly, respect confidentiality, and offer tools and support to clients to assist them to reach their goals. Crucially, harm reduction services avoid paternalism by not assuming that the client needs the worker in order to reach these goals.

While there has been much speculation about the potential role that harm reduction can play in preventing and intervening in domestic violence situations, few specific recommendations for philosophy or practice in this area have emerged from either the domestic violence or substance abuse treatment fields. (Note: in an effort to de-stigmatize drug-using populations, harm reduction practitioners most often refer to substance use rather than substance abuse. Recognizing the extent to which histories of violence lead women to use substances, this article refers primarily to use, not abuse. The term ‘abuse’ is used only in relation to services and treatment.)

THE LIMITS OF TRADITIONAL DOMESTIC VIOLENCE AND TREATMENT PROGRAMS

The domestic violence movement, which emerged at the grassroots level during the women’s movement of the early 1970s, understandably shied away from addressing women’s alcohol and drug use in an effort to make it clear that alcohol and drugs do not cause violence. The result, unfortunately, has been a lack of attention on the part of the movement to the needs of substance-using women involved in violent relationships. Battered women who use—and who are thus extremely vulnerable—are often judged harshly and denied services by domestic violence shelters.

The male-centered, depoliticized confrontational nature of traditional substance abuse treatment programs, particularly 12-step approaches, has to an even greater extent hindered the development of appropriate services for battered, substance using women. With its emphasis on control, a grounding in disease/ medical models, and original target of white, upper-middle class males, the 12-step model has been unsuccessful with women in general, and particularly with women who have current or past physical or sexual abuse histories. Twelve-step programs rarely address the impact of post-traumatic stress disorder and fail to acknowledge the situational nature of substance use. Simply put, violence causes pain and gives rise to feelings that lead to the desire to use drugs and alcohol as a way of alleviating that pain. Bepko and Krestan suggest that an addictive behavior is a way of avoiding shame, which often comes from the failure to live up to the dictates of society’s rules and boundaries about what it means to be a woman.

Traditional substance abuse treatment models are alienating to battered women in a number of other ways. The assumption that addiction is a progressive disease which can only get worse, rather than being context-dependent, can be daunting to women with histories of violence who may be using in order to cope, and may have every intention of refraining as soon as the violence stops. The concept of codependency, which can imply that women’s need to care for and nurture other people is dysfunctional rather than a result of female socialization, supports the common misunderstanding of women’s reluctance to leave...
A growing number of individuals from domestic violence, substance abuse treatment and related fields are refusing to ignore the clear links between domestic violence and women’s substance use.

battering relationships (e.g. they are presumed crazy or masochistic for wanting the violence to stop but the relationship to continue). Finally, the expectation that when entering treatment one must be in control may seem ridiculous to the battered woman who has for long periods of time been controlled by tactics of fear and intimidation.

**Linking Domestic Violence Services and Treatment Programs Through Harm Reduction**

The links between substance use and violence make harm reduction a logical concept to embrace in the course of developing domestic violence services and treatment programs. Yet, organizations representing these two fields have only recently begun to explore ways of tailoring services to meet the needs of women affected by both issues. This seems ironic given the degree to which many domestic violence organizations have integrated the stages of change model, widely used in harm reduction practice, into their own work with battered women.

The parallels between the stages of deciding to leave a battering relationship and deciding to enter substance abuse treatment are clear (see table). Domestic violence advocates estimate, for instance, that most women make an average of eight attempts to leave violent relationships before they actually do so successfully, and that disclosure contemplation and preparation (safety planning) are key elements of the process of leaving. Most domestic violence interventions developed for use within the health care setting are also based upon the stages of change model in that they urge providers not to counsel women to leave violent relationships; instead, they try to educate patients, assist them with safety planning, and make appropriate referrals. Unfortunately, like domestic violence advocates, health care providers are largely ill-equipped to work with substance-using women. They are doing so by developing gender-specific services which draw from neither traditional domestic violence nor treatment modalities, but which recognize the cycles and stages of both substance use and domestic violence. The big problem, as these services acknowledge, is that the women in need of help are whole human beings, but the ‘system’ treats them as separate problems belonging to separate people.

Harm reduction, with its emphasis on establishing trusting, supportive relationships between providers and clients and accepting the client at her/ his own level, can in many ways be viewed as a bridge between currently fragmented domestic violence and substance abuse treatment services.

Safety is a key concern of this harm reduction bridging approach. Thus, the goals of treatment for women impacted by substance use and domestic violence are:

1. To help the woman become more conscious of her risky behaviors and situations; and
2. To help her develop a plan for reducing the risk to her personal safety and the safety of her child(ren).

Below are a number of recommendations for those interested in furthering the development of programs and policies which support this vision:

- Educate yourself and others in your organization about the relationship between women’s substance use and violence, and about harm reduction. Make sure your organization addresses these issues in orientation and ongoing training. It is important for providers to understand that they are not responsible for “saving” women, but that their response to each woman’s situation is a critical step in what could be a lengthy process of leaving a relationship.

- Explore the possibility of using harm reduction methods within your organization. If organizational policy or funding requirements prohibit use of a harm reduction approach, explore organizational values to determine for whom the values exist (e.g., to satisfy/protect staff or to best serve clients), and advocate for change at the appropriate level(s).

**For substance abuse treatment agencies:**

+ Develop and implement policies which require that all women be screened for violence, and train staff appropriately. Research has shown that asking women directly about violence increases rates of disclosure. Individuals from communities that are socially ostracized, like the substance using community, disclose less often than other women unless asked directly. When a woman does disclose, it is important to:

  - Emphasize that the battering is not her fault; educate her about domestic violence and substance abuse; reduce the stigma; and, perhaps most importantly, ask her how you can best be of assistance.

**For domestic violence organizations:**

+ Work with substance abuse treatment providers to develop innovative services for substance-using battered women. Shelter beds, though necessary, are far from being the only way to assist a woman in a violent relationship.
Explore other ways of supporting and advocating on behalf of women who use, for example, office visits with advocates to develop safety plans or take legal action, support groups and alternative shelter settings which do not immediately require abstinence.

Be creative and committed to the rights of all women to violent-free relationships.

Initiate dialogue with other organizations in your area; familiarize yourself with their services; invite them to participate in task forces, coalitions and collaboratives; develop cross-training programs; and work together on education and training about harm reduction, violence and substance use.

Advocate locally and beyond within the prevention arena for the development of youth violence and substance abuse prevention strategies which take into consideration the high rates of dating violence and sexual assault among teens, and acknowledge that experimentation with substances is a normal part of adolescent development.

Advocate within the batterer treatment field to raise awareness of the link between violent behavior and substance use.

Encourage substance abuse treatment programs for men to assess patients for histories of violence, and to establish links with batterer treatment programs.

Advocate at the local, state and federal levels for research and funding which take into account the connections between women's substance use and past and current violence.

Amy Hill is Domestic Violence Prevention Coordinator, Contra Costa County Health Services Department, Martinez, CA.

This article originally appeared in the Winter 1996-97 issue of the National Abandoned Infants Assistance Resource Center's newsletter, "The Source," Vol. 7(1). The author would like to acknowledge and thank Carol Draizen, Oakland, CA for her contribution to many of the ideas and suggestions expressed in this article. For more information contact M.s. Hill at 510.313.6827.


the stages of change
(applied to harm reductionists and domestic violence advocates)

Views of the Change Process
Harm Reductionist: there are stages of readiness to enter substance abuse treatment
Domestic violence: there are stages of readiness to leave a battering relationship
Harm Reductionist & Domestic Violence: lapse does not have to mean relapse; people cycle in and out of both substance abuse and violent relationships

<table>
<thead>
<tr>
<th>Stage of Change</th>
<th>Harm Reductionist</th>
<th>Domestic Violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precontemplation</td>
<td>substance abuse is not a problem</td>
<td>violence is not a problem; batterer will voluntarily end violent behavior</td>
</tr>
<tr>
<td>Contemplation</td>
<td>admit problem to self/friend/provider</td>
<td>admit problem to self/friend/provider</td>
</tr>
<tr>
<td>Preparation</td>
<td>explore treatment options</td>
<td>lethality assessment, safety planning, explore legal options</td>
</tr>
<tr>
<td>Action</td>
<td>enter treatment</td>
<td>leave batterer; take criminal or civil action</td>
</tr>
<tr>
<td>Maintenance</td>
<td>lifetime support to maintain the change</td>
<td>lifetime support to maintain the change</td>
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SHALALA’S LACK OF DETERMINATION

BY CHRIS LANIER AND ALAN GREIG

“A meticulous scientific review has now proven that needle exchange programs can reduce the transmission of HIV and save lives without losing ground in the battle against illegal drugs.” The words of Health and Human Services Secretary Donna E. Shalala on April 20, in announcing that the Clinton Administration would be maintaining the ban on federal funding for this “proven” method of saving lives.

This determination to avoid saving lives is breathtaking, both for its dishonesty and its cowardice. For many years now, the science has been telling anyone who would listen that needle exchange works. There is nothing new about this scientific knowledge—it is old news. Shalala’s refusal to accept this “old news” up until the morning of April 20 has cost many people their lives, and great suffering to many more, as a result of becoming needlessly infected with HIV. The fact that she now accepts the science but still refuses to put federal money being used to provide clean injection equipment to those who need them will continue. The experiences of the Chai Project in New Jersey and the shameful threats and politicking by right-wing Republicans which killed an effort to pass needle exchange in New Jersey and the shameful threats and politicking by right-wing Republicans which killed an effort to pass needle exchange programs in a hostile political, legal and social climate. This determination symbolizes their victory, salutes their bravery and affirms that people shooting drugs have the same basic rights to public health and hygiene as everyone else.

But the dangers in Shalala’s April 20 “determination” mean? It does not alter the legal status of needle exchange. States’ paraphernalia and prescription laws remain unaffected by this decision and the prosecution of people for attempting to provide clean injection equipment to those who need them will continue. The experiences of the Chai Project in New Jersey and the shameful threats and politicking by right-wing Republicans which killed an effort to pass needle exchange legislation in Colorado will be repeated.

Nor does the determination alter the funding status of needle exchange. In fact, Shalala’s refusal to lift the ban on federal funding is as acceptance of the science marks her craven capitulation to the drug warriors in Congress, in the White House (at ONDCP for example) and elsewhere (e.g., the execrable Family Research Council). The gulf between the science of public health and the politics of the drug war has never been more openly exposed. In turn, this exposes the misinformation spread by the right wing to the ridicule they deserve. By agreeing with the science, Shalala’s determination makes easier targets of McCaffrey and conservative legislators who can no longer lay claim to any rational basis for their drug war propaganda against needle exchange.

The determination also shifts attention to the state level. The Federal government now agrees that needle exchange programs work, so states will have to justify their continuing prescription of it. Whether you are participating in or providing needle exchange services, you can use the federal determination as a basis for going to state legislators to get state needle laws changed, for defending yourself in court if you get arrested for doing an exchange and for trying to shift public opinion in your locality, and pressing government and agencies to respond to your needs. The determination also strengthens your hand with foundations and individual funders—it’s official, needle exchange is a legitimate public health intervention! The symbolism of the determination is powerful, too. The Federal government’s acceptance of the science on needle exchange vindicates all those people who, at great risk to themselves, have started and sustained needle exchange programs in a hostile political, legal and social climate. This determination symbolizes their victory, salutes their bravery and affirms that people shooting drugs have the same basic rights to public health and hygiene as everyone else.

But the dangers in Shalala’s determination are evident: “The science reveals that successful needle exchange programs refer participants to drug counseling and treatment as well as necessary medical services, and make needles available on a replacement basis only.” This statement represents a basic challenge to the harm reduction ethos of needle exchange programs by seeking to impose the criteria by which needle exchange programs will be deemed “successful.” Programs which do not include “necessary medical services” (undefined) and which do not operate one-for-one exchange will be considered “unsuccessful” and may on this basis face challenges from state authorities and risk the withdrawal of funders.

Whether you are an NEP participant or provider, don’t let these arbitrary criteria be used against your local program. Identify the strengths of your program and what makes your program uniquely able to respond to the needs of the local community of users. These strengths are the basis on which you judge your program to be a success and it is your knowledge and experience which should determine the criteria by which programs are judged to be a success or not. Challenge any statement that insists on one-for-one exchange as the effective way to run a needle exchange program. As participants, you are in a position to demand cooperation—it takes two to make a needle exchange happen and requires your consent as well as the government’s. Resist Shalala’s imposition of arbitrary criteria by asking for needle exchange from any service provider you think should provide it. This could be a hospital, clinic, your case manager, your local department of health, drugstore, church, etc. Ask often. If no one listens, find others who will also ask and ask together.

NEPs have grown in response to the needs, and as a result of the efforts, of local communities of injectors, and not in conformity with criteria imposed by the Administration or Congress. This is what defines needle exchange as harm reduction—it connects with users as people, as members of community. Shalala’s lack of determination to seriously address the AIDS epidemic in the community of injecting drug users is, at the same time, a determined effort to undermine the harm reduction ethos of needle exchange as it is currently practised in this country. It must be resisted.

Chris Lanier is with the National Coalition To Save Lives Now!, Call 212.213.6376x17, fax: 212.213.6582; email: ncsln@dti.net; web: http://www.safeworks.org/savelivesnow/ or write to OHRC. Join the discussion by sending email to “ncsln-request@drugtext.nl” with the line “join ncsln.”
GOT WORKS?

Shalala says that “the science reveals that successful needle exchange programs...make needles available on a replacement basis only.” We asked people actually working in needle exchange what they think...

One-for-one exchange is a uniquely American phenomenon. The political argument is obvious. One-for-one enables exchangers to say: “We’re not adding to the number of syringes in the community; we are only increasing the proportion of sterile syringes to potentially infected ones on the street and reducing the amount of time that a used syringe stays available to be in circulation.” That is a sound political argument which has been persuasive to politicians who use drugs and those in “recovery.” But the fact remains that these folks have built the largest exchange in the country with this cumbersome model, where they work in so many neighborhoods, at so many times of day, on so many days of the week that they have made fluid access to sterile syringes possible on a routine basis in San Francisco.

However, “effectiveness” must be understood in terms of local conditions. The one-for-one model as propounded at Prevention Point in San Francisco (according to taped interviews that Dan Waldorf and I conducted with folks who formed the core group from PP’s first meetings) was developed out of twelve step philosophy where several people expressed concerns that by distributing syringes in greater numbers than were taken in, they would be “enabling” that behavior, which they were only interested in making safer. Many of the folks there were deeply concerned about the danger of encouraging drug use by providing extra syringes.

This is easy for me to criticize, since I do not share their 12 step philosophy or what I consider to be the artificial distinctions that are made between people who use drugs and those in “recovery.” But the fact remains that these folks have built the largest exchange in the country with this cumbersome model, where they work in so many neighborhoods, at so many times of day, on so many days of the week that they have made fluid access to sterile syringes possible on a routine basis in San Francisco.

This could only work in an urban environment whose culture makes it attractive for very large numbers of people to volunteer for needle exchange duty. This model would not work in the suburbs or in the mountains where I work — in a project that encourages the participation of active drug users in a system of self-protection and relies upon secondary distribution to maximize our penetration. Yet, it must be said, Prevention Point goes the extra mile to make what I consider a crude and potentially disrespectful model serve the IDU community of San Francisco.

However, in general, I still say that one-for-one model is bad for the public’s health; wasteful of the limited resources of syringe exchange and disrespectful of the integrity of drug injectors. Since it only takes one dirty shot to get infected, what is the difference between no clean rigs and an inadequate number of clean rigs, from the point of view of preventing the spread of HIV? This is not to blame anyone who is doing the best they can under the yoke of a Needle Exchange scheme that was twisted and diminished by politicians, but it does not change the fact that turning away any person at-risk of infection, because they do not possess a used rig is life-threatening behavior, as is supplying an obviously inadequate number of sterile syringes.

When a client comes to an APAN exchange, our outreach workers ask: “How many syringes do you want?” We list a litany of supplies (alcohol wipes; rubber ties; antibiotic cream; 2 sizes of cotton; cookers; condoms; dental dams; etc), then ask: “What can you use?” Finally we append: “How else can we help you?” And out of respect for the legitimate concerns of our community around the irresponsible abandonment of syringes, we have established a syringe retrieval project. Any citizen or public agency, in San Mateo County, can call or fax our office to report the existence of syringes at any location in the county. We pick them up promptly for proper disposal.

Needless to say, this is the practical harm reduction model I prefer.

Joey Tranchina is the Executive Director of AIDS/Hepatitis Prevention ACTION Network Inc. (APAN), Redwood City, CA
One-for-one exchange is not harm reduction

By Corinne Carey

Critiques of one-for-one needle exchange are not new; and as we learn more (or wake up more fully) they become indisputable. The philosophy behind one-for-one exchange is seriously flawed because it fails to take into account so many things that make exchange a ridiculous concept for many people. Not only ridiculous, but life threatening.

One of the reasons, early on, with regard to one-for-one exchange, was that the “distribution” philosophy played into the stereotype that users can’t take responsibility for their own healthcare. By asking users to bring back their dirty works and thus to engage in “exchange,” was to view them as responsible and accountable—both to themselves and to the community. One-for-one exchange charged users with a dual responsibility: keeping the community safe by safe disposal, and doing something affirmative to protect themselves against HIV. The theory was that once users realized that “providers” recognized them as competent to take such responsibility, this would increase their sense of self-worth.

The theory was wrong. Far from promoting responsibility, one-for-one exchange has proven to be an irresponsible public health policy. Let me share a Philadelphia story from the winter of ’93 which illustrates the tragic danger of enforcing a strict one-for-one needle exchange.

We ran an exchange out of a large van in North Philadelphia, “the Badlands” as many local authors and the police called it. The exchange was open from 5:00 p.m. to 7:00 p.m., and by the time we got there each Thursday night, there was a line a half a block long of people shuddering in the cold clutching shopping bags, cans, and tin cases of used syringes. We had very few consistent volunteers at that time, so it was pretty much four or five of us that went out every other day to do exchange—most of us had full-time jobs besides the exchange. It was about 7:20, and we’d been trying to close up as each new person frantically rode a bicycle into the vacant lot to exchange, or ran up and pounded on the windows of the van as we were pulling out. We stopped and re-opened up for a while, but some of the volunteers and staff were getting pissed off and wanted to leave. It was cold and we were tired.

The last person to pull up to the lot was this guy who came every week with hundreds of syringes in one plastic shopping bag inside another. The syringes were often crusted with dirt and in many, many pieces. He regularly collected discarded syringes from lots and shooting galleries around the Badlands. Everyone was always annoyed with him; he held up the line as volunteers and staff made him count out each and every one (because, you see, everyone knew that he sold the new syringes around the neighborhood for a dollar a piece, and no one approved of that...) Sometimes, we would make him take his trash and count it out and rubber band it up in groups of ten away from the rest of the line, and then come back when he was more “organized.”

This time, as he shivered (maybe from the cold, maybe from something else), one staff person made him band them up in groups of ten in front of her. She kept rushing him along, and I will never forget watching as he scooped up bundles of uncapped syringes to bind them in rubber bands—the exposed needles scraped his chapped hands and he bled all over the snow on the ground that surrounded him. There was blood everywhere as his hands moved faster to count them out, one by one, these syringes from so many people throughout North Philadelphia, each exposed tip cutting into his hands as he continued to count.

It is really hard to write this, as I think back on how the staff person was yelling at him, and I was yelling at her, and I can’t help but feel complicit. This was the antithesis of public health. And it stemmed from a policy we had, one that mandated one-for-one exchange.

I’m not saying that people who have to adopt one-for-one exchange for political reasons are more of a hindrance than a help in this harm reduction movement. But it is undeniable, regardless of the community you are in, that the easy availability of a sterile syringe, in its own little wrapper for each and every injection drug user, for each and every time she or he shoots up, is the only way to really ensure that someone won’t inject themselves with someone else’s blood. This can only be done in a program that recognizes the grave limitations of one-for-one and either fights for distribution and gets it, or works around it. The danger in “working around it” is exactly what I tried to illustrate above. You get someone who is impatient, or power-hungry, or just fucking tired on the line, and one-for-one gets strictly enforced—especially against someone who people may not like, or who everyone thinks is “scamming” the program.

There are many laws on the books that would shock any of us—laws against different forms of sexuality being the most easy to point to—but that almost never get enforced. The danger in having them on the books is that all it takes is one fascist to start a crusade or set someone up as an example. Then the law becomes a real, and not just latent, threat to not only liberty, but to life.

Corinne Carey is a Soros Justice Fellow.
Hygiene vs. Politics

BY DONALD GROVE

I am from New York City, where the regulations require us to do one-for-one. The hard political reality of one-for-one is obvious here, as it is elsewhere. But just because it is all we can get from our governments does not mean that we should act like it is the solution to all problems. We don’t have to pretend that what seems politically possible is actually what is needed.

Ideally, injectors should have access to some form of disposal wherever they are injecting. That way they can get rid of a used set immediately after using it. Naturally, this will never happen when the injectors don’t have enough works to last until the next time they can get more. They must hold onto their works, used or not, in order to inject.

Not only must they hold onto them, but even if they have enough, they must still hold onto them in a way which makes them individually retrievable for strict counting requirements at the needle exchange program. This is probably the most difficult problem with one-for-one, aside from giving inaccurate numbers of works: it requires saving, transporting and re-handling of potentially infectious waste.

All this is done in the name of “educating” injectors about hygiene. Politically speaking, one-for-one may be as good as we can get. It may be all which conservative non-injectors will allow, and it may be all we can do based on limited supplies (a reality which I know well). But the arguments are always skewed as though one-for-one had some sort of hygienic legitimacy.

In fact, one-for-one is most frequently being portrayed as a model which effectively addresses disposal, by requiring it, as though it would never happen otherwise. The reality is that injectors show much more willingness to dispose than needle exchange programs have ever offered support for. Injectors have come up with their own ways of disposal for years. The legendary horror stories of abandoned buildings littered with used works, or shooting galleries with boxes and cans and glasses full of used works for rent may all be true. But it is equally true that many other injectors have carefully and discretely discarded their old works with great attention being given to concealment. The authorities will never know what happens to most used works, because injectors have a sensible investment in avoiding arrest or discovery.

Why is it that local authorities are unwilling to examine their obsession with one-for-one exchange? Perhaps because one-for-one is a very comfortable compromise for people who do not understand that the genuine issues of HIV prevention are about something very simple: hygiene. The public health authorities cannot grasp this, and continue to seek models of HIV prevention which identify the source of infection as being inextricably tied to the pathologies of chronic substance abuse, in which the only solution is “behavior change”. Unfortunately, these same well intentioned authorities do not provide injectors with the access to sterile syringes in a manner which would allow for effective, in other words hygienic, “behavior change,” i.e., a new syringe for every injection, and easy access to disposal resources.

Donald Grove is a Research Assistant at the Beth Israel Medical Center, New York City.
THERE IS NO “MUST” IN ONE-FOR-ONE

BY MARLA STEVENS

At Prevention Point of Indiana, we encourage exchange and find that, when we’ve developed a good working relationship with people—one of trust and equality—and it is safe for them to hold syringes until we next meet, that we get back very close to one-for-one and sometimes more. But we don’t require it and this is why:

1) It is often unsafe for people to hold syringes long enough to exchange them because of selective intense police enforcement (especially in old city areas being gentrified). Our distribution of syringes falls under a research exemption in Indiana’s paraphernalia laws. We believe that participants’ syringes would as well—but that side of it has yet to be tested in court. Our clients rightfully do not want to put themselves in the position of depending on both the speculation of our lawyer given the harsh anti-drug political climate in which our judges face re-election and the willingness of our local prosecutor to exploit that at election time to get the judges he wants as well as our very shaky ability to support such a test case financially.

Thus, although we have a very high rate with lower-profile shooting galleries, our athlete/steroid user outreach (where police pressure is essentially non-existent) and some of our secondary exchanges like the truckers and biker gatherings, our rate of exchange in our street outreach is very low. Under these circumstances, we encourage safer syringe disposal by suggesting that clients drop off syringes at hospitals and other health facilities or use the hard case syringes or plastic videotape boxes we give them when we can afford to. If we notice a problem of unsafely discarded syringes in the vicinity of our exchange sites, we deal with that by cleaning it up periodically ourselves and by reasoning with our clients that we have a relationship of mutual trust and that irresponsible syringe disposal makes it more likely for the project to be criticized and put in jeopardy. This has worked so far.

2) Equally important, the power dynamics inherent in a strict one-for-one exchange are antithetical to the development of the trust and equality that we believe are necessary for true harm reduction work where the client’s growing autonomy and power opens the way for honest self health and life-choice evaluation and better decision-making by the client’s definition of what is good for the client—not ours. We thus see this sort of avoidable power-play as counterproductive to our entire mission.

By the way, while we do try to discourage sales of the syringes we distribute, we look on high levels of sales as a failure on our part—not on the salesperson/client’s. Our experience shows that, as we do a better job of making people aware of our services and a better job of making them safe, convenient, and pleasant to use, the sales radically diminish. Because of this, the only punitive attitude about sales we adopt is with our volunteers—including formal secondary exchange volunteers. We must absolutely forbid sales by our volunteers lest we jeopardize our entire project’s legal status.

Marla Stevens is the Public Policy Director at Prevention Point, Indiana.

HRC OPINION

The one-for-one system for syringe exchange is the least optimal model from the point of view of the drug user. To have this promoted as the gold standard at this critical juncture will have serious ramifications. If federal regulations insisted on a one-for-one exchange policy, 80% or more of all syringe exchange programs in the country would not be able to apply for funds.

A worse scenario is that federal regulations would apply across the board, in a similar fashion as they do with drug treatment, and many syringe exchange programs would be impacted negatively. No NYC, no Chicago Recovery Alliance, no APAN (or SASE), no Prevention Point Pittsburgh, no SANE, no Benton Harbor, no Chai Project, no starter kits, no extras. From big to small, from legal to underground, regulated one-for-one syringe exchange would end the system of syringe exchange in this country as we know it. And it’s not in great shape now.

HRC advocates for unrestricted availability of sterile injection equipment. Syringe exchange needs to be useful for drug users, not bureaucrats. HIV/HCV does not respect age limits, racist drug laws or geographic boundaries. This means that drug users must have access to the injection equipment they require, in the quantity they desire. HRC thus calls for the deregulation of syringes, the repeal of all paraphernalia and possession laws and the expansion of non-coercive, non-restrictive syringe access, delivery and disposal services.
What works in Canada?

THE POLITICS OF NEEDLES AND AIDS

BY JULIE BRUNEAU AND MARTIN T. SCHECHTER

Opponents of needle exchange continue to cite two Canadian studies to show that needle-exchange plans have failed to reduce the spread of HIV, and may even have worsened the problem.

As the authors of the Canadian studies, we must point out that these officials have misinterpreted our research. True, we found that addicts who took part in needle exchange programs in Vancouver and Montreal had higher HIV infection rates than addicts who did not. That’s not surprising. These programs are in inner-city neighborhoods and they serve users who are at greatest risk of infection. Those who didn’t accept free needles often didn’t need them since they could afford to buy syringes in drug stores. They also were less likely to engage in the riskiest activities.

Also, needle-exchange programs must be tailored to local conditions. For example, in Montreal and Vancouver, cocaine injection is a major source of HIV transmission. Some users inject the drug up to 40 times a day. At that rate, we have calculated that the two cities we studied would each need 10 million clean needles a year to prevent the re-use of syringes. Currently, the Vancouver program exchanges two million syringes annually, and Montreal, half a million.

A study conducted last year and published in The Lancet, the British medical journal, found that in 29 cities worldwide where programs are in place, HIV infection rates dropped by an average of 5.8 percent a year among drug users. In 51 cities that had no needle exchange services, drug-related infection rose by 5.9 percent a year. Clearly needle exchange is working.

But clean needles are only part of the solution. A comprehensive approach that includes needle exchange, health care, treatment for drug addiction, social support and counseling is also needed. In Canada, local governments acted on our research by expanding needle exchanges and adding related services. We hope the Clinton Administration and Congress will provide the same kind of leadership in the United States.

Julie Bruneau is an assistant professor of psychiatry at the University of Montreal. Martin T. Schechter is a professor of epidemiology at the University of British Columbia. This article is based on an OpEd piece in The New York Times, Thursday, April 9, 1998, p. 27.

WORKING WITH LIVES AND NOT JUST VEINS

BY WALTER CAVALIERI

I heard a blip on the news this morning about research in Montreal that tells us that the use of needle exchanges actually causes an increase in HIV infection. Will someone please research the quality of the exchanges themselves, not the number of needles they “give out”?

Harm Reduction programs, needle exchanges being a prime example, must be driven by the principles of social justice and public health. These are the words of Imani Woods. They are also driven by love (Edith Springer put this idea forward, I was afraid to). They are also driven by the needs and knowledge of the service user, not the provider. Think about what all this implies in the provision of services. Are these measured in the research? I think not. Failure is evaluated only in terms of HIV infections. No one evaluates how successful service users have been in jumping through hoops to get the limited “assistance and support” they receive in at least one large exchange I visited in Canada.

The failures that should be measured are those in service providers, administrators and the people in power, who have displayed an almost fundamentalist rigidity in the face of need and change. They are the vectors of disease.

We must also learn from successes. I think that we do many things right in our exchange programs in Toronto — not everything, just many. I am proud of the work that we have done here, and that I have been a part of it. Workers here have pushed the limits to make our exchanges safe places to receive assistance, friendly help, good information, attention, validation, and so forth. We are involved with peoples’ lives, not exclusively with their veins. With the whole person. With their families/communities. With the community as a whole. Enlightened managers and administrators have supported this — and some have looked the other way — so that we could do our work. Some have no clue what is going on, which is not a good situation. The result: We still have one of the lowest HIV rates of any major city in North America.

Of course this may all change. Whatever happens, I hope that we will give up ego and establish a real collaboration among the various constituents of harm reduction programs to protect and enhance them for the good of the persons using drugs, and for the good of humanity. I don’t know if we will be successful, but it will be a glorious battle.

Walter Cavalieri is a harm reduction consultant while seeking employment in a place where he will be able to run a small but feisty street health/harm reduction program.

We must also learn from successes.
BY JUDY MCGUIRE

There are many factors involved in the HIV situation up here. The two which, in my experience, are most closely tied with the higher rates among exchange users are their preference for injecting cocaine, and the targeting of exchange services to highest risk clients in a climate where needles can be obtained from other sources by more stable users. Montreal and Vancouver have injectable cocaine in common. This alone has proven to be a major factor in increased HIV conversion rates. Further, as needles are fairly readily available in Canada, particularly in metropolitan areas, the Montreal and Vancouver exchanges target services to users with the highest risk lifestyles. In a sense, somewhat higher rates for our clients go with the territory. Where we have differed, is that the Vancouver exchange has operated 24 hrs/day for the past three years, whereas the Montreal exchange has operated only partial hours with some limited outreach although this situation may have changed over the past year or two.

While I can’t speak for Montreal, all the research in Vancouver has told us that the overwhelming availability of clean needles (exchange, distribution, sales, etc.) has likely delayed the increase in the rates of HIV infection by a number of years. The vast majority of users say they have no problem getting the needles they need. That is not an issue for them or for those of us trying to deal with the situation here.

It is singularly frustrating that so much of the discussion on this issue has revolved around needle exchange as if any of us somehow can control this epidemic by ourselves. We are a necessary front end service, but there have to be other health supports for IV drug users as well. In Vancouver, there is extremely easy access to drugs from a number of sources—

for example, today we have warnings going out to all users because we have had at least 7 ODs in the past 24 hours because there is extremely strong heroin (usually over 90% pure) out on the street. Our clients (we will see over 1,000 people today alone) tell us that in some cases, people ODed on heroin thinking it was cocaine. This has been confirmed by our local ambulance service.

We are a necessary front end service, but there have to be other health supports for IV drug users as well.

A large number of our street-involved users are crammed into a few block radius in Vancouver’s Downtown Eastside. Some live in hotel rooms. Some live on the streets.

Corrupt hotel owners and/or managers charge people $10 if they want to take a friend up to their hotel room, even for 20 minutes. Some hotels apply the charge to people who have paid rent for the rooms if they go in and out more than once a day. As a result, people shoot up in the back alleys or in shooting gallery situations. The ensuing chaos sometimes makes it difficult for users to keep track of their needles, particularly users who have mental disabilities or those who are extremely high. Even those who are more stable have problems. For example, we have had long time clients who have become positive tell us that they slipped when they were on a coke run, in a situation where they were partying with a number of people. Although they had their own needles, after a number of hours they simply lost track of which needles were theirs or else someone handed them a needle already loaded and they did the fix without thinking about where the needle had come from. These were people who knew what to do and had the equipment to do it—their judgment was simply screwed up at the time.

I think it is simplistic to expect all exchanges will or should operate in the same way. We all work with very different political, community and law enforcement situations. Obviously, an exchange that opens only a few hours per day or a few days per week must distribute needles as if any of us somehow can control this epidemic by ourselves.
Looking at needle exchange as a silver bullet that can single-handedly halt the spread of HIV or any other pathogen helps no one.

Global Voice

By Allan Clear

“From the struggle of working in isolation in the slums of Delhi and working in isolation in the slums of Santos comes a new network. A network of international cooperation and support.” And with the words of Palani Narayanan of the Asian Harm Reduction Network—Global Voice—was born. Global Voice is a global networking tool for the regions of the world which are struggling to provide healthcare and dignity to their most disenfranchised citizens or, as in the case of the Eastern-Europeans, are confronting the import of “Western” problems without having “Western” infrastructure. The Asian Harm Reduction Network, Central European Harm Reduction Network, Rede Latino-Americana de Reducção de Danos and the Harm Reduction Coalition along with the North American Syringe Exchange Network met in São Paulo, Brazil in April 1998 at the invitation of UNAIDS. Nigerian activist Moruf Adelekan, was also present and intent on establishing a continental network within Africa. After struggling for a day to establish a cohesive framework for a meeting, the network representatives took themselves to a street corner cafe and did business where we do it best—away from the strictures of bureaucrats and among the people involved in day-to-day life.

The two day meeting was aided by the presence of representatives of the UNAIDS, United Nations Drug Control Programme, Médecins du Monde, the World Health Organization, the European Community and the Lindesmith Center. Central to Global Voice is the International Harm Reduction Association which is the body that Global Voice will join in its effort to coordinate international advocacy.

Realizing from the experience of domestic activities, the goals are modest for the first year of life. Global Voice will establish a web page outlet, will ensure the exchange of newsletters and articles and will meet again next year at the next International Conference of the Reduction of Drug Related Harm. Significantly, given the US’s export of its genocidal war on drugs, representatives of Global Voice will seek to educate policy makers in the United States on the consequences of its domestic and foreign policies. Stay tuned for more within the Harm Reduction Communication. Find out more at http://www.hrc.net/.

Judy M. McGuire works at the DEYAS Needle Exchange, Vancouver.

Do you make long distance telephone calls? If you do, you might be able to help the Harm Reduction Coalition get a grant. Working Assets Long Distance, a telephone carrier based in California, is known for its support of progressive causes. HRC recently approached WALD about becoming one of the groups eligible for WALD donations at the end of the year. (They do this by sending out a ballot with all eligible groups’ names; the customers vote; and the funds are given based on the proportion of votes each group receives.) It would be helpful if recipients of the HRC newsletter who are also WALD customers would write to the company and encourage them to select HRC as one of the nonprofits to be listed on their end-of-year ballot. Deadline for nominations is May 31, 1998. Write to:

Working Assets Long Distance
701 Montgomery Street, Fourth Floor
San Francisco, California 94111-9474

If you have any questions, please call George Worthington, HRC Director of Development, 212.213.6376. George also welcomes your ideas about other progressive companies, foundations and wealthy individuals to approach with a request for support of HRC.
HEPATITIS

This edition we look in depth at the hidden epidemic of hepatitis C. We review the current state of knowledge about hepatitis, offer guidelines for prevention, testing and counseling and provide wellness advice for those living with it.

what we know...

A to B

Hepatitis is literally “inflammation of the liver.” In this article, we will be focusing on what is known about the hepatitis caused by certain viruses, as opposed to inflammation caused by other agents, such as bacteria, parasites, or chemicals. Research initially identified two diseases caused by different viruses; hepatitis A (HAV) and hepatitis B (HBV).

It is known that most people get hepatitis A by drinking water or eating food contaminated with the human stool. HAV tends to occur in areas where sewage treatment and water purification are a problem. It is not common for drug users to get hepatitis A infection. Rimming poses a sexual risk of HAV transmission.

HAV can make you very sick (nausea, vomiting, jaundice) for a couple of weeks but it does not cause long-lasting liver disease, unless there is HCV co-infection in which case HAV can cause fulminant liver failure. For this reason, the new HAV vaccine may be especially important if you are already infected with hepatitis C, (see the section on “HCV testing, treatment and management”).

HBV is similar to HIV in the ways it is spread. You can get it from sharing needles and from having sex. Newborn babies can get hepatitis B at birth from their mother if their mother is infected. 95% of infected newborns with immature immune systems become asymptomatic chronic HBV carriers.

For adults, the big difference between hepatitis B and HIV is that most people who get hepatitis B will recover completely. They may be very sick when they first get infected, but more than 95% of adults who get hepatitis B will get rid of their infection within a few weeks. They will not have any more problems from hepatitis B, and will never get infected with hepatitis B again. A few people (3-5% or less) develop long-lasting (“chronic”) disease from hepatitis B that can lead to cirrhosis or liver cancer. People with chronic HBV are very infectious to other people for many years.

An HBV test and vaccine are available. It is worth getting tested for hepatitis B so that you know if you have:
+ been infected with HBV (and should get the hepatitis B vaccine);
+ been infected with HBV in the past but have completely recovered; or

...and then to C

In 1989, the virus causing a third form of hepatitis (“non A-non B”) was identified as hepatitis C virus (HCV). Like HIV, HCV appears capable of mutating and six major genotypes of HCV have now been identified.

HCV and illness

Most of the estimated 4,000,000 Americans with HCV face a far more hidden and serious illness than that produced by either hepatitis A or B. The most common symptoms of initial infection are malaise, weakness and anorexia: jaundice is less common. These symptoms may disappear but for 85% of HCV-infected people the virus establishes long-term residence in their blood, liver, and other organs and they remain infected with HCV for the rest of their lives. The symptoms produced by this chronic infection vary. It seems to lead to an increased susceptibility to many other illnesses, and there is a complex relationship with auto-immune diseases.

Sixty to eighty percent of people with this long-term HCV infection will develop chronic hepatitis. At least 20% of those with this chronic hepatitis will develop cirrhosis (dense scarring) of the liver.
liver within 20 years, particularly those who are heavy users of alcohol. HCV-induced cirrhosis is now the most frequent indication for liver transplantation in the United States. 20% of those with cirrhosis will develop liver cancer (hepatocellular carcinoma).

HCV transmission

HCV can be spread through contaminated blood or tissue fluid but since 1990 blood-screening has nearly eliminated transmission via transfusion or blood products. Spread to and from health workers is possible, but is minimized when standard procedures (including gloves) are used. The sharing of injecting equipment by injecting drug users represents the most important mode of spread. The prevalence of HCV infection among injection drug users in the United States has been tested at 100% in at least one group (Anchorage, AK), and is estimated to be over 80% nationally.

HCV is much more easily transmitted via contaminated needles and syringes than HIV because it is harder and more abundant in host blood. Even when needles or syringes are not directly shared, HCV seems to be transmitted by small amounts of contaminated blood in other injection equipment which is shared, e.g., cookers. Beyond injection, there is evidence that communal snorting of cocaine or heroin, when sharing the device used for snorting, allows enough blood-to-blood contact to transmit the virus. The risks of communal snorting are not as great as communal injecting and haven’t been quantitatively assessed, but may be significant. Sexual transmission of HCV does occur but is thought to be much less common than with HBV or HIV. Similarly, it is thought to be very unusual for placental transmission from an HCV-infected mother to her baby to take place and it is probably safe to breast-feed.

HCV testing, treatment and management

There is no vaccine for hepatitis C, but an HCV blood test is available. Alpha interferon, a hormone produced by the body to fight virus infections, is prescribed in injectable form to treat HCV (typically for 6-12 months if not longer). Alpha interferon treatment may be improved if used in conjunction with Ribavirin. However, alpha interferon treatment is ineffective for some people either because it does not work or because of intolerable side effects. Research is currently being conducted into HCV protease inhibitors.

Complementary therapies are used by people to address their symptoms of HCV, including vitamins and minerals, Chinese herbs and other herbal teas and preparations. These therapies are used on their own or in conjunction with alpha interferon, in part to mitigate its side effects. Witches’ Brew has more on this. There are several ways that people with HCV can stay healthy. An Australian study of 104 people living with HCV reports that the most frequently used methods to stay healthy were (in descending order) reducing alcohol intake, changing the diet, reducing stress through meditation or exercise and changing drug injecting behavior, either by not sharing or reducing or stopping injection. Secondary prevention measures, such as not sharing toothbrushes and razors, and not donating semen or organs, are also important.

This article was prepared from information provided by Joey Tranchina, Executive Director of the AIDS/Hepatitis Prevention Action Network Inc.; Tom O’Connell, M.D.; Dr. Steve Jenison M.D., Medical Director of the HIV/AIDS Section, Infectious Diseases Bureau, New Mexico Department of Health.

Dr. Steve Jenison adds...

Rapid progress is being made in our understanding of hepatitis C and how to treat it. New treatments for HCV infection may be available in the next few years. If you are infected, it may be best for you to get alpha interferon treatment now, or it may be better for you to wait until the next generation of HCV medicines become available. Seek out the advice of a health care professional who really understands the issues surrounding hepatitis C.

If you want more information on hepatitis C, the recommendations of a group of experts brought together by the National Institutes of Health (NIH) can be found on the Internet at http://consensus.nih.gov under the section on “Consensus Development Conference Statements—1997”, Document #105 entitled “Management of Hepatitis C”. The same information can also be found in the medical journal “Hepatology” Volume 26, Number 3, Supplement 1; September 1997.

Lee W, Hepatitis B Virus Infection, New England Journal of Medicine, 1997; 337: 1733-45

On Snorting

The same old adage would apply from straws to anything—“If it’s wet and not yours you have the best chance of avoiding disease by leaving it alone” to other harm reduction options for snorting * make as fine a powder as you can to increase absorption and decrease damage to your mucus membrane * test the substance on your fleshy inner lip and, if it burns there, consider treating it to make it more neutral. Note that if it doesn’t dissolve in water easily, it likely will not dissolve well in your nose * as usual, try a little to see your reaction, but remember to wait longer with snorting than injecting * have a nice Kleenex nearby in case you need to blow your nose to moderate your dose—country blows are considered rude in most circles...

Dan Bigg is with the Chicago Recovery Alliance and a Board member of HRC.
As this area has been promoted as the availability of my various drugs of choice. 

I live in a small community in Northwestern Montana. I moved here from Reno, Nevada as a single mom hoping to protect my daughter from urban teenage temptations, and myself from the easy availability of my various drugs of choice. As this area has been promoted as the “Last Best Place,” I looked forward to an environment that not only is naturally beautiful, but safe and serene as well.

This worked for us for a few years, but eventually, after almost 6 years of clean time, my addiction called my name in a way I was powerless to resist. I picked up a U-100 and began injecting speed. While my relapse only lasted a year, it was long enough for me to be involved with the death of an innocent man, to lose not only my few material possessions, but my employability as well.

My sister came from California to take my daughter away, my boyfriend went to prison, and at some point during my go-fast adventure, I injected the hepatitis C virus.

At first, I shrugged the whole thing off. Big deal. At my age, 48, there are a number of things that can get me first. Actually, I had no idea what it meant in terms of any threat to my general health, nor did anyone else seem to. There were vague suggestions of liver cancer or cirrhosis somewhere down the line, but other than fatigue and loss of appetite, nothing very dramatic seemed pending. The fatigue seem inevitable following a year of very little sleep, and frankly, I was happy about the loss of appetite, as putting on weight is a common terror of recovering speed freaks.

My daughter however, did not share my indifference. She was profoundly shaken and certain that having miraculously escaped death while using, I was now doomed to drop dead at any minute from hepatitis. I made an effort to learn about my options, to get her off my back.

What I have discovered is that not much is known about the virus, and that any treatment is experimental at this stage. I decided against the interferon injections because I don’t believe I can self-inject without relapsing, and because the interferon treatments, in my case, may not make much of a difference anyway. Instead, I have changed my diet, eliminating all flesh except fish, I take handfuls of supplements, the most important being Vitamin C and Milk Thistle. In addition, I practice meditation to relieve stress, and exercise semi-regularly. As a result, I experience an energy level, while not quite as extreme as while I was active for Hep C. I suspect the rest of them are positive, but have been unsuccessful in convincing them to get tested. My using circle was made up of junkies old enough to drink legally. Many of them were my age and had come to this area to escape opiate habits easier to maintain in the big city. Opiates, while around, are not yet consistently available in quantities sufficient to support a habit without getting dope sick. Speed is. Many long time opiate addicts are now slamming speed.

Most of us have been around long enough to know something about the risks, but many of us have made mistakes, assuming that shooting dope is shooting dope. I disagree. There is something about speed that encourages carelessness. Personally, I did share needles, even though I knew better. Although I did not know it would take two minutes of shaking a syringe with bleach to kill the Hep C virus, there were times that information would not have made a difference. When it is time, it is time and for my part, two minutes would have seemed like two days. In Montana, anyone can walk into a pharmacy and buy needles, no questions asked. But, pharmacies are not open late at night, or somehow or other you have spun into tweakland too far to negotiate a trip to the pharmacy and out comes a matchbook, but seldom in my experience, a bleach kit.

Of greater concern to me are the kids, picking up with little or no information on the risks. The community I live in refuses to acknowledge that junkies even live here, let alone that teenagers may be using needles. I know otherwise. A few weeks ago, a kid injected what he thought was crank, and dropped dead on the spot because he had been sold crushed heart medication. The other kids in the group survived the experience only because they had the presence of mind to cut the dope out of their arms. None of this made the local paper or news broadcast.

Any suggestion that kids are shooting up, and as a result may be at risk for HIV or Hep C, is met with total denial. It is very difficult to...
dealing with hepatitis
some facts for injectors

SOME GENERAL SIGNS
AND SYMPTOMS OF ACTIVE HEPATITIS INFECTION
The most common symptoms are fatigue, mild fever, muscle or joint aches, nausea, vomiting, loss of appetite, mild abdominal pain, and sometimes diarrhea. Although not as common, some people notice dark urine and light colored stools, followed by jaundice in which the skin and/or the whites of the eyes appear yellow. Some people who are infected with hepatitis lose their taste for cigarettes. Many cases go undiagnosed because symptoms are mild or suggest only a flu-like illness. Sometimes people have no symptoms at all.

HOW TO AVOID GETTING HEPATITIS A, B AND C
Hepatitis A, B and C are preventable diseases.

You can prevent hepatitis A by:
+ being as careful as possible to eat food prepared under sanitary conditions
+ using fresh, clean water that is not shared to inject (if you use water from a toilet, take from the tank, not the bowl)
+ washing your hands thoroughly after using the bathroom
+ using a barrier for oral/anal sex
+ getting vaccinated

You can prevent hepatitis B by:
+ injecting with a clean syringe (see section on Bleach)
+ using clean injection equipment (see section on Bleach)
+ having protected sex
+ getting vaccinated

You can prevent hepatitis C by:
+ injecting with a clean syringe (see section on Bleach)
+ using clean injection equipment (see section on Bleach)

ABOUT BLEACH
Bleaching your rigs and equipment is effective against killing the hepatitis B virus, but only if the bleach is in contact with the syringe for at least 2 minutes. This is different from the usual recommendations for cleaning with bleach to kill HIV. The hepatitis virus is harder than HIV and is harder to destroy.

Bleaching for at least 2 minutes is probably necessary in order to kill the hepatitis C virus, but studies have not yet been done to prove this.

WHAT IS THE HEPATITIS VACCINE?
Hepatitis A and B can be completely prevented by getting vaccinated. Currently, there is no vaccine for hepatitis C.

Hepatitis A vaccine consists of two shots over the course of 6 months.
Hepatitis B vaccine consists of 3 shots over the course of 5-6 months.

For complete protection (immunity) against hepatitis A or B, you must get all of the shots in each series. While no vaccine is 100% safe, there have been very few side effects with the hepatitis A and B vaccines.

If you are interested in getting vaccinated, discuss your decision with your provider.

WHERE CAN YOU GET HEPATITIS A AND B VACCINES?
Whether you have a regular provider or not, be confident in asking for the hepatitis A and/or B vaccines (you may want to bring this brochure with you). Some clinics will offer the vaccines only if you are a certain age, or only if you ask, and others will vaccinate you only if you are a regular patient.

For more information about hepatitis, call the National Hepatitis Hotline: 1-800-GO-LIVER (1-800-465-4837)

This information is taken from a leaflet provided by University of California, San Francisco (UCSF) Department of Epidemiology and Biostatistics San Francisco General Hospital 095 Potrero Avenue, Bldg. 90, Ward 95 San Francisco, CA 94110

For copies of the leaflet, please call (415) 206-5693 and/or email kochoa@itsa.ucsf.edu
PUBLIC AWARENESS = POLITICAL POWER

An estimated 4,000,000 Americans are already infected with hepatitis C. This figure is a conservative calculation. But this HCV epidemic continues to be most-ly ignored by public health and drug policy authorities alike. Its huge impact on the health and well-being of large numbers of people, whether infected or affected, is neglected. Its implications are disregarded. Paraphernalia laws and non-availability of sterile equipment promote transmission of HCV but remain in place. The mode, and ease, of transmission of HCV should be a powerful argument against novice experimentation with drug injection but, despite recent allocation of $195 million for standard drug war propaganda, there appear to be no plans for a federally-funded campaign of education for potential injectors about HCV. Similarly, there is no federal government interest in providing the education, testing services and support to established users to enable them to prevent HCV infection or protect their health if already infected.

The number of infected men and women makes HCV a massive social problem. But in the USA, of course, the actual problem is never the only problem. Given the way public health resources are allocated, important medical decisions are made by politicians along fragile fault lines. We must begin by advocating for funds to match the obvious impact of this disease. First, the public needs to be aware of the scale of the epidemic and its impacts; then we must use that public awareness to generate an appropriate funding stream for research, prevention and treatment of disease. Each of us is doing that already, by discussing the impact of HCV on our own work and in our own lives. If we then write about HCV in our local papers and bring that ink to our representatives, we will begin to see results. This process is underway in many places. If nothing is happening in your area, place a call to your favorite reporter and plant the seed for an HCV story. This is a massive, emerging epidemic and as such it is the story of the decade.

We know how to do this. Many of us have done it before, gaining public understanding for HIV disease, needle exchange, methadone maintenance, medical cannabis, harm reduction centers, ecological survival or reproductive rights. Once again, it is time to inform the public and to turn the light of that informed community into the dark corners of our political process— this time around the needs of people living with or in danger of being infected by hepatitis C.

RESISTING EXCLUSION

HCV poses more complicated problems for harm reduction practitioners. What must we do, to change what we do to include the new and significantly altered demands of hepatitis C?

The collective first reaction of the harm reduction movement to Hep C was to do the same things we do for HIV, only more of them. Like the workers in “The Jungle,” Upton Sinclair’s 1930s novel about working conditions in a Chicago meat packing plant — the more plant management speed up the assembly line, the more slaughterhouse workers pushed themselves to catch up, repeating the mantra “I will work harder... I will work harder.” If more work is the only response of outreach workers to HCV, we will fail to address this epidemic for the same reasons that Sinclair’s meat packers got ground up in management’s greed— lack of perspective and lack of an appropriate plan to address a situation that had change under their noses and without their assent. We must step back for perspective, then build a fresh plan to address changed circumstances.

Of course, we must continue to advocate for more syringe exchange schemes in more places, for more counseling, and for the ability to make more referrals to ever more threadbare services, but this alone won’t prevent the spread of HCV or the terrible progression of its epidemic. Why? Because if what we have been doing for ten years, or more, to effectively prevent the proliferation of AIDS also prevented the spread of hepatitis C, then 80–90% or our clients would not be infected.

This is not to say that participation in a syringe exchange does not contribute to the reduction of new HCV infections, or that the implements supplied and the practices taught do not reduce the incidence of infection. Two excellent studies in Pierce County, Washington—one by Holly Hagan, Don Des Jarlais, Sam Friedman, et al—demonstrate significant reductions in new HBV & HCV infection. Yet, even with participation in exchange we are speaking about a population that is overwhelming HCV+.

In order to improve the effectiveness of our outreach, we must remember that syringe exchange is more than a valuable service. In the unforgettable words of Judy Byrne of Australia’s IV League, “Once you have a syringe exchange, you’ve got a key to the community.” Syringe exchange offers access to a hard to reach and hidden culture of men and women, who live at great risk of blood borne disease. Many, if not most of these folks, are hunted and stigmatized by society, beyond the capacity of conventional medical interventions to contact, let alone serve them. Outreach targeted to the IDU community is essential, and syringe exchange is the most efficient and effective contact point for the obvious reason that we offer something that injectors want.

Yet we must accept the fact that our best syringe exchange practice has failed to have a dramatic effect on HCV and look at the reasons. First, there is little evolutionary precedent for parental administration of drugs (i.e. injection). As a consequence, humans have limited native defense against blood borne pathogens. Injection is inherently high-risk behavior. Too often, in the course of running the ridiculous political gauntlet which we have been forced through in order to establish minimal harm reduction services in the USA, it has been politically useful to trivialize that fact. We can no longer afford to do that.

Second, HCV is a very different virus than the HIV around which our interventions were designed. HCV is more persistent in the environment and easier to get into the bloodstream. Imagine one drop of blood from an eyedropper (approximately 1/20 of a ml.). If that
blood was HIV-infected, it could contain as few as 1-5 virus particles. On the other hand, one drop of HCV-infected blood, may contain as many as 100,000 particles. Therefore, proportionally smaller quantities of infected blood spread HCV. Microscopic quantities of blood on unwashed hands may spread HCV from injector to injector.

Third, far too many injectors arrive at syringe exchange programs already HCV-infected. This is a virus that is routinely acquired early in an injection career. What can be done to deliver an educational/prevention message that will enable uninfected injectors to protect themselves from HCV infection? What possible intervention could we preach or teach or advocate, that would protect these almost invariably young people, who may never have heard of syringe exchange and almost certainly have never seen one? And, what can we teach that will empower regular injectors to protect their shooting partners, from infection via the presumptive majority who are already infected? The answer is PROBABLY NOTHING.

Of those people who continue to inject, a significant percentage will become HCV-infected no matter what we teach and no matter how well injectors empower themselves to routinely employ sterile technique. This epidemic is problematic even in hospitals where, for example, some 30% of kidney dialysis patients at San Francisco General are HCV+ along with a high percentage of the nurses; it is easy to imagine the degree of difficulty at achieving sterile injection under conditions where many of our needle exchange customers inject. Here, once again, social class and economic status will affect the conditions under which one injects and consequently the rate of infection, but HCV will spread even given the inherently more sanitary injection practices of the relatively privileged.

What can we, as outreach workers, trainers of outreach workers and directors of outreach projects, do to slow the silent epidemic of HCV? These are the questions about which we have been thinking for the past year and a half. After long discussion with many thoughtful folks, we make the following recommendations...

ON PREVENTION

- Discourage injection, by encouraging other means of ingestion. Chasing the dragon, snorting, kestering, anything that would lower the number of injectors and/or reduce the frequency of injection;
- Demand that all syringe exchange clients have access to anonymous HCV testing, with culturally appropriate and professionally competent pre- and post-test counseling, which would be followed up with the offer of vaccination for Hep A, B & Tetanus, combined with referral to treatment;
- Teach clients about the risk they pose to their partners if they help them to inject;
- Begin outreach to snorters, to help them recognize the serious HCV risk of sharing straws. There has been no outreach to this community since we learned that little or no HIV was spread this way. Snorting is less risky than injection, but not if one shares straws; and
- “Wash your hands.” At the risk of sounding like my mother, these are the words I repeat day-after-day at syringe exchange... “Wash your hands, that can help protect you from HCV.” Cleanliness offers a significant—and often difficult to achieve—barrier to infection, but we must remember that the standard is VERY high.

ON LIVING WITH HCV

- Teach people living with HCV about the dangers of alcohol consumption. On the basis of our observations of the participants in the APAN Syringe Exchange Program, we say: “Our HCV+ clients who drink, die.”
- Teach patients to recognize the danger of re-infection, possibly with a different strain of virus (there are at least 6 distinct genotypes of HCV), which can accelerate the progression of disease and complicate treatment.
- Recognize the impact of nutrition on the health of HCV+ people; and
- Recognize the intimate, complex and under-reported relationship between hepatitis C and auto immune disorders, in order to advocate for better medical care for needle exchange clients.

ON HCV POLICY

- Advocate for the inclusion of drug users, former drug users and substitute drug users at all levels of medical treatment for HCV, including liver transplants and clinical trials. Make certain that the standard is not drug use status, but compliance with protocol. If persons must be judged suitable to receive the transplantation of a scarce organ, that judgment should be made on the quality of that persons entire life and not on the single factor of drug use.
- Demand an adequate funding stream for HCV treatment, prevention, research and care;
- Expand the mission of existing HIV Organizations to incorporate the demands of hepatitis C upon the communities we serve; and
- A vital recommendation is the development of an activist core of HCV+ individuals, who become experts on the virus and its consequences. When we become experts in the epidemics which impact our community, we can demand appropriate treatment. In order to address this unfunded epidemic, we must become informed advocates for our own health care. As the large banner, which hung at the entrance of the Berlin AIDS Conference read: “We Will Stop the AIDS Epidemic Through the Empowerment of Affected Communities.” This is the way we will stop HCV.

We must acknowledge the contribution of all members of the Working Group of HCV Global Foundation in helping us write this article, especially, Ron Duffy, Dave Burrows; Nick Crofts, Reda Sobky; Erik Froemberg; Mark Bieowski; Dennis Isaaks; Alan Francis; Neil Flynn; Rachel Anderson; Barbara Cahooin-Young; Roulette Smith, Jimmy Hallo- ran; Erik Froemberg; Andy Rosenbloom; John Irving and Lucinda Porter plus the support of the Lindesmith Center West, Marsha Rosenbaum, Director.

“The first human right is the right to be human.”

1 Personal communication with Mary Pat Kelly, MS, RD, Nutritionist and Dietitian at the Dialysis Unit, San Francisco General Hospital.
Welcome to the second “Witches’ Brew,” a regular item in Harm Reduction Communication. It features recipes for herbal remedies, holistic health care tips for general wellness as well as drug usespecific medical issues. This edition’s Brew focuses on liver health as it relates to hepatitis C as well as general support and detoxifying of the liver.

The liver processes everything that comes into our body, metabolizing carbohydrates, proteins, fats, and vitamins, activating hormones, and detoxifying our body from toxins including: pollutants, food additives, drugs, and other substances that are toxic to our system. In general, drug use creates toxins to be processed by the liver. While this is true of both street and pharmaceutical drugs, street drugs are often cut with extremely toxic chemicals that are particularly hard on the liver. There are no regulations and no warnings on street drugs as there are for pharmaceutical drugs. However, the two most damaging substances to the liver are alcohol and nicotine, alcohol being the most poisonous. Prolonged use of either can create damage to the liver with or without the introduction of hepatitis C.

Hepatitis is an inflammation of the liver that may interrupt the normal functioning of the liver, allowing toxins to build up in the system. Hepatitis C, because it is incurable and chronic, needs to be addressed in order to prevent or reduce the interruption of liver functions. The typical Western medical treatment for hepatitis C is Interferon. For information on this treatment, contact your local needle exchange, public health clinic or your medical doctor. Medical treatment and vaccinations are also available for hepatitis A and B.

The intention of this article is to provide holistic alternatives to supporting and detoxifying your liver, and reducing the effect and preventing the progression of hepatitis C. Below are some dietary suggestions and herbal information for general liver health and addressing hepatitis C. In addition, we have included a summary of three interviews of people who have either chosen herbal medicine exclusively to address hepatitis C, or have integrated it into their Interferon therapy. While the focus of this entry is on alternative approaches, Witches’ Brew makes no assertions about Interferon or the decision to use both, either, or neither to address hepatitis.

Presently, I am back to the Western Herbal capsules; Hepato-Plus formula from a health food store. I’ve had no side effects, and I’m still awaiting a liver panel. I use herbal medicine as a respite from and in conjunction with Interferon, but I also adjust the Interferon regimen so that it works for me. You have to find something that works and feels right for you.

MARK: I never used Interferon, instead I’ve been using tinctures (liquid extractions of dry herbs taken out of a dropper bottle—see below) of the following western herbs: Dandelion root, Milk Thistle, Echinacea, and Licorice. My liver panels are excellent, my doctor said not to worry, one of my panels is normal, the other is slightly elevated. Before I started herbal therapy, my liver levels were very high. (Mark also exercises consistently which is very important for detoxifying the body).

JOY: I am on a Chinese Herbal regimen. After speaking with a lot of people, some using Interferon and others using alternative therapies, I decided to use Chinese Herbal Medicine instead of Interferon because everyone on it complained about the side effects and felt sick, when they hadn’t felt sick before taking it. All of the folks who took alternative medicine felt physically and mentally better and have better results with less stress. I have done a lot of research, and the recovery rate is really small with Interferon. I also didn’t want to inject.

I am working with a Chinese medicine practitioner who has created several Chinese herbal formulas for me. I only take one of the formulas at a time, but I rotate formulas every two weeks to prevent any one of them from losing its effectiveness. The Chinese medical practitioner also adds various herbs depending on the current condition of my system. In order to take the herbs, I make a tea every morning and drink it. I only have to do this once a day. Every three to four months I stop with the cooked herbs for 2 months and take herbal pills, and then I go back to the teas.

My Western medical doctor gives me liver panels every 6 months. One of my panels is within the normal range, the other is slightly elevated. My doctor is not concerned, both of my panels have gone down since I’ve used the Chinese herbs and I have had no side effects.
There are several points which emerge from these three different accounts, in which each has used different herbal regimens:

☆ Taking herbs by tea or tincture is much more effective and powerful than taking capsules. One of the reasons that the herbal regimen may have worked for Joy and Mark and not as well for Jason may be because of this difference in method of intake.

☆ Chinese herbal medicine is a very complicated system and it is important to use it in conjunction with seeing a practitioner of Chinese medicine. The herbs described below are Western, and while ideally taken in conjunction with seeing an herbologist, they are readily accessible in herb stores and many health food stores.

☆ Whichever way you chose to address hepatitis C, find something that works for you and that makes you feel mentally and physically healthy.

HOLISTIC SUGGESTIONS AND HERBS FOR THE LIVER

The following are some suggestions for general liver health, herbs that support the liver, and some formulas to address specific conditions of the liver. Again, teas and tinctures are the most powerful use of these herbs.

☆ Tinctures you can buy in herb and health food stores or mail order (for information on mail order, you can contact Witches’ Brew at the Email below).

☆ Teas you make yourself by placing herbs in a container, pouring boiling hot water over them, covering them and letting them steep for 20 minutes, then straining the herbs and drinking the tea.

HOLISTIC HEALTH SUGGESTIONS

☆ Water flushes the liver and assists with the removal of toxins, one of the best things we can do for our livers is to drink a minimum of 8 full glasses of water a day, preferably filtered or bottled water.

☆ Exercise is another important part of detoxifying the system, 30 to 45 minutes of aerobic exercise (exercise that gets your heart going) 4 or 5 times a week.

☆ Lemon water in the morning is an excellent way of getting your liver going: squeeze the juice of two lemons into a glass of water, preferably filtered or bottled. I also add honey (not sugar).

☆ Bitters are excellent for helping and decongesting the liver. Bitters include some of the herbs listed below but are also found in some greens, some of the more common ones are arugula, raddichio, and dandelion greens.

HERBS

Most commonly used herbs:

☆ Licorice: is an anti-inflammatory to reduce inflammation of the liver

☆ Dandelion: a hepatic, meaning that it cleanses and tonifies the liver and entire body

☆ Golden Seal: a bitter for decongesting the liver, but very strong and should only be taken as one rotation of herbs

☆ Milk Thistle: increases bile, the substance that the liver creates to remove toxins from the body

These can be used in equal parts as tea or separate tinctures, or you can purchase herbal formulas as Jason did, or look for the following combinations.

HERBAL FORMULAS

For hepatitis, there are two herbal combinations that are useful, one is a liver tonic, the other an anti-inflammatory. Both are available in tincture form in these exact combinations from Herb Pharm, or you can look for formulas with similar herbs, the active herbs are the most important, the others may have substitutes depending on the formula you find.

LIVER TONIC FORMULA

ACTIVE: Dandelion root and leaf, Oregon Grape root, Milk Thistle seed
SECONDARY HERBS: Artichoke leaf, Beet leaf, Fennel seed

ANTI-INFLAMMATORY FORMULA

(this is also useful for other inflammations—including TB and arthritis):

ACTIVE: Turmeric, Chamomile, Meadowsweet, Licorice root, St. John’s Wort
SECONDARY HERB: Arnica flower

David Hoffman’s book “The New Holistic Herbal” also recommends the following two herbal combinations, one is a liver tonic, the other is to specifically treat jaundice (jaundice is the yellowing of skin and eyeballs due to build up of toxic substances in the liver). These are recommended as teas, the indication of the parts being as follows: 2 parts means that for every amount of the 1 part herbs that are used, double the amount of these should be used. In general you want to make a strong tea that produces two cups of liquid (about two tea bags-worth of herbs total).

LIVER TONIC (can be taken as a tea and drunk after each meal)

Dandelion (2 parts), Meadowsweet (2 parts), Fringetree Bark (1 part), Golden Seal (1 part)

JAUNDICE TONIC (should be taken as tea every two hours during the day while symptoms last)

Balmony, Black Root, Dandelion, Fringetree Bark, Golden Seal (all in equal parts)

The staff at herbal stores are usually very knowledgeable and helpful about herbal therapies. It is recommended, however, that you work with an herbologist on developing an accurate herbal formula to meet your specific needs.

An informative article, “Natural Help for Hepatitis,” by Andrew Wylie, is in the April 1998 edition of Self Healing. To obtain a copy, contact Witches’ Brew or Self Healing directly at 42 Pleasant St., Watertown, MA 02172.

Please write and let us know your experiences with any of the information above and with treating hepatitis C. If you have further questions or want to suggest topics for future editions, please feel free to contact Witches’ Brew by Email, fax or phone: kershnar@harmreduction.org, fax: (212) 213-6582, phone: (212) 213-6376 ext.14.
HEPATITIS COUNSELING AND TESTING

PRACTICAL GUIDELINES FOR PROVIDERS

BY KRISTEN OCHOA, PAULA LUM, MD, MPH AND ANDREW MOSS, PHD

In 1985, publicly funded HIV antibody counseling and testing services were initiated as a tool to encourage HIV prevention. Though little was known at that time about the prevalence and natural history of HIV infection, providers saw that linking testing and counseling together was important in helping persons interpret the meaning of test results.

Today, we are faced with a similar problem with hepatitis C (HCV). A serologic test for antibody to HCV became available for the first time in 1990, and many people are just now learning that they have hepatitis C. Knowledge of transmission, however, is limited and few treatment options exist. Although HCV is not as uniformly fatal as HIV, the diseases bear many similarities in their viral etiology (origins) and genetic diversity, their blood-borne transmission, a chronic course, and the absence of definitive cure or preventative vaccine. How do you do hepatitis test counseling in this climate? What constructive messages and prevention tools exist? In an effort to provide hepatitis testing and counseling to young injection drug users, we have developed some strategies for staff counselors and medical providers aimed at providing hepatitis education, risk assessment and disclosure in a harm reduction setting. (These general guidelines may also be adapted for screening for hepatitis B.)

OBJECTIVES OF HEPATITIS C COUNSELING AND TESTING
1. To provide a convenient opportunity and comfortable environment for persons to learn their current HCV serostatus.
2. To provide information to those who are infected with HCV; secondary prevention, evolving treatment options and strategies for slowing disease progression.
3. To identify persons who are unaware or uninformed about their risk of infection for hepatitis HCV and to foster within the individual an understanding of their personal risk and options for prevention.
4. To prevent further spread of HCV by informing people of their status and risks.

NECESSARY ELEMENTS OF HEPATITIS TEST COUNSELING, TESTING, AND REFERRAL SERVICES

Outreach: We must start by finding people, and reaching out to them. As simple as this may sound, many current and former IDUs are not aware of their risk or their status for HCV and would not enter testing without outreach. Outreach should go to where people are, raise consciousness, and offer easy access to HCV-related services.

Maintenance of Confidentiality: Just as anonymity and confidentiality are important aspects of HIV testing, so should they be in hepatitis testing. Assign, or have the person choose a unique identifier (letters or a number) so that you can do follow-up.

Education: This should start during outreach and be developed by the test counselor. Begin with the ABCs of hepatitis. How are hepatitis A, B and C different from one another (many people confuse them)? How are they transmitted? What options exist for hepatitis A and B vaccination? Why are we concerned about hepatitis now—who has it and who’s at risk?

Risk Assessment: In risk assessment, the counselor responds to the individual’s needs for reducing his or her harm in general and his or her risk for HCV in particular. Consider whether or not the person could be in the window period for HCV (2-8 weeks). Focus should be on assessing where the person is now in terms of risk and developing a harm reduction strategy for reducing future risks.

Harm Reduction: Focus on the individual’s goals and offer viable, incremental options for change relevant to his or her life. Validate their current attempts, while recognizing and clarifying the relevant, remaining risks or places to grow. A risk assessment form should be developed for each person with space for a harm reduction plan.

Disclosure/Interpretation of Test Results: Providing HCV antibody (ELISA-2 or EIA-2 are the most commonly used) test results is challenging in light of the many questions that remain about HCV transmission and treatment. Unlike tests for HBV infection, antibody tests for HCV cannot distinguish between current acute infection, chronic infection, or past resolved infection. For the person who is HCV negative, the harm reduction plan should be completed with guidance from the counselor. For HCV positive people, several secondary prevention tools exist which are important in disclosure: reducing alcohol use, getting into regular care and getting vaccinated for hepatitis A and B to prevent co-infection. New evidence exists that HCV positive patients with HAV co-infection can develop fulminant liver failure. Co-infection with other viral illnesses, such as HIV and HBV, may have similar effects.

False-positive HCV test results are more likely to occur in low prevalence populations, such as blood donors. This group should receive supplemental testing with a RIBA-2 or HCV RNA PCR testing to confirm or rule out HCV infection. In high-risk populations, such as injection drug users, the accuracy of the commonly used HCV tests is 88-95% and does not require supplemental testing.

Vaccination and Referral: Vaccination against hepatitis A and hepatitis B for those who are eligible should be available on-site or at a convenient community-based organization. Fortunately, there are few adverse effects from these vaccines. The person’s decision whether or not to receive vaccinations, however, is also part of the harm reduction discussion and plan. Developing a referral network with health care providers who also use a harm reduction approach is helpful. Outreach workers should be available for accompaniment or advoca-
Clinicians and outreach workers should collaborate on following-up with clients so that they may complete their vaccination series.

Kristen Ochoa is Project Coordinator, Paula Lum, M.D., M.P.H. is Medical Director and Andrew Moss, Ph.D. is Principal Investigator for the “UFO Study,” a collaborative project between the UCSF Department of Epidemiology and Haight Ashbury Youth Outreach in San Francisco. The project seeks to measure the seroprevalence hepatitis B, hepatitis C and HIV in injection drug users under age 30, and to provide hepatitis A and B vaccination, follow-up and community-based outreach. For more information contact Kristen at (415) 206-5693/email: kochoa@itsa.ucsf.edu or Paula at (415) 597-4965/email: plum@itsa.ucsf.edu.

2 New England Journal of Medicine, 1998; 338: 286-90

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Please send payment and camera-ready copy to: Harm Reduction Communication, 22 West 27th Street, 9th floor, New York, NY 10001.
“Drugs and HIV in the Rocky Mountain States,” took place here in Denver back in October. We—the Harm Reduction Coalition and the local harm reduction organization I work for, People Engaged in Education and Reduction Strategies (PEERS)—put it on together.

I agreed to write about it, because I also work as a journalist sometimes. Unfortunately I’m not a scrawl-frantically-in-skinny-notepads-kind-of-scribe: I prefer audio cassettes to refer back to for exact quotes and for a refreshed vantage point. Distressingly, the hotel sound people neglected to tape some of the crucial plenaries. So I have been in a quandary regarding this assignment/chore. How do I relate the highlights—the conference’s gestalt—using just my overloaded and fractured memory?

But late at night it struck me. Since articles in Harm Reduction Communication tend to get personal, why not lead with the above? Doing an effective job on this article with the cards I’ve been dealt serves aptly as an analogy on how HRC and PEERS overcame obstacles to put on our conference; and how we effectively handled stumbling blocks during its course. It helps to remember that wherever we are in life, we can, to quote Stacey Rubin of NYC’s Streetwork Project, “use our artistic souls to create harm reduction.”

For instance, as Dr. Steve Jenison of the New Mexico Department of Health noted, “AIDS is a major focus of harm reduction providers, but in this region where seroprevalence is still low, hepatitis is the major concern.” Only we’d neglected to include a breakout session on hepatitis. After requests came in, we quickly corrected our oversight with a round table discussion facilitated by Jenison.

I could have probably begun this article with a far more important observation. The conference broadened the base for harm reduction methodology throughout the Rocky Mountain West. Conference sponsors included the state health departments for Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, and Wyoming. Denver Mayor Wellington Webb, a convert to the cause of needle exchange, sent his blessings; Denver’s District Attorney, Bill Ritter, came to learn more and to establish a dialogue; and Patti Schwayder, who heads the Colorado Department of Public Health and Environment, welcomed participants with introductory remarks. Good thing a briefing by the CDC’s Tim Quinn on the funding for Ryan White working groups took place: representatives from Montana held their statewide planning group meeting right at the Adams Mark Hotel in Denver, the conference site, following the two days of events.

Just as important, the conference provided a harm reduction focus on an oft neglected region. For instance, it allowed states to compare each others’ experience in attempting to implement syringe exchange programs, each others’ quirks in the law: in New Mexico syringe exchange is allowed by law, in Montana over—

One of the beautiful aspects of the conference was the confident and copious presence of members of the Regional Users’ Group. During the question and answer period after one of the plenary four of the six questions and statements came from RUG members. The RUG meeting I attended at the PEERS storefront in Denver was informative, productive and efficient. It was also packed to overflowing. There’s a scene happening in Denver and you don’t what it is, do you Mr. Jones?

— Allan Clear, Executive Director, Harm Reduction Coalition
the-counter sales at pharmacies are hindered by corporate offices not necessarily state law; in Colorado syringe exchange is underground everywhere except Boulder.

The conference spotlighted innovative and personal approaches to harm reduction work. From Dusti Moats of the Empowerment Project in Denver offering to show women in her project how to roll a condom over a dildo using her mouth or explaining how to use a dental dam; to Gayl Edmunds of Kansas instituting sacred sweat lodges in prisons and presenting how Native American spirituality mirrors harm reduction practices; to Mitch Garcia of Center, Colorado, discussing his outreach through “teatro” — theater skits and improv—which explain health risks, such as needle sharing, to his engaged audience of Spanish-speaking migrant workers.

PEERS offered a tour of its El Progreso Harm Reduction Center, which hosts Denver’s Regional Users’ Group. “We don’t do anything without consulting the people who our interventions are going to impact,” said PEERS director Paul Simons. “We need to be in constant contact with users’ organizations.” Program participant Chris Wheeler spoke on the significance of the group to him: first learning about bleaching syringes and even acknowledging that he’s since done some underground syringe exchange. Another participant, Dominick DiSalvatore, was tickled that a health worker from Montana told him that she’d love to have him come to her state to offer further advice on starting a drop-in center. What had he explained to her during his talk? DiSalvatore had proffered the saga, Field-of-Dreams-like advice: offer free coffee and a place to congregate and the junkies will come. In other words, as Mitch Garcia put it, “the basic basics of harm reduction,” such as providing rides to health services. “We help meet their needs and they become our advocates,” added Garcia about his own experiences.

It wasn’t always what people wanted to hear. The conference allowed a chance for other users to vent their anger at health providers regarding restrictive methadone regulations. And the lack of adequate pain care after injuries when doctors discover their patient is an addict. “If you’re on methadone clinic lists, it puts you on bad lists when you come up on hospital computers and you don’t get anything stronger than a Tylenol 3,” one woman complained. Boulder County Health Director Chuck Stout concurred, saying that, “we need to pay very close attention to the people we are working with and listen to them. They have truth that we don’t have a clue about in our day to day jobs as bureaucrats or people who run programs.”

Like a good conference we managed to generate a bit of press for harm reduction. Boulder’s KGNU radio broadcast a segment. And the Rocky Mountain News covered the conference by focusing on our “rock star,” Dave Purchase of the North American Syringe Exchange Network. (It attracts reporters when you send out a press release on your conference accompanied by an excerpt from Rolling Stone magazine about one of your speakers.) The News also quoted Denver ethnographer Dr. Stephen Koester: “Once you get to know drug users, you realize they are no different from the rest of the population. Some are extremely irresponsible. Some are very responsible. Some are moral, others are immoral. Many hold jobs and many have families that are intact.” Koester would take flak from disbelieving Denver politicians for those truthful comments over the coming weeks. That is the climate we live in.

Denver’s weather turned inhospitable when the sky dumped the biggest blizzard of the season during the conference’s grand finale. But the locale did allow HRC director Allan Clear a safe space in which to parade his fetish without feeling hostility or ridicule directed at him: in other words, he wasn’t out of place in his cowboy clothes.

There. I got this done. We need to do it again sometime.

Greg Dauver is the Program Coordinator with PEERS’ Needle Exchange Forum, Denver, CO.

The first brochure in HRC’s STRAIGHT DOPE education series on drugs and drug-related issues, H is for Heroin addresses what heroin is 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 heroin users themselves, H is for Heroin provides accurate, non-judgmental, and practical information about the drug—including the benefits that users report as well as the risks, dangers, and potentially negative effects of using heroin and other opiates. The second brochure, Overdose: Prevention and Survival, discusses what overdose is; how it happens; how you can prevent it happening; how you can prepare for it happening; how to recognize if someone else has overdosed and what to do and what not to do in an overdose situation. Written by users themselves, Overdose: Prevention and Survival provides accurate, non-judgmental, and practical information in straightforward language.

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Last October, a diverse group of mental health professionals and harm reduction service participants and providers came together at a one-day conference on Mental Health and Harm Reduction. Three of the speakers from the conference describe the meaning of harm reduction in their mental health work.

peers and the possibility of change

By Ana Olivera

Any discussion of harm reduction and processes of transformation, be they psychodynamic or cognitive behavioral, has to be grounded in the historical realities of people’s lives. All human beings live in contexts, and these external realities influence and construct the ways that we perceive both ourselves and those that share our world, such as colleagues and neighbors. Thus, the stigma experienced by substance users or addicts, whatever name we want to use, is not necessarily a psychodynamic process but a very real social and cultural process which is located within specific economic, social and political contexts.

Thus, it is impossible to think about the "mental health encounter", and its transformational potential, without acknowledging that such an encounter happens in society. Indeed, the societal contexts for the mental health encounter set up many of the dynamics for that encounter. With this in mind, it seems clear that people’s processes of change cannot be abstracted from their contexts; such change takes place in people’s own environments, within their groups and networks.

People don’t change on their own, alone. Nor do people change in dyads, meaning in one-to-one encounters. Change happens in and because of social settings, as is illustrated by the link between lived experiences of reliability and a person’s capacity to trust themselves and others. This link is widely acknowledged but it is less commonly noted that such lived experiences of reliability happen and continue to happen throughout a person’s life in their larger networks, and are not confined to parental or partner relationships. Our capacity to trust, like our capacity to change, is generated socially and talking about change with people means acknowledging their contexts.

This appreciation of people’s lives in their group contexts can help us to speed up the process of change. We do this when we create networks, when we rebuild community, and by community, I don’t mean just very large communities, I mean all kinds of sizes. It is within community that people share experiences of developing relationships, of belonging, of being in a place of people that begins to show possibilities that are not readily available for individuals or groups of persons otherwise.

While acknowledging the richness of a one-to-one therapeutic relationship, it is also important to recognize its limitations. It is limited precisely because there is only one other person in the room. If we accept that the process of exploring different choices for oneself is highly dependent on how many other possibilities of being, how many other different trajectories in life people are exposed to, then the dyadic therapeutic encounter limits this exposure to one other person’s view of the possibilities. In a society such as this, a highly stratified society in which people are divided and graded in so many ways (e.g. class, race, gender, sexual orientation, age, physicalness, ableness, and other ways) it is so important for people to be exposed to other ways of being and to be able to practice and experiment with the possibility of different lives. Change begins with a belief in and familiarity with options and this begins with questions like:

How many other ways are there “of looking for balance in one’s life”, looking for ways to deal with pain, if that’s the interpretation of substance use, or looking for ecstasy, if that’s another interpretation of substance use? How many other possibilities of coping with ecstasy or coping with pain are available for people?

The answers people find to these questions depend on what people are exposed to in life. Models of behavior change, like the stages-of-change model, need to pay attention to the complexity of people’s potential. There are many, many seeds growing in all of us. Parts of us may be in the planning stage about something. Other parts are in the action stage about some other stuff. Other parts are in maintenance, and yet others are in relapse, other parts in pre-contemplation or contemplation. We are very complex persons. My ability, for instance, to conceive of myself in a different kind of relationship with substances depends very much on my knowledge that there are other ways to relate. How do I learn that? I learn that from my fellow human beings. I learn that because I am welcomed in a group where people are exploring it. Recovery abstinence-based programs have provided something really important for folks, which is a very reliable network that they belong to, and that is always there. Through harm reduction efforts, persons that have chosen to use substances are just now beginning to develop those same kind of networks, that same kind of community.

But whether the focus is on abstinence or on use, the danger remains the same: concentrating on the “drug” and forgetting the person and their own...
process. I worked at Lincoln Acupuncture for several years and learned much from its group approach to what was, traditionally, a very elitist form of medical intervention, at least in this country. At Lincoln, the acupuncture takes place within a process of people being together. The process of transformation becomes a community issue, not an individual process only. The internalization of change really happens here because the community provides a container in which I can try and experience movement with things, in which I am unconditionally accepted, and in which I am in spite of every stigma and whatever damaged identities I carry in this society. I can actually experience another part of me. I can come to know, in spite of the “me” of the stigmatized identity, that I am different. I can change. I see the possibility of a future. I construct a future.

In this respect, the power of the peer relationship, or however one terms it, is really important because it’s impossible for a practitioner to provide that kind of context for individuals in a process of transformation, particularly around substance use issues. This is something to do with peers being the embodiment of different possibilities in other human beings, different ways of being in relationship with substances, that actually permits the reconstructing, the redefinition of the damaged identities that we carry, that permits the development of self efficacy, self esteem, a sense of a future which can be constructed. By this mean I the possibility of action, the possibility of movement.

The issue of substance use is an issue that, in this society, produces marginality for people. It limits access to centers of power, to centers of respect, to centers of dignity. And to “transform” oneself when those very basic and needed qualities of safety are not readily available is a very harmful thing to try to do. A psychoanalyst would say you can’t let go of the defenses until you have something to substitute there. For this reason, the community setting for transformation is critical because that’s where the support is, where the role modeling of transformation takes place continually. When mental health practitioners take on work with harm reduction and persons who are using substances, it is important to connect such work into a communal kind of experience for those same persons.

Whether we call ourselves peers, clinicians, practitioners, whatever our label, one of our greatest strengths in working with others will be our ability to do what our partner or partners in that experience are not yet doing. Many of the people with whom I work, almost always in group settings, see no possibility of being other than a victim, unable to change having tried so many times, and having exhausted all the techniques that are available to them. They are trapped, defeated by this sense of themselves. But if a change does take place, whether it be a reduction in use, a change in substance or mode of use, it doesn’t matter how great or small, it is essential that this possibility of difference, the possibility of contrast is affirmed by others, by the group, or the participants, or the facilitator, or the mental health practitioner.

It is scary to witness somebody, having a hard time, going through pain, making choices we judge not to be the best choices for that person or going down a road which we think will lead to bad outcomes. Counter-transference experiences and emotions like these are difficult and painful. But one of the issues around counter transference in harm reduction is that the feelings we get when we work with folks are not so much about them but rather focused on us. They are much more about what we must do, rather than being an indicator necessarily of what the other must do.

This can be very difficult to deal with and, because of that, I think interventions that rely on more than a one-to-one interaction have a tremendous amount of potential for the very reason that the “transferential process” is not to an individual. In group settings, there are many opportunities for transference, and mirroring, and contrast production. There are also many opportunities for a diffusion of that process, thus permitting a focus on the person, or persons in the case of groups, that really should be at the center of the action.

It is evident that in a harm reduction approach, we are working from the points of strength in persons. We’re not working with the emptiness. There is a belief that it is from the fullness that the emptiness is transformed. But this is not necessarily the predominant approach in traditional mental health schools. Nor is it an easy thing to practice. It’s easier for us to say than it is for us to do. It challenges us, at any one time, and in all circumstances, a point of strength, from which to weave that process of transformation. Moreover, it means changing our values about what strength means, and what constitutes worthy behavior or a worthy way of being, and that is not easy to do.

All of this suggests that practitioners need their own networks, their own communities where their own process of transformation can also take place. This is something very different from a practitioner getting individual supervision. It is a different proposition from offering individual supervision to peer workers, or peer educators. It’s been my experience that every time that a process goes to a group level or a communal level, then the issues of control and the usual hierarchical society structures get really questioned, and changed. I find that beneficial.

It’s very difficult to access the experiences of oppression in a very transformative way in a one-to-one relationship because, by definition given the hierarchy of society, that relationship is already structured. As much as we have exceptional practitioners and individuals, it’s not an issue that an individual can overcome completely on their own. There are many larger societal structures of power and privilege that precede and follow one’s own attempt to neutralize them. So it’s...
MAKING CHOICES IS GOOD FOR YOUR HEALTH

BY FRED ROTGERS

There is a growing body of research in the broad psychological and substance treatment literature that supports a harm reduction approach which focuses on people’s own choices, and works towards helping people make commitments to chosen behavior goals. Accepting that drug users can and do make healthy decisions about their lives and about substance use is a critical step for clinicians to take if they are to be effective in engaging with and supporting people’s own change processes.

Much of the research is drawn from the field of alcohol treatment, which is unsurprising given the reader access that researchers have to people who have problems around alcohol use. However, the conclusions of the research are applicable to the substance use field as a whole and have significant implications for the ways that clinicians think about and practice their work with drug users. The research has three main threads: research on goal choice which looks at the extent to which having a choice about goals affects whether or not people achieve these goals; research on the effect of commitment to goals and how that interacts with the degree of movement towards healthier lifestyles; and, research on the process of behavior change itself.

GOAL CHOICE RESEARCH
People who get to choose their treatment goals have better treatment outcomes than those who do not. A study by Ojehagen and Berglund in Sweden offered a two year out-patient treatment program to people who wanted to change their drinking and one of the unique aspects of the program was that clients were asked when they walked in the door what they wanted to change and the program then addressed what they wanted to do. The clients were also repeatedly asked during the two years if they still wanted to do what they had said they wanted to do at the beginning. 86% of the people who entered the program completed it. This is remarkable in itself, but a full 84% of people met the goal that they chose and sustained through the course of the study, whether that goal was abstinence or moderation. Notwithstanding the many differences between Sweden and USA, that level of success is not supposed to happen given our usual thinking about how people resolve drinking problems.

One common reaction among clinicians to this emphasis on client choice is to worry that people will never choose abstinence if they are offered the choice. In fact the opposite appears to be true. Across 5 studies which looked at client choices about abstinence or reduced use, an average of 70% of clients actually chose abstinence as their goal. But whatever the choice, the bottom line from goal choice research is that allowing clients to choose their goals has an impact on subsequent behavior.

An important study by the Correctional Services of Canada, as yet unpublished, provides striking evidence for this. Canada’s correctional system is unique in North America in that the entire substance abuse treatment system is based on harm reduction. They have bleach and needle cleaning stations in prisons and they give out condoms. The CSC has just done a follow-up with a proportion of the several thousand people who have been through their treatment programs, looking at recidivism based on goal choice in their alcohol treatment program. The astounding, if preliminary, finding is that at the very least, the people who chose moderation did as well as the people who chose abstinence in terms of important indicators like new offenses, technical violations and readmission to prison as a result. Once again, this goes against the grain of our abstinence-only thinking here in the U.S.

RESEARCH ON THE PROCESS OF BEHAVIOR CHANGE

The work of Prochaska and DiClemente is well known to folks working in drug services. Their research makes it clear that people who have not done the cognitive work to commit to a particular plan of action for their lives but instead are pushed into action, tend either to resist the push or fail to reach the goals that they have been pushed to address. In progressing through the stages of pre-contemplation, contemplation and preparation prior to action, it is evident that client choice and client decision-making is a critical piece in determining whether people are going to take action to change their behavior, and if they do take action, how successful it will be.

The use of a decisional balance technique has been critical in developing the stages-of-change model into a useful tool for helping people to decide on changes and then implement them. This involves helping people assess for themselves the pros and cons of continuing the behavior versus the pros and cons of changing. When you do that kind of procedure with people, you get increased compliance with behavior change programs that they may elect to design for themselves or seek help from others in designing. You also get increased retention in intervention...
Harm Reduction Psychotherapy
With Active Substance Users

BY ANDREW TATARSKY

Since 1982, I have worked as a psychotherapist, clinical psychologist, supervisor, program director, and teacher in the field of substance use treatment. Coming out of the mainstream abstinence-oriented treatment community, I have learned from many different theoretical traditions about how to support people in moving toward achieving stable sobriety from drugs and alcohol. And I have evolved my own perspective that integrates psychodynamic, cognitive-behavioral, and biological theory in understanding and treating issues that are unique for each substance user. I am still in touch with clients that I worked with over ten years ago who have been able to maintain stable sobriety through some combination of psychotherapy, self-management, and self-help participation.

But the fact is that the overwhelming majority of substance users in this country either “fail” these treatments or are never effectively engaged in treatment. A major factor contributing to this is the abstinence-only philosophy that dominates the treatment of, professional training in, and government policy toward substance use problems in this country. While abstaining from mood-altering substances may be the most appropriate, self-affirming goal for many substance users to work toward, the abstinence-only philosophy states that abstinence is the only acceptable goal for most, if not all, substance users who are experiencing problems in connection with their use. According to this model, substance users are required to agree to work toward this goal in order to be accepted for treatment and they must effectively maintain abstinence in order to be retained in treatment. Substance users unwilling to accept this goal for themselves or unable to achieve it are routinely denied or “terminated” from treatment with no alternatives offered.

Substance users are a broadly diverse group of people who can’t possibly all be treated effectively in the same one-dimensional manner. I met people with a wide variety of differences in the nature of their problems with substances, their personal goals regarding substance use, their emotional and personality difficulties and strengths, and social, economic, and cultural backgrounds. Many of these people were unwilling or unable to accept abstinence as a goal for themselves for a variety of different reasons and were not effectively engaged by the prevailing abstinence-only approach; many were hurt in the process. The need for more creative, flexible ways of working with active substance users became clear to me. Three years ago, I discovered harm reduction as a philosophy and a movement working to bring together a number of different attempts to meet this need. And I immediately realized that what I had been doing with many clients, often in isolation, was a form of harm reduction psychotherapy.

In this paper, I will discuss the relevance of harm reduction philosophy for psychotherapy with substance users and describe the approach to harm reduction psychotherapy that I have been developing in my practice and implementing with a group of colleagues at Psychologica, a group practice in New York City. I will also discuss the reasons why many substance users have great difficulty giving up their use of substances even though their use has become problematic in some way.

The Role of Harm Reduction Psychotherapy with Active Substance Users

Harm reduction approaches to psychotherapy with substance users may be defined as those approaches that attempt to help substance users to resolve problems that they have in connection with their use of substances without having abstinence as the goal or prerequisite to receiving treatment. There are a variety of treatment approaches which have been developed and practiced for many years now which can be grouped under this umbrella. Examples are motivational interviewing, controlled drinking training, and moderation training for problem drinkers. Abstinence may emerge as a goal and outcome out of this work but is not necessary to these approaches.

My approach is to engage people in a therapeutic context that will support them in clarifying the problematic, or “harmful” aspects of their substance use and working toward addressing these problems with goals and strategies that are consistent with their needs, values, lifestyle, etc. Treatments must be individually tailored to who people are and where they are if they are to be acceptable to most people.

By contrast, the abstinence-only approach is ideologically-based and not individually tailored. Its ideology insists that abstinence is the only reasonable or responsible goal for problem substance users, and thus restricts users who are unwilling to embrace abstinence from receiving help for their substance use problems. Such an approach is not supported by clinical outcome research or scientific theories of how people change. Furthermore, it makes it difficult, if not impossible, for substances users to get psychotherapy or other health services they find that the only treatment available to them is one which requires that they accept something that they cannot accept: the commitment to work toward abstinence.

Harm reduction recognizes that there are active substance users who want help and are able to actively and effectively involve themselves in helping relationships despite the fact that they intend to continue using. In fact, an argument can be made that this is the overwhelming majority of substance users. Harm reduction accepts that people’s use of substances must be accepted as a prerequisite to engaging in a therapeutic process that has a possibility of being useful to the client who is, after all, the consumer of services. From this perspective,
the high failure rate of all standard substance use treatment is not due to the “cunning and baffling nature of the disease” as many claim but rather to the failure of most treatment approaches to really begin where the client is, lip-service notwithstanding.

**The Clinical Rationale for Harm Reduction Psychotherapy**

Harm reduction psychotherapy as consistent with good psychotherapy and counseling practice and based on a scientific understanding of how people change. Any psychotherapy or personal growth process requires the active commitment of the client. The commitment will grow from a treatment alliance between the client and clinician around goals that are mutually agreed upon. The treatment alliance is the cornerstone of all effective psychotherapy. So, the initial focus of the therapy must be on what the client defines as the problem and what goals the client is interested in pursuing; whether this is an interest in moderating one’s substance use, stopping using altogether, or focusing on issues that are not directly related to substance use. These issues may be survival concerns such as housing, relationship crisis, etc. or emotional issues like hopelessness or self-hate. If the focus is not on the substance use, whether or how substance use impacts on the problem is an area of therapeutic exploration rather than something assumed a priori by the therapist.

Substance use is also seen as having positive, adaptive value for many people. This is another reason why harm reduction psychotherapy does not begin with the assumption that substance use is necessarily harmful to the user, but rather raises the question of its harmfulness as part of the therapeutic exploration. In this way, the clinician is not experienced as someone who wants to take something away from the client that is felt to be vitally important or someone who is like others in the user’s life who have failed to adequately understand, empathize with, and respect what is important to the user. But rather, the clinician may more likely be experienced as an ally trying to support that person in discovering better solutions to the issues being addressed by the substance.

Harm reduction psychotherapy also recognizes that behavior changes incrementally. As small positive changes are made in the use of substances, e.g. a lessening in the intensity or frequency of use or greater openness about use with people in one’s life, confidence in one’s ability to make changes increases and motivation to work toward greater change grows. Any reduction of harm is a step in the right direction.

Psychotherapy can be successfully conducted with many, if not most, active substance users. The degree to which the use of substances interferes with the therapeutic process varies in the same way that it does with other defensive or potentially harmful behaviors. Substance users are the only group of clients who are typically required to give up their symptoms or potentially problematic behaviors before they obtain help for them!

To the extent that the substance is serving important coping or defensive functions, this requirement is likely to be experienced as impossible to comply with until the functions and difficulties with the substance use are recognized and better alternatives are discovered. Failing to meet a requirement for abstinence may be experienced as a personal failure and an assault on the user’s self-esteem. Plummeting self-esteem and frequently associated shame, guilt, and self-hate may in turn precipitate a binge of intensified substance use as a response to these feelings. That approach to “helping” is likely to increase the harm associated with the substance use rather than reducing it; what began as an attempt to begin working on one’s substance issues turned into another reason to feel worse about oneself and intensify the substance use as an expression of these feelings.

In contrast, an approach that accepts active drug use while the reasons for using are clarified has a greater likelihood of engaging the user in beginning a therapeutic process that will lead to positive changes regarding the substance use. The initial engagement itself can reduce the pressure to use and increase the user’s motivation to seek alternatives to using and to develop less harmful ways of using. The therapeutic setting itself,
individual or group, can reduce feelings of isolation, shame, and hopelessness. This may occur simply as a result of the relationship with someone who accepts and respects the user regardless of substances use status and is hopeful about being able to support the client in finding positive solutions to his or her issues. A reduction in these feelings may reduce the pressure to use and break into the vicious cycle often associated with intensified substance use. But this work can also address the reasons for using by a wide variety of active interventions which directly target the issues.

REASONS PEOPLE FIND SUBSTANCES COMPELLING EVEN WHEN THEIR USE BECOMES PROBLEMATIC

We might define substance use as problematic when it is in conflict with other important needs or values such as health, relationships, finances, or work. Substance use becomes so compelling that these other values are superseded when it addresses vitally important emotional or psychological needs, needs which may be conscious or unconscious.

Substances may be used in an attempt to cope with otherwise unmanageable feelings such as despair or rage or vague, uncomfortable, unnameable feelings which cannot be clearly identified. Using may also reflect an inability to soothe oneself effectively in other ways or turn to others for support because of feelings of shame or fears of depending on others. It may also reflect a profound hopelessness about ever being able to feel better or get one’s needs met in the world. Substances may be used to bolster failing self-esteem, to feel alive and strong, to assert one’s autonomy, to punish oneself because of guilt or anger at oneself, to feel part of a group, to strengthen one’s identity, or to get some respite or brief pleasure in an otherwise painful reality. These motivations may be compounded by conditioning, habit, lifestyle, and the biological effects of using itself.

Thus, if the substance use continues to fulfill some of these important functions, the prospect of stopping or moderating one’s use will be very threatening to the user. An appreciation of this threat must come before any work on modifying one’s use can begin.

THE PROCESS OF THERAPY

The first phase of therapy focuses on assessment and engagement. People who have not thought about or decided to directly work on their substance use need to be engaged with the question of whether there is anything problematic about their use. Prochaska and DiClemente have called these people precontemplators and contemplators. People who come with other presenting issues who use substances fall into this group.

We support them in self-assessing the nature of their substance use pattern and explore whether their use impacts on their presenting concerns or other important issues. As problematic aspects of their use are identified, it becomes possible to focus directly on the substance use. Now, as with clients who come initially with concerns about their use, it becomes possible to discuss goals and strategies for modifying their use that are in line with what is important to them.

It is important to listen for and reflect the client's ambivalence about changing rather than just side with the concern about using. The ambivalence contains the often unspoken personal meanings and importance that the substance has for the individual. As people become aware of these meaningful aspects of their use, a plan for change can be developed which considers how people can modify their substance use while meeting or expressing these needs in other ways. This may include both more effective substance-free self-care strategies and less harmful ways of using substances.

The question of moderating one’s use versus working toward partial or complete abstinence now arises for many people. It is important to support people in clarifying for themselves what they are ready and interested in working toward as they set goals. Whatever I or you believe is realistic for them is less important than what the client is ready to work toward. I feel free to share my opinions about how realistic I think their goal is for them based on my experience with other people but I freely admit that I have no way of knowing whether or not they can achieve their goal. I suggest specifically identifying and working toward their goals, whether to moderate or to stop using, with an experimental attitude. How realistic the goals and strategies are is assessed as the work proceeds and revised when necessary. We continue to clarify what issues need to be addressed as they arise as obstacles to achieving the client’s goals.

The work has a supportive focus on modifying the substance use pattern with a combination of cognitive and behavioral self-management strategies. There is an exploratory focus on the emotional issues that are associated with the substance use and conflict with changing. As these issues become clarified, it becomes possible to work on achieving more effective ways of...
HEP C and me
CONTINUED FROM PAGE 20

find support for any harm reduction philosophy and legal needle exchange is completely out of the question. Nevertheless, a small group of addicts is doing what we can to get the word out. Our message is basically shoot clean, watch out for each other and get tested.

At the Denver Harm Reduction Conference, I saw pictures of addicted kids in drop-in centers from urban areas on both coasts. The impact was overwhelming. As a mother of a 14 year old girl whose odds are pretty much in favor of her picking up someday, I was not only terrified by the precarious future our children are facing, if they have one at all, but filled with gratitude for the people willing to go out on the front lines with the harm reduction message.

I realize that in terms of numbers, there are probably more kids in one city block infected with Hep C than will turn up in the whole state of Montana. The point is, that it is happening here. With the easy availability of meth amphetamine nationwide, it is naive to think any community, no matter how pristine, how conservative, how small is spinfree. Because of the nature of the drug, the difficulty in killing the Hep C virus, and the popularity of self-injection among kids, I am afraid of what the future holds for a growing number of children contracting an incurable, chronic, fatal liver disease. It is one thing for an old broad like me to have it, but the ramifications of a significant number of young IV drug users being infected with Hep C, have yet to be revealed.

Vicki Peterson is a resident of Kalispell, MT.

Editor’s Note: Unpublished data from a UCSF Department of Epidemiology study suggests that 50% of young IV drug users are infected with hepatitis C.

Peers and the possibility of change
CONTINUED FROM PAGE 31

very difficult to get at the transformation of the experience of sexism, of racism, of poverty, in a one-to-one relationship. And how can we talk about substance use, transformation and harm reduction without addressing these issues? I don’t think we can.

When we ask people to practice safer use it is critical to understand the contexts in which use happens in that person’s life. This means moving beyond the psycho-dynamic to consider the sociological context. In what relationships of power in that person’s life does this happen? When we ask that, what issues do we raise, what feelings do we touch? And if we have or provide no context in which these issues and feelings can be safely explored, we could run the risk of saying, “You know, it is implicitly your sole responsibility to transform yourself in your access to resources and to survivalship in life”.

People don’t survive alone. People don’t transform alone, it’s always within a community effort. Harm reduction is such a powerful paradigm because the word “harm” permits a breaking away from an individual process to a collective process. But it automatically makes it more difficult for me as a practitioner because I then must work in community. I then must acknowledge that the process of change is not fundamentally determined by the brief interactions that we have in traditional mental health settings. Somehow we must integrate within a community approach, group approach, where the peer experience is extremely powerful. I’m not sure what the word “peer” means, but I think it usefully refers to persons who acknowledge their sharing of a process of transformation. But there are many processes of transformations going on at the same time. What the colleague, the buddy, the peer, really represents for people is the possibility of change.

Too often, however, we start to think that this peer’s experience is the recipe, that I need to do what this peer of mine did. Or I need to do what my colleague in mental health does. That can become a significant burden, both for the peer who is himself or herself in this process of trying new possibilities, creating new possibilities, as well as for the other people in the process.

There is a danger, too, in adopting harm reduction as the new orthodoxy in a way which closes down possibilities for our abstinence-focused peers to embrace it. In working to promote harm reduction, we must also practice what we are saying and not become intolerant of other approaches because such intolerance only mimics the intolerance of the abstinence model which harm reduction challenges. We need to recognize that institutions usually change when they cannot tolerate their own internal conflicts, and internal conflicts for institutions in this case would mean failures. When the “outcomes” reach a certain point of failure that is intolerable for the institution to maintain, it tends to want to change. So it’s very important to be looking for those windows of opportunity but also to be actively welcoming the conversation around the abstinence model and its value for practitioners; a conversation in which people feel safe to express their attachment. As elsewhere, applying harm reduction principles to our conversations with our own peers will help to create a safe environment for the possibility of their own transformation.

Ana Olivera is currently the Director of Women’s Services at GMHC and is an acupuncturist and has worked for years with substance users, primarily in the South Bronx at the Lincoln Acupuncture clinic.

MAKING CHOICES IS GOOD FOR YOUR HEALTH
CONTINUED FROM PAGE 32

programs and increased percentages of goal attainment.

SELF-DETERMINATION WORKS

Client self-determination is central to harm reduction philosophy and practice and there is plenty of research to show that it works with substance users. Clinicians embracing this type of harm reduction approach may have to wait longer for changes to occur and may not exactly get the changes that they would wish for their clients, but they will increase the likelihood of both constructively engaging with people and those people actually making their desired changes in behavior.

Fred Rotgers is a clinical psychologist and director of the Program for Addictions, Consultation and Treatment (PACT) at the Rutgers Center for Alcohol Studies.

36
Andrew Tatarksy is a clinical psychologist with a private practice specializing in the assessment and treatment of the spectrum of substance use problems from a harm reduction perspective. He is currently President-elect of the Division of Addiction of New York State Psychological Association and a founding member of Mental Health Professionals in Harm Reduction.

I see this approach as supporting the user in a self-generated process of change in which the client is in charge of his or her own growth and change. Insights which are revealed can then arise from the client’s own experience and are, therefore, more readily accepted than when they are imposed by others.

I suggest flexibly combining cognitive and behavioral with psychodynamic and medical interventions as appropriate to the needs of the particular client. Modalities must also be matched to the unique needs, vulnerabilities, and strengths of the client. Most importantly, these decisions are based on what the client finds most useful and acceptable.

2Personal communication with Richard Elovich, September 20, 1996.
4This statement is frequently used in the 12-step recovery community to refer to the compelling, self-destructive aspects of addictive problems. It is derived from a sentence in the “Big Book” of Alcoholics Anonymous that reads, “Remember that we deal with alcohol, cunning, baffling and powerful.” (Alcoholics Anonymous, pp.58-59, Alcoholics Anonymous World Services Inc., New York, 1939.)
In response to evaluations from the First National Harm Reduction Conference and to numerous requests for intensive training in areas of harm reduction practice, the Second National Harm Reduction Conference will offer more interactive sessions aimed at helping participants build practical skills and develop networks and organizing strategies, while leaving adequate time and space for discussion.

Pre-conference Meetings: October 6, 1998— These meetings will enable members of specific communities or those interested in particular issues to meet and organize for a full or half day. They are intended to provide participants with in-depth training, skills building, and opportunities to organize around a variety of harm reduction issues: methadone consumers advocacy, user organizing, integration in mental health and medical services, providers in twelve-step recovery, and perspectives on drug treatment. Will require pre-registration, as space is limited. Contact Christy Robb, Conference Coordinator, 212-213-6376 x 31.

Forums and Caucuses— Meeting space will also be available during the conference for community organizing, networking, and caucus meetings. Thus far, these include: a women’s policy caucus luncheon, a community of color evening caucus, and a youth evening caucus. Each evening will feature regional organizing forums, twelve-step recovery meetings, and substance use management groups.
Program Development
- designing and implementing harm reduction programs
- incorporating a harm reduction approach into existing direct services
- designing interventions for specific populations of drug users and those affected by drug-related harm
- presenting the complex issues faced by harm reduction workers and programs, including working with and supporting staff members who use illicit drugs, managing stress, and addressing bereavement

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

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

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

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

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

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

For registration booklets or additional information contact JPD Communications at 510-843-8048, fax 510-843-8050. Remember to book accommodations early.
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