At the First National Harm Reduction Conference in 1996, when HRC was looking for someone to speak about “the politics and complexity of being an active user in the harm reduction movement,” the list of potential speakers was quite short. The list for this presentation today, on essentially the same topic, was equally short. Not the kind of short list where you’ve whittled down a longer list of 20-30 or so names to a handful. The kind where you start off with three or four, scratch off a couple and then you have your short list—maybe one or two names.

I was the speaker in 1996, and here I am again.
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The harm reduction coalition (HRC) is committed to reducing drug-related harm among individuals and communities by initiating and promoting local, regional, and national harm reduction education and training, resources and publications, and community organizing. HRC fosters alternative models to conventional health and human services and drug treatment; challenges traditional client/provider relationships; and provides resources, educational materials, and support to health professionals and drug users in their communities to address drug-related harm. The Harm Reduction Coalition believes in every individual’s right to health and well-being as well as in their competency to protect and help themselves, their loved ones, and their communities.

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

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

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Our common struggle is the theme of this edition of Harm Reduction Communication. It is not news that the War on Drugs is an assault on social justice that blames drugs, and people who use drugs, for the social and economic blight in the lives of poor and marginalized communities. The struggle for harm reduction is also a struggle for basic rights and freedoms, and access to health care, housing and welfare support. Contributors to this edition describe not only the extent and fundamental nature of this common struggle but also suggest strategic targets and identify opportunities for partnership and coalition-building.

The War on Drugs is bound up with that other favorite American battleground, the war on reproductive rights. Each affirms and advances the other, as Lynn Paltrow makes clear in Our Common Struggle. The efforts of anti-choice advocates to establish the notions of fetal personhood and fetal rights, and thus rule abortion as an infringement of those rights, has finally succeeded as a result of the paranoia and misinformation of the Drug War, in which drug-taking during pregnancy has been declared prima facie abuse and/or neglect in some states (see Corinne Carey’s summary of the current legislative position on page 11).

At some basic level, these wars are about our bodies, and a struggle over their control and the rights and responsibilities invested in them. It only becomes possible to take a woman, bleeding, from the delivery room to the holding cell, as Lynn Paltrow reports, when her humanity is denied and she is stripped of her right to take responsibility for her own body. Racism, misogyny and class-based oppression fuel this denial of human rights. But drug use is also central to this process of dehumanization—not a person’s drug use itself but the meanings that are attached to drug use and their stories of loss of self-control and abandonment of personal agency.

These kinds of meanings have sustained, and been sustained by, the abstinence-only approach to drug treatment. Contributors to our “Bridging the Gap” theme, which runs throughout this issue, are clear about the role the abstinence approach has played in denying users rights to be responsible for their own bodies and in deepening, rather than challenging, feelings of loss of control and agency. Gayle Thomas and Harry Simpson describe their own journeys, personal and professional, across the gap from abstinence-only treatments toward harm reduction practice. These journeys were, and are, a redefinition of the meaning of drug use and a reclaiming of a right to be responsible for our bodies.

Harm reduction as a reclamation of rights is the basis of Vicki Jacobs’ Junkie Bill of Rights. But such a reclamation, with its reassertion of responsibility and control, must also seek broader coalitions in a common struggle against the racism, misogyny and class-based oppression that maintain inequality and injustice. Kate McCoy, in her piece Drug Research and The Politics of Knowing and Being Known, calls on researchers to contribute to such coalitions by recognizing the part they play in colluding with current states of injustice and the part they can play in challenging the inequalities of current research practice.

But if harm reduction is about rights and responsibilities over our bodies, Paul Cherashore in his cover article reminds us that the harm reduction movement itself must pay attention to the way that it disrespects drug users’ humanity. His own experience of ‘coming out’ as a drug user within a movement that then defined him solely as The Drug User speaks for many others. This act of definition replays the dehumanization of the drug warriors by confining users within a label, denying them their right and responsibility to create their own meanings about their drug use in the context of their lives and their participation in the harm reduction movement. Our struggle, in common with other progressive movements, is to resist the meanings and stigmas that others impose on us and reclaim control.

—Alan Greig

HARM REDUCTION COALITION POLICY STATEMENT ON HEPATITIS C

The Hepatitis C virus (HCV) is inordinately affecting injection drug users nationally and globally. As with HIV, injection drug users experience hepatitis C progression that is facilitated by stigma, criminalization and denial of basic human rights. Drug users are refused access to prevention materials and denied treatment when infected. Symptoms are often overlooked or dismissed by providers as the effects of illicit drug use.

The Harm Reduction Coalition is demanding the following standards with regard to HCV and drug users:

- Full pre- and post-education and support must accompany all screening for HCV.
- At-risk individuals who present possible symptoms of HCV infection must be advised of the availability of counseling, education and screening as a standard of care.
- HCV testing cannot be mandatory.
- Routine testing should be accompanied by comprehensive education following the patient’s consent. Such education should include information on transmission and prevention; the meaning of the various diagnostic tests; outcome of HCV; eligibility for and outcomes of currently available treatments.

- All counseling provides safer injection education.
- Drug users cannot be restricted from appropriate treatment based solely on their drug use. Drug users must be offered treatment just like any other HCV+ patient.
- All infected individuals should be provided with vaccinations for Hepatitis A and also Hepatitis B when appropriate.
- HCV screening must be freely available to all injectors and cannot be limited to institutional contact points such as drug treatment or jail.
- New and young injectors, particularly higher risk youth, must be a focus of education.
- Clinical trials must not exclude drug users.
- Research on transmission of HCV among drug users must be intensified.
- Individuals on drug maintenance therapies, such as methadone, cannot be restricted from accessing care, clinical trials or treatment—including transplants.
A DOG AND PONY SHOW?

USERS IN THE HARM REDUCTION MOVEMENT

BY PAUL CHERASHORE

When it comes to the state of harm reduction in 1998, with regards to the personal drug use of our comrades and the (lack of) willingness to come forward and speak openly about it, things aren’t much different than they were in 1996. I only hope that people will be banging down HRC’s doors to speak on this issue in the year 2000. Not very likely, is it? Well, how about settling for just a real “short list”. If we want to face a different picture in the new millennium we will have to work—on ourselves and on our movement—to create an environment considerably more hospitable to the users in our midst.

Last time around I was vague when speaking about my personal life. I was a newcomer to harm reduction, and I was feeling my way around. Over the last few years, though, I’ve been gradually opening up about my own use. Not because I want to, but because I’ve felt compelled to do so, both politically and personally.

I had kept my drug use in the closet for 13 years until it just became unbearable to continue doing so, as it was impacting negatively on my mental health and overall happiness (or lack thereof). Because I had used for much of my adult life, and because I had sold drugs to support my habit, I had a lot to hide. My drug use, though, was an integral part of my life, and concealing it had major negative personal consequences for me. In effect, I was forced to fragment myself into very different private and public personas. We all do this to a degree, but I had to carry this charade much further. I couldn’t talk openly about my life; when the subject did turn to me I found myself constantly on guard, watching my words, often lying, usually through omission, but sometimes blatantly. I wasn’t comfortable living this lie, and it wasn’t healthy. I wound up withdrawing further into my drug use.

Four years ago I reached a point where I’d finally had enough and could no longer keep up my charade. At that time I couldn’t conceive of being open about my current drug use. Although I had been exposed to harm reduction, I hadn’t been introduced to the concept of user empowerment. (Some users come to that idea naturally, but in the U.S. most of us are introduced to it.) I saw that if I really wanted to live a whole existence I would have to put my drug use into the past. Only then, after giving in to the system and stopping using, could I talk about my life at twelve step meetings. So, after having used dope for over 12 years without a substantial break, I finally did what I thought I couldn’t. I was excited to be drug free and wanted to tell my story. Unfortunately I was still in the middle of a methadone detox, so in the “rooms” I was not considered to be clean, and consequently not permitted to speak to the group. Of course in my mind I was clean, and couldn’t wait to tell the world.

It’s interesting how ex-users have these forums for talking about their substance use. It’s ok to talk about your past use, especially when you’re remorseful. The past is a great psychic divide, especially when it comes to drug use. People will forgive and forget the most horrible things that are over and done with. But the same person talking about those same activities in the present tense will get flayed alive. The active user who is not apologetic for his/her sins will not receive forgiveness or redemption. In our society 12 step rooms are the places ex-users go to tell their stories. When I found myself unable to “confess my sins” in the rooms I made the mistake of going outside of the established boundaries and talking about my drug use at any old time I felt like it. It was just such a liberating feeling to no longer be hiding such a big part of myself. Of course losing the job I happened to hold at the time wasn’t so liberating, nor was being rejected by erstwhile friends who pretended that nothing had changed between us. (Nothing had, except for the fact that I was being more honest about my life, and I had made the mistake of assuming that the honesty would prevail over bigotry.)

It was during this period that I began making use of the facilities of the Lower East Side Harm Reduction Center. As I got more immersed in the harm reduction philosophy, I began to see there were alternatives—one could be forthright about one’s current drug use. Eventually, for reasons too complicated to delve into here, I decided that altered states were preferable to sober ones, especially if one could be part of a community of
active users, and I resumed using.

As I began to get more involved with the harm reduction movement I felt the need once again to be open about my personal use. The more I spoke with other users, the more I realized how compelling personal disclosure could be. The act of speaking out about something that society would prefer to keep hidden is in itself a powerful statement of rebellion. One of the drug warriors’ most successful strategies has been the intimidation that has kept most users silent in the face of incredible oppression; as we remain silent we are isolated and alienated from each other and from ourselves. When we speak up we see that we are not so different: that many others have common experiences and problems and have chosen similar methods of dealing with them, i.e. self medication. By lifting that veil of secrecy we feel better about the decisions we have made, and that in turn gives us additional strength to fight against oppressive drug policies and laws.

Some people come into the harm reduction movement as non-users or recreational users and became more active. Others come in as ex-users. I will speak about the difficulties encountered by those of us who come into the movement as known users, because that’s what I know best.

I’ve always believed that expectations shape our lives to a much greater degree than we would like to acknowledge. What we believe to be free choice is often a combination of our opportunities, abilities, and experiences filtered through others’ perceptions of those things. It’s not that we don’t have options. It’s just that, for most of us, doors open for many of life’s choices at a point where our own expectations intersect with the expectations held by those who happen to have influence and power over our lives. Because the equation is inherently unequal (the individual on one side, society on the other) the danger is that we will find ourselves living out our lives according to how others perceive us to be, as opposed to who we really are—or what we want.

These expectations apply to people who come into the harm reduction movement as drug users. It will always be easier to remain identified as a user in the movement if you come in with that label, and in some ways the expectation that you are a user encourages you to continue your drug use. You will have to struggle to step out of that role. I know that when I came into harm reduction there were individuals who believed I could be a user activist, and that was the path that was easiest for me to take. There were certain perceptions that others had of me, and whether consciously or unconsciously, I responded to those perceptions. It would have been a hell of a lot harder for me to convince people I could be a grant writer or a treatment referral specialist. Of course, my willingness to be an open user and my particular political vision which saw coming out as a powerful political tool assisted me in going down that road. I am not saying users are victims of the movement’s tendency to see us just as users, but that it is easy to fall into that trap -and we must be aware of this if we are to prevent it from happening.

My experience is not so different from those of many of the users who have eventually gotten paid jobs in this movement. We start out putting in our time—usually as volunteers, or on stipends. We are cultivated because as users we lend legitimacy to programs that crave just that. And we bring a point of view that is desperately needed, the “privilege of experience.” The downside of such a relationship is that our continued use is often necessary to fulfill our part in the bargain. Because many times we lack skills and job experience, it is our drug history that has landed us employment. In fact, I’ve wondered at times what my value to the organization I work for would be if I were to stop my drug use.

As long as active users are at the margins of the movement situations like this will continue to develop, with dangerous precedents being created where users can feel obligated to meet others’ expectations. This may mean using when they really would rather not, or, in a more likely scenario, feeling obligated to disclose their personal drug history when they would be better off not doing so. All harm reductionists need to be cognizant of the potential for such situations arising. Users, when encouraged to speak out about their personal lives for the benefit of the movement, need to stop and ask themselves, before jumping into these situations, “Is the benefit to myself and other users worth the personal risk? Am I doing this for myself and my fellow users, or am I doing this because some agency needs to trot out a pretty face for some dog and pony show?” And each of us, as fellow harm reductionists who may be needing a user for public display, must ask ourselves, “Am I doing the right thing here? Have I really taken into consideration the risks to which this individual may be exposed?”

It can be so easy to rationalize, “This is for the greater good… it can help to keep my program open, my exchange going, and that will save lives.” But what about the life of the person we’ve asked to speak out in public? We can all get caught up in the excitement of the moment when the opportunity arises for a program participant to speak in public (or to the media) about how needle exchange or harm reduction has saved his or her life. Because users are often so grateful to be treated with dignity and respect—something that everyone deserves but that drug users feel privileged to receive— they will sometimes go out on a limb in order to express their appreciation. Unfortunately we are not practicing
harm reduction when we put users on the spot like this, and we are usurping the very process we have asked the them to publicly praise.

Before we ask a user to speak in public we need to make sure that we have outlined all of the potential risks and benefits, listed the alternatives, and set limits with which he or she will feel comfortable. I believe as a movement we need to practice harm reduction on this level if we are to do it on a grander scale. We need to remember that it’s not just about the reduction of direct, obvious use-related risk, but also about improving the overall quality of user’s lives.

Of course it would be far better if users in the movement were not as marginalized as they often are; users in positions of authority would be more likely to be sensitive to the issues their comrades face. We as a movement need to think about this; too often we assume users are content to volunteer, or accept part-time menial positions. We expect them to work for free or a small stipend, and we expect them to be satisfied to be just given an opportunity to participate in the delivery of services to fellow users. We wouldn’t ask that of any other disenfranchised group of people—why should we ask that of users?

We must consciously make efforts to bring users aboard—especially as paid staff—not because they are users, but because they happen to be individuals with skills and abilities who can make a contribution to our programs—who also happen to use drugs. Bringing people on as harm reductionists first and users second will help pave the way towards creating programs that are partnerships with users; this will in turn lead to the demise of the barriers and hierarchies that naturally arise when your point of view is either that of a service provider or service recipient. Of course it’s not enough to just say we’re partners in this, we have to take concrete steps to make this a partnership. And that will only happen when we create an environment where we can go beyond the labels, and where it no longer matters whether you use or not.

Paul Cherashore has been a involved in user activism since 1995. He currently works at the Harm Reduction Coalition.

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The Junkie Bill of Rights

What is “Junkie-Apartheid?” Remember South Africa where the majority of people were segregated and controlled by the minority? That’s what’s happening to drug users here...We are segregated and persecuted...anybody who uses drugs is scared shitless these days and for good reason...our civil rights have vanished. To that end, I suggest the following dream list to keep in mind...Please feel free to add to this or subtract from it.

1. Decriminalization of All Drug Laws...hands off our bodies...like the abortion struggle, the principal is control over our bodies, not government control.

2. Clean Drugs With No Bullshit: Think about it...what other business is so unresponsive to consumers? Whatever happened to customer satisfaction? Would any other big business last this long while delivering such an inferior product? Demand testing of drugs for purity or content—not drug-testing of consumers!

3. Consumer-Controlled Junkie Services—detoxes where the client determines the method of treatment, rather than the provider...demand availability of the latest technological advances in detox including electro-stimulation machines and electro-acupuncture to reduce withdrawal symptoms. The people should control their own technology. Harm reduction therapy...drug-management therapy...these services are supposedly for the client, yet they are controlled solely by the system of “Junkie-apartheid”.

4. Consumer-controlled Drug Maintenance: This means methadone clinics where the client determines the dosage and is not penalized for dirty urine, etc....demand the right to be treated with dignity...demand injectable methadone for shooters and heroin maintenance for those who prefer it (probably most of us).

5. Non-discrimination in health services: We all know too well what happens to drug-users in the health-care system...resulting in a well-rounded reluctance to seek medical care...To most doctors, we’re just drug-seeking scum...demand respect.

6. Housing for Drug-Users: It is nearly impossible to obtain any kind of decent housing for known drug-users, leaving the only options shelters—which ain’t nothin’ but de facto prisons—or the alienation of the streets. As citizens of the richest country on the planet, demand respect.

7. Jobs for Junkies: IQ testing of drug-prisoners in San Quentin found their IQs higher than the national average, yet known users are not hired or summarily fired. Demand an end to drug-testing; replace it with competency-testing for the job itself.

We’re talking basic civil rights here. We are a disenfranchised minority. Nobody will hand us our civil rights—we will have to fight for them, especially now when the battle lines are obvious. Let’s stop bickering and think, dream, and organize for our collective future.

Above Manifesto is dedicated to Rod Sorge, who I pray is watching over us from a better place. Rod, we miss you more than we can say...you gave your life for this cause...I hope we’re deserving of your sacrifice.

Vicki Jacobs has been doing needle exchange on the Lower East Side since 1991, and now works at the Lower East Side Harm Reduction Center.
BY LYNN PALTROW

THE first person I saw when I arrived at the Second National Harm Reduction Conference in Cleveland, Ohio last October was the Reverend Howard Moody. Reverend Moody is a great hero of mine, and not only because of his current work organizing clergy to speak out against the drug war. As a reproductive rights litigator, I came to learn of his very critical and radical work to help legalize abortion. When abortion was illegal in this country—and to say free abortion on demand was as radical as it is to say today “free drug treatment on demand”—Reverend Moody and Arlene Carmen organized the Clergy Consultation Service. At that time, the number of parishioners who were suffering with unwanted pregnancies and who were desperate for safe abortion services overwhelmed many clergy members. In response, Reverend Moody announced that the clergy consultation service would refer women who asked for their help to abortion providers. The clergy members identified those providers legal—outside of this country and illegal ones here—who were the safest. The clergy members made referrals even though to do so was against the law. The clergy members were willing to be arrested for helping the women who sought their advice and support. Perhaps this will remind some of you of today’s activists working for needle exchange and access to medical marijuana.

But, I think the fact that Reverend Moody and I both found our way to a harm reduction conference says something about the intersection of war against abortion and the war on drugs. I can’t speak for Reverend Moody, but I know I found my way here in part because it has become obvious to me that by linking the war on reproductive rights with the war on drugs, our adversaries are making gains that they could not otherwise have made.

We have a common struggle and common enemies and must therefore be willing to work together to stop policies that undermine public health, public confidence in the criminal justice system, and the well-being of children and families.

In 1973, in the Roe v. Wade decision, the United States Supreme Court recognized a woman’s fundamental right to choose to have an abortion. In order to reach that decision, the court specifically held that fetuses are not persons and therefore women’s lives and health may not be subordinated to their interests. Since that decision, anti-abortion activists have worked extensively to overturn Roe v. Wade. One way has been to try to have fetuses recognized as persons under the law. If treated as legal persons, abortion would have to be outlawed as murder.

Until very recently their fetal rights efforts were largely unsuccessful. But today, by linking fetal rights claims to the issue of drugs, they have achieved one of their greatest victories. In the late 1970s prosecutors began arresting pregnant women with substance abuse problems. Building on anti-abortion arguments, they claimed that fetuses were really “children” with rights. Building on drug war propaganda, they asserted that women with addictions could easily stop their drug use, and by failing to do so were abusing their unborn children. For many years, lawyers were able to convince courts to dismiss these cases. But, by linking fetal rights arguments with the war on drugs, anti-choice activists have now obtained an unprecedented and ominous victory. In October of 1997, in a case called Whitner v. State, the South Carolina Supreme Court, held that a viable fetus is a person and as a result a pregnant woman who uses an illegal drug may be prosecuted as a child abuser and sentenced to ten years in jail.

The holding in Whitner goes to the heart of today’s abortion debate, lending support to the anti-abortion position that fetuses are persons and that pregnant women’s health and freedom may be subordinated to those rights. Right wing legal groups (such as the American Center for Law and Justice), conservative pundits (like Rush Limbaugh), and opportunistic politicians have seized on Whitner and related cases as the long-awaited chance to overturn Roe v. Wade. The opinion has provided grounds for the South Carolina State Attorney General to assert that he now has legal authority to make all post-viability abortions murder and to put the women who have them and their doctors to death. In other words, fetuses in South Carolina became persons through the backdoor of the drug war.

The opinion has done something else as well. By linking the war on drugs and the anti-abortion wars, the decision in Whitner effectively overturns another Supreme Court decision, California v. Robinson. In 1964 the Supreme Court held that people couldn’t be arrested simply for having the status of being addicts. While subsequent cases have made clear that you can arrest people for being in possession of even the smallest quantity of an illegal substance, the Supreme Court’s
addicts who were pregnant. As a result of the Whitner decision, the little bit of constitutional protection that still exists for people with substance abuse problems is being eroded as a result of the war on reproductive rights.

The growing battle to end legal abortion coincided with the Reagan-Bush “war on drugs” and the unprecedented media coverage of the “crack crisis.” Pregnant women became an appealing target for law enforcement officials who were losing the war on drugs, and to the public who had been convinced by the media’s sensational, distorted reporting of scientific research that crack use during pregnancy caused significant and irreparable damage to the developing fetus.

Not only the public, but judges as well, read biased and inaccurate news accounts of cocaine’s effects and assumed that every child born to a drug-using woman would be devastated. If you had a child who had a health problem and a positive drug test for cocaine, then everyone assumed that cocaine caused the problem. This of course is terrible science that failed to control for many other factors that might have explained the poor health outcome. Or, you might find that the child wasn’t even exposed to cocaine in the first place.

The research simply doesn’t support many of the things that people have come to believe about the effects of prenatal exposure to cocaine. Rather than causing the permanent mental, neurological damage that excessive exposure to alcohol can cause, cocaine appears to act more like cigarettes, contributing to a less healthy pregnancy, but not necessarily causing specific permanent harms or any harm at all. Philip Coffin’s piece, for the Lindesmith Center, Cocaine and Pregnancy does a terrific job of summa-

It’s about the intersection of reproductive rights and drug policy and the fact that racism pervades our culture.

ding current research on the issues. Nevertheless, the myth that cocaine is always damaging is pervasive and controls judges and policy makers alike.

The media created “crack babies” and continues to portray their mothers—primarily poor, inner city and African American—as depraved women who voluntarily ingest crack to poison their children. All of this helps prosecutors who want to deflect attention from their inability to stem the tide of illegal drugs, and to the anti-choice forces whose goal has been to develop “fetal rights” superior to and in conflict with the rights of women.

The prosecution of pregnant women who use drugs has been fueled by some of the most highly charged and deeply entrenched political issues of our day, including not only reproductive freedom and drug policy but also America’s long tradition of racism and the legacy of slavery. Most of the women, especially in South Carolina, who have been arrested are African-American. The Southern Regional Infant Mortality Project did a survey and found that the typical drug using woman in the south is in fact a white woman, in her thirties, divorced or never married, with two or three children, dependent on an illicit drug and alcohol. Despite the fact that white women use drugs more frequently, black women in states that have mandatory civil reporting are ten times more likely to be reported.

In South Carolina, criminal justice officials and the Medical University of South Carolina sat down together and developed a policy of arrest and prosecution specifically targeted at black women. Almost everything you read, even the critical material, will tell you that this policy offered treatment to women first, and only if they didn’t go to treatment would they be arrested. That is simply not true. In fact in 1989 there was not a single drug treatment program in the state setup to meet the needs of pregnant women or even to reach out to them. Once they put the policy in place, African-American women who had been coming in for prenatal care and who had been testing positive for drugs, and who had never been counseled or referred for drug treatment, were arrested and taken to jail in chains and shackles, still bleeding from giving birth.

What was this policy about? It’s about the intersection of reproductive rights and drug policy and the fact that racism pervades our culture. The white nurse who administered the policy in South Carolina, admitted that she thought that mixing of the races was against god’s will. Every single woman who was arrested out of that hospital was African-American except for one white woman who gave birth to a mixed race baby. In that patient’s records the nurse made a special note of the fact that the patient “lives with her boyfriend who is a Negro.” We did get the policy stopped briefly, because the nurse and others published an article purporting to show that their punitive policy worked. We argued that the study was not only totally without scientific basis, but that it also constituted illegal research on human subjects. Without their knowledge or consent, a group of low-income African-American women were subjected to an experiment to test the hypothesis that throwing pregnant women and new mothers in jail would somehow get them to stop using drugs. I believe that this is one of the worst examples of inhuman research on people since the Tuskegee syphilis experiments. The National Institutes of Health thought it egregious enough to put the hospital on probation, and the Office of Civil Rights came in and got them to stop arresting women. But now with the Whitner decision, they are back in business.
Although the Whitner case represents the culmination of years of prosecutorial focus on pregnant cocaine users, the decision itself was not limited to illegal drug use. Women in South Carolina can now be arrested for engaging in any other behavior that might endanger a viable fetus, including drinking alcohol. The Whitner ruling turned virtually all pregnant women in South Carolina into potential criminals. Because the state has a mandatory child abuse reporting law, the Whitner decision also had the effect of turning all of the state’s health care and social service providers into mandated child abuse reporters when they learn that a pregnant patient uses drugs or engages in any behavior that may endanger the fetus. Although everyone is supposed to be guaranteed confidentiality if they seek drug treatment, South Carolina has apparently carved out an exception for women, by—again—linking the wars on abortion and drugs. The result has been to drive pregnant women in South Carolina out of the health and social service systems endangering their health and that of their future children.

The effect of Whitner decision has also been to put more mothers in jail. Melissa Ann Crawley is one of them. Like Cornelia Whitner, she was arrested when her healthy newborn tested positive for cocaine. Although Ms. Whitner begged for inpatient drug treatment and was given 8 years in jail instead, Ms. Crawley was luckier and got five years of probation. While on probation, however, she was beaten up by her boyfriend, she called for help. The police came three different times and each time refused to arrest him. In response to her fourth and most desperate call to the police, they arrested both of them on a city domestic violence charge. That arrest constituted a probation violation for the child abuse charge and Ms. Crawley had to go back to jail to serve out her sentence. We won, until the Supreme Court ruled in the Whitner case. What did that mean? During the time she was out of jail, Ms. Crawley was able to get treatment, and in fact was drug free. She was home working part time and raising her healthy three young children. She was not on welfare. But as a result of the Whitner decision she had to go back to jail at taxpayer expense to serve out her sentence.

Mr. Charles Conden, the South Carolina Attorney General who sees himself as the “defender of god, the south and the unborn” can be proud, I guess of imprisoning mothers and destroying families. Mr. Conden, who assured the public that the Whitner decision meant only that women who use illegal drugs would go to jail, has not addressed the fact that women in South Carolina have been arrested for drinking alcohol. The familiar argument that he and others make is that “we’re just trying to get them into treatment”. But many women are never offered treatment in the first place and even the prosecutors admit there is insufficient treatment available. Moreover why is it that prosecutors are deciding what drug treatment and what healthcare people should get. How did they get to be the decision-makers on statewide health care policy?

The prosecutions of pregnant women reveal that both law enforcement officials as well as many judges believe that addiction is a choice and that treatment is readily available. Similarly they believe that pregnant women have been able to make choices regarding their pregnancies. They assume that women have easy and free access to abortion and other reproductive health services. Many judges do not understand what addiction is and that neither drug treatment nor abortion are available on demand.

Many judges do not understand what addiction is and that neither drug treatment nor abortion are available on demand.
officer to take into custody a pregnant woman who he or she viewed as endangering the unborn child by the use of alcohol or an illegal drug.

Many other legislatures are also considering punitive legislation. The republicans and conservatives, who opposed restrictive tobacco legislation, need to look tough on drugs while they continue their attacks on abortion and poor people.

The prosecution of pregnant women gives them points on all of these fronts. Our efforts to stop the dangerous and counterproductive war on drugs and women will need to be sophisticated and coordinated. It will also have to be enduring.

It took hundreds of years to end slavery. It took nearly eighty years to win the vote for women. We will not win the battle for sane drug policy or for women’s equality and reproductive freedom in five or ten years. Change comes about over the course of lifetimes. I hope you will join me in committing yourselves to a lifetime of activism—so that we can make change happen.

Lynn Paltrow is the Director of the National Advocates for Pregnant Women, NYC, a Program of the Women’s Law Project.

POLICING PREGNANCY

THE LEGISLATIVE ATTACK ON WOMEN WHO USE DRUGS

BY CORINNE A. CAREY

Talk to a group of women who use needle exchange and other harm reduction programs, anywhere in the country, and you will hear chillingly similar stories of childhood sexual assault, domestic violence, and children born and lost to child welfare agencies. These histories are intertwined with drug use—both as an expression of and a response to their pain and trauma. Unfortunately, neither the women’s movement nor the drug reform movement have paid very much attention to women drug users and the difficult issues they face. To the women’s movement, women drug users are seen as a liability. To many in the drug reform movement, women are often invisible, the issues that affect them abstract, and the lines not as neatly drawn as the fight for medical marijuana, the reform of New York’s Rockefeller drug laws, or asset forfeiture.

Policymakers and child advocates have, in contrast, paid a great deal of attention to women drug users. “Concurrent increases in prenatal drug exposure and the rates of cocaine use among women during the 1980s, fueled by the conservative political climate in the United States,” explains Dr. Denise Paone, Director of the Chemical Dependency Unit at Beth Israel, “caused an unprecedented backlash against women who use drugs during pregnancy. The crack baby,” she has noted, “became an icon of the seemingly selfish and immoral behavior exhibited by female addicts.”

A 1995 study funded by the Ford Foundation identified a trend towards drug testing and reporting drug using mothers and pregnant women to law enforcement and child protection authorities. Utilizing a telephone survey of substance abuse and child protective services directors, the authors of the study found that there was a steady increase from 1992 to 1995 in the incidences of maternal and neonatal toxicology, mandatory reporting of toxicology results, legal and agency practices of defining positive toxicology as child abuse or neglect, and criminal prosecution of drug using women.

As a result of such policies, “thousands of women have lost custody of their children, been forced into treatment programs against their will, and, in some cases, undergone criminal prosecution”
for their use of drugs while pregnant. At least 35 states have prosecuted women for taking illegal drugs while pregnant. Some states stretched penal laws beyond their limits by prosecuting pregnant women under existing criminal child abuse and drug laws, charging them, for example, with endangering a fetus and delivering a controlled substance to a minor. Due to the work of legal advocates like Lynn Paltrow, Director of National Advocates for Pregnant Women, however, many of those charges were dropped and convictions reversed.

In response, policymakers turned towards state legislatures to design and adopt legislation specifically targeted towards pregnant women who use drugs. Many states have now amended their child abuse statutes to include a presumption that a child is neglected or abused if the child was born exposed to or dependent on controlled substances. Other states have opted to involuntarily confine or even jail women who use drugs while they are pregnant. Many states, however, have combined these punitive approaches with laws expanding the availability of treatment and prohibiting existing treatment programs from denying access to pregnant women.

Below is a survey of state legislative responses specifically aimed at pregnant women and mothers who use drugs. The harm reduction and drug policy reform movements ought to pay close attention to the development and enforcement of these drastic and punitive laws and advocate for rational legislation that responds to the healthcare needs of women and their children. It is just as important to recognize, however, that even without these laws, children are quietly and routinely taken away from their mothers at birth and placed in foster care, while mothers struggle with hostile child welfare systems to get them back.

Corinne Carey is a Soros Justice Fellow working as an attorney with the Legal Harm Reduction Project in New York City. The information contained in this article was excerpted from a longer report, “Statutes Affecting Pregnant Women Who Use Drugs or Alcohol,” a study made possible with the assistance of Family Watch, a network of individuals and groups concerned about the impact of drug policy on families, women and children; and National Advocates for Pregnant Women. For more information about the report, you can contact Corinne at cacarey4@aol.com. For more information on Family Watch, visit http://www.FamilyWatch.org or call (703) 354-4002.

3 Paone & Alpern, supra note 1, at 102.
4 Center for Reproductive Law and Policy, Reproductive Freedom in Focus (1996).

STATE OF THE STATES

16 states have adopted legislation requiring public education and awareness campaigns, educational programs targeted towards pregnant women and women of childbearing age, and training for healthcare and social service providers. (AK, AZ, CA, DE, FL, IL, IO, KS, MA, MO, NY, NC, OK, OR, PA, WA).

At least 8 states have made budget appropriations specifically targeted towards drug treatment for pregnant women. (CA, MI, MN, MO, NJ, OR, PA, WI).

22 states and the District of Columbia have adopted comprehensive treatment programs, required that state-funded drug treatment programs give priority to pregnant women, and prohibit programs from refusing to accept pregnant women. (AZ, AR, CA, CO, CT, DC, FL, GA, IL, KS, KY, LA, MD, MN, MO, NE, OH, OK, OR, PA, TN, VA, WA).

13 states have formed committees or task forces to investigate the problems associated with maternal drug use, explore options, and recommend policy.

7 states have guaranteed that women seeking drug treatment will not be subject to civil or criminal penalties.

18 states have put into place procedures for identifying, testing, and reporting pregnant women for maternal drug use.

25 states have adopted some form of civil child abuse law to deal with the issue, some defining maternal drug use as:

- prima facie evidence of child abuse (FL, IL, IA, VA)
- one factor in decision to terminate parental rights (AL, AZ, CA, GA, IO, ME, MD, MN, MS, MT, NE, NV, RI, SC)
- a factor when looking at whether remaining with a parent is in the “best interests of the child.” (AK, AZ, CA, MA, MT, UT)
- a reason to effect emergency removal of a child from his or her home (IN, VA, SC, SD)

6 states have adopted laws which allow for the civil commitment or involuntary detention of pregnant women who use drugs. (MS, NC, SD, VA, WI). Both Alaska and South Carolina have considered similar laws.

South Carolina’s welfare reform law makes a woman who gives birth to a child with evidence of the effects of maternal substance abuse and tests positive for a controlled substance ineligible for public assistance. The woman can continue to receive assistance if she submits to random drug tests and/or participates in an alcohol or drug treatment program.

Tennessee, Indiana, Hawaii, Indiana, Michigan, Oklahoma, and Tennessee have all considered creating new criminal statutes making it a misdemeanor or a felony for a pregnant woman to use drugs or alcohol while pregnant.

Washington State considered passing a law in 1997 mandating involuntary long-term birth control for women whose children are born “addicted.”
I introduced myself to Rod Sorge in early 1990 down in Georgia. We were invading the Centers for Disease Control and, while in Atlanta, protesting the sodomy laws. We were on a sightseeing trip to the Martin Luther King, Jr. Center when we met. I didn’t know many of my companions in ACT UP at the time, so I picked upon Rod because he looked fierce and radical. (If you’re going to make friends you might as well go to the top.) Of course, Rod did turn out to be both fierce and radical but nose rings don’t tell the whole story. He was fun, gentle, witty, vitriolic, self-aware, and had a tremendous belief in the need for universal human rights and social justice.

Rod had an integrity that wouldn’t allow him to be silent in a culture that fosters the murders of Matthew Shepard, James Byrd III, Dr. Barnett Slepian, Billy Jack Gaither, and Amadou Diallo. He was not gentle in his views of the elitist Governor Christine Todd Whitman denying access to HIV prevention to New Jersey’s injectors, of New York’s pig-headed Mayor Giuliani’s contempt for methadone consumers, or of the federal government’s prosecution of its class and race confrontation with America’s drug users. He detested the mind set that allows the daily bombing of Iraq without national comment, or the financing, training, and equipping of death squads in Latin America. Rod was as eloquent discussing the consequences of putting Chile’s Pinochet on trial as he was about the need for comprehensive health care—and he saw the links between the two. He abhorred privilege and its misuse, and was as unflinchingly critical of co-workers as he was of any politician. Ironically, his desire to be treated like an ordinary consumer led to a worsening of his health condition and hastened his death.

Rod had an unparalleled intellectual acumen and clarity. We’ve included some excerpts (see page 14) from his writing of the early 90s which stand-up as well today as they did then. These reveal a glimpse of the farsightedness of his ideas and the sophistication of his language. Rod was a person who identified hypocrisy for what it is. He was calling for repeal of syringe laws. He wanted syringe exchange rooted directly in the drug-using community, as a continuum of care that was not only a conduit to drug treatment but truly comprehensive. He was clear that harm reduction doesn’t stop and start with syringe exchange, and that syringe exchange has an intangible beauty that civilians have a difficulty grasping. He was concrete about drug, set, and setting; about the range of forces that impact an individual’s drug use; and about how drug use does not strip an individual of their human rights and dignity. What is equally remarkable is that Rod was a 21-year old, working-class college dropout when he produced this work.

In the intervening decade since Rod wrote his pieces, needle exchange has become legal in New York State—New York City alone has 11 programs—and syringe exchange has grown nationally to encompass about 135 programs. We’ve seen the harm reduction movement gain momentum, and the birth of the Harm Reduction Coalition and the North American Users Union. We’ve finally started to see materials that are relevant for people who use drugs. Rod was a lynchpin for those materials generated by HRC.

Rod did incredible work for this world in his short life. We’ve lost a real leader.

—Allan Clear
It was the blizzard of ’96. I was living in New Jersey. The snow was several feet high and a state of emergency was declared by the Governor. No one was allowed to travel unless it was an emergency. No public transportation was running; cars were not permitted on the road. I had a heroin jones which I had developed along with Rod over the prior year or so. Rod did all my copping for me, as I had a record and was in jeopardy if I had another arrest or conviction. He called me immediately when he woke up that morning and realized what was going on. He said he’d try to cop and then see how to get the dope to me. It took him a couple of days to cop because no one was out there. Then there was no way for him to get to me or me to get to him. Calls came from him several times a day. “How sick are you now,” he’d ask. I kept reassuring him that I’d kicked many times before and I could do it, but if there was a chance to get dope, I was game and would go anywhere or do anything. Finally, on the fifth day public transportation resumed. I called him frantically. “I’m coming up to your house.” Now Rod, who was ill himself (not dopesick), said, “No, you’re too sick. I’ll meet you half way at the Port Authority Bus Terminal.” We met at the Port. I was a mess, all teary and snuffling. He handed me a deck of bags; I ran into the bathroom and got off, came back and we just stood there hugging each other and he was laughing and I was crying. “Oh, Rod,” I said. “I love you so.” “Go home,” he said. “But first wipe the snot off your face.” —Anonymous

Rod Sorge and I were roommates in the exciting early days of ACT UP-New York. Throughout the time that I knew him, Rod was a dedicated, intelligent and impassioned activist. During the late 80s, ACT UP was full of dedicated, intelligent, and impassioned activists. Yet Rod stood out from the crowd. This was in part because he was goofy and beautiful looking all at once. But more importantly, Rod was a sweet, generous, down to earth, working class, Midwestern kid who loved being gay and being in New York. I remember Rod going out on Friday nights to our local Mexican restaurant, El Sombrero, and drinking margaritas with the needle exchange crew who earlier in the evening had spent painstaking hours putting together bleach kits and painting sharps. Then this same crew, weary with fatigue and still hung-over would head out early Saturday morning for the Bronx and Harlem to save lives by providing clean needles. In the apartment Rod and I shared on Rivington Street, this ritual was performed week after week with love, humor, and conviction. It was just what Rod and his comrades did every weekend, without fail. Rod did needle exchange on these Saturdays with the same unflinching commitment that brought him to Atlanta to protest the CDC’s insufficient AIDS definition, and go to trial with other ACT UPers arrested for STOP the CHURCH. He was so righteous and smart it scared me. This guy could write an article for a health journal in the morning, create a demonstration flyer in the afternoon, go to a temp job, facilitate a meeting at night, pick up supplies for bleach kits on his way home, and then cook dinner for the two of us, before he sat down to do some personal writing before going to bed. I feel lucky to have known him. —Heidi Dorow

Spring still reminds me of Rod. It was the time when we would venture out into the city again. Our excursions varied. Sometimes we would walk south into Chinatown for Maria’s hot pork buns, sandalwood soap and tiger balm or steamed dumplings at 10 Pell Street. Another trip would take us over the Brooklyn Bridge all the way to our own private Versailles, the Brooklyn Botanical Gardens. It was a magical estate, the only place that confirmed the royalty we were forced to hide during the week at our nonprofit jobs. Our route was regular: past the wisteria, in front of the gingko trees to the benches overlooking the rose garden. Here we would admire the garden’s symmetry and assess how well our groundskeepers were caring for the place in our absence. Then, usually, chased out by one bee or another, we would descend the stairs to the lilac bushes where Rod would press his nose into the frothy blooms and take the most enormous, comical whiff! Ah, la dolce vita! It was a time when, unbeknownst to us, we were physically our strongest, financially our richest, and certainly at one of our happiest. —Ann Otto
Drug use as it exists in the United States is largely the result of diverse forms of socio-economic coercion, but the sources of that coercion are made diffuse and indirect, shifting the focus away from the physical considerations and the origins of addiction to the presumed recalcitrance of the individual user. The “Just say no” approach to drug “education” typifies this attitude: the recalcitrant individual is the one who won’t or can’t say no. The “choices” are clearly set forth. What type of person are you/will you be? The life conditions that often lead to drug-related problems are seldom raised in the mainstream discourse about drug addiction. Rather, the addict is solely accountable for her or his addiction, while racism, classism, poverty, and heterosexism almost never enter the picture. Each addict is viewed as a separate case, a separate individual having made a personal choice to use drugs. In the age of AIDS, the logic goes, choosing to become addicted and choosing not to end one’s addiction makes HIV a self-inflicted condition. The just-say-no approach also denies the fact that drugs can be used more safely than they often are, and establishes the equation drug use = drug abuse. Our culture hypocritically calls those who use heroin and cocaine “drug abusers,” while “social drinkers,” and cigarette smokers escape even the label of “drug user.”

“Just say no” introduces the appearance of a choice when in actuality often no choice exists, thereby establishing a structure through which blame and accountability can be meted out. Drug-related harm prevention programs aimed at intravenous drug users and their sexual partners and families are essentially non-existent in New York, except for the work of ADAPT (the Association for Drug Abuse Prevention and Treatment) and a few other community-based organizations that distribute bleach kits and show addicts how to clean their needles. Drug addicts must be given realistic choices if they are to avoid health problems and change their drug-taking behavior: There must be immediate implementation of community-based needle exchange programs and the decriminalization of hypodermic needles and drug paraphernalia to prevent further HIV infection among this population. Such measures must be seen as components of a larger effort that includes drug treatment and health care for users. U.S. drug policy must be reworked to acknowledge and confront the AIDS crisis and the realities of addiction. HIV will continue to spread unchecked until effective needle exchange programs and safer drug use education are standards of preventive care for drug users.

Drug users will not be given choices—of treatment, needles, or safer injection education—if, as is currently the case, they are considered to have relinquished some of their rights merely by using drugs. In the United States, an addicted person is expendable. That intravenous drug users are prohibited from obtaining life-saving clean needles and unable to obtain drug treatment constitutes a government-sanctioned violation of their human and constitutional rights. The user’s right to the pursuit of life has been abandoned.

From “Drug Policy in the Age of AIDS: The Philosophy of Harm Reduction” in Health/PAC Bulletin Vol. 20, Number 3, Fall 1990

Principles of Harm Reduction

One of the defining principles of harm reduction is that successful, relevant, and life-enhancing services can and must be designed for active drug users as well as for those individuals who are seeking to end their addiction (many of whom, of course, are also active users). Again, abstinence is not seen as the only clinically desirable endpoint or the only morally acceptable measure of success in providing care and services for drug users. The notion that drug-related problems are largely public health issues greatly influenced by the social environment has been officially adopted in Australian and British drug policy and has been put forth somewhat more tentatively by the World Health Organization.

In such an understanding, drug treatment’s role in public health theory and practice is also reevaluated. The desired endpoint of treatment for many people might be total abstinence from drugs, but intermediate steps taken toward that endpoint are seen as valuable, and they could mean the difference between life and death. Relapse is not viewed as an utter failure by the client or the provider but recognized as a common feature of the process of working toward abstinence. In the United States, “getting off” drugs (what is called drug “treatment”) and using drugs more safely (an intervention such as needle exchange) are conceptualized as separate and even contradictory strategies. Proponents of harm reduction see these as consistent strategies with the common goal of helping drug users reach and maintain physical and emotional health, regardless of where they are on the abuse-to-abstinence continuum. They recognize that between these two endpoints there are a whole range of behaviors that can be ranked in terms of safety. Similarly, drug services must operate on a continuum in order to address the needs of all drug users. Most services that now exist are designed for those who seek treatment. Drug users who are unable to get into treatment, and those who are not interested in treatment, are left without services.

Harm reduction focuses largely on the social and environmental aspects of drug taking, looking at the way that drug use is “produced,” learned, experienced, organized, and controlled and then implementing interventions based on this information. The contexts and social networks of drug use are viewed as important vehicles for health information and interventions. Whereas before services were aimed at taking drug-using individuals out of their drug-using contexts, these contexts are now being seen as the very means by which services can be brought to people. Because most drug users do not have the luxury of leaving their drug-using circumstances behind after or even during treatment, interventions are focusing more and more on helping them make use of their...
contexts and communities to survive.

Viewing drug-related problems as a public health issue allows the drug user to be seen as a rational actor who will respond to public health information. While such a perspective puts responsibility on the individual drug taker, it recognizes that a drug user has an ability to make choices if presented with them, as well as the ability to stop or modify risky behaviors—in other words, that a drug user has agency. More and more data, much of it from studies about needle-related behaviors, corroborate this proposition. Finally, this perspective assumes that drug users have an ability and a right to represent themselves.


Needle Exchange: One Model

The terms “needle exchange” and “needle distribution” do not do justice to the concepts that they try to name. The words refer to only a small part of the event that needle exchange is. What is often overlooked or ignored by critics of needle distribution is the interaction that takes place during the encounter. It is this interaction between the giver and receiver of the needle that is the significant component of needle exchange, especially when encounters are repeated, and trust—may be even friendship—is established.

Along with getting needles and bleach kits, drug users get counseling sessions where they can ask questions—sometimes for the first time—about HIV transmission, receive advice on how to care for their abscesses, or simply have an opportunity to talk to someone who will listen to what they have to say. The exchange comes to encompass more than the needle.

ACT UP’s Needle Exchange Committee has ironed out most of the practical problems it faces in order to operate viable programs: obtaining needles, which is, of course, illegal in New York State; having enough supplies; maintaining a consistent exchange schedule; and setting up pro bono legal support and a bail fund for addicts or outreach volunteers who are arrested during an exchange. The group is now trying to set up opportunities for users to receive more far-reaching care by connecting them with medical services, drug treatment, and other services from community-based organizations (the “bridge” concept). These services should all be a part of needle exchange. In Australia, where needle exchanges are located in the same building as drug treatment facilities, the connection between AIDS prevention and other services is difficult to ignore.

But while the concept of needle exchange as a “bridge” to drug treatment is important, needle exchanges must be viewed as helpful and life-saving independent of further linkages. In a place like New York City or Newark, New Jersey, where very little drug treatment exists and primary care for drug users is extremely limited, needle exchange can be a bridge to other services only insofar as those services exist. The drug treatment that is available in New York and New Jersey is mostly methadone based, so that many methadone patients who are addicted to more than one drug are shooting cocaine or other non-opiates while “in treatment.” In addition recovery from drug addiction is usually a long process with much recidivism. And, finally, there are many people who will use a needle exchange program who do not wish to stop using drugs at that point in their lives. While needle exchange can and should be viewed as one step in a continuum of care, an addict must be able to use it to the extent she or he wishes. If that means going no further than obtaining needles to shoot up more safely, this must be respected.

Because the personal interaction that occurs during a needle exchange is so important, decriminalization of needle possession in itself would not be a sufficient AIDS prevention measure for IVDUs. Even if the needle possession statute were removed, deeper-rooted cultural stereotypes about drug users and drug use would persist as barriers to easy access to needles and syringes. Members of ACT UP’s Needle Exchange travel to states without paraphernalia laws to purchase needles, but are often perceived as drug users and thus refused service. In England, where syringes have long been legally available from pharmacies and where the philosophy of harm reduction is much more widely accepted, many drug users have traditionally been turned away, and thus do not consider this a viable route for obtaining injection equipment. Finally, although needles are less expensive in pharmacies than on the street, all economic restrictions are lifted in free needle exchanges. The street price for a needle in New York City is currently two to three dollars.

Reflecting back on the years of the AIDS epidemic we have lived through so far, it is clear that the most effective prevention methods and systems of care have been community-initiated and based. Needle exchange programs will not be helpful if they are inconveniently located, staffed by judgmental people, or coercive in any way. They must be located in neighborhoods where people buy and use drugs, be staffed by people who know the language spoken there (both the ethnic and street language), and offer points of identification and support to a user of the exchange. This means having active and former addicts and HIV-positive people involved, as well as residents of the neighborhood in which the exchange site is located. Needle exchange on a significant scale cannot take place without the removal of hypodermic and paraphernalia statutes, but the repeal of such laws would not make needle exchange unnecessary.

There must be a shift in drug policy from the punitive, law enforcement philosophy that now serves as its base to an understanding that drug use is a socio-medical phenomenon that cannot be “treated” by jailing people. It is this mindset that is responsible for keeping needle exchange interventions so limited in the United States. Needle exchange must be viewed as a medical intervention against infection that results from the fact that people use drugs, and must be recognized as providing real, life-saving options to users. These advances will come, however, only when drug users gain their rights, and are treated as people rather than criminals.

From “Drug Policy in the Age of AIDS: The Philosophy of ‘Harm Reduction’” in Health/PAC Bulletin Vol. 20, Number 3 Fall 1990
Creating Gender-Specific Chemical Dependency Programming

BY GAYLE THOMAS

The state of Ohio was where I sobered up, probably back in 1986. I never did the traditional treatment route but did AA, and at that point in time you could not identify yourself as dually addicted in some programs. This was in Toledo. If you were an alcoholic, you had to go to an AA meeting. If you were somebody that used other chemicals, you needed to go to Cocaine Anonymous or NA meetings. About three years ago I went back to self-controlled use. So here I am, somebody that did not access traditional treatment services and am now back using again.

These are difficult things to say in the state of Minnesota, where I come from. We have been abstinence-based for over twenty-five years. The home of the Johnson Institute is in Minnesota. We are the home of Sex Addicts Anonymous. In the drug treatment field, we refer to ourselves as “the land of 10,000 treatment centers,” predominantly all abstinence-based. As women living and working in that state, we recognize very clearly that the treatment programming that exists there now was designed by and for men. And that there are only two alternatives to the abstinence-based approach: insanity or death.

I found harm reduction, or I should say harm reduction found me, probably about six years ago. But since then, it has been a difficult fight to try to talk about it. I had to be careful where I opened my mouth because, as happens with women in treatment, there is shame, and blame, and guilt attached to anyone who goes looking for alternatives. This was not only a personal struggle for me, coming out of a totally abstinence-based mentality, but it was a professional struggle, as well, to look at how was I going to begin to develop alternative treatment programming for women. The kinds of messages that were running through my head were that I was coddling addicts and I was coddling alcoholics, that I was actually enabling women to use drugs, or teaching them how to use drugs. Or that harm reduction was only about the legalization of drugs.

Sometimes during this struggle, harm reduction seemed a very elusive and intangible concept. But what I have come to believe is that it’s about the dignity and worth of all womankind and it’s about my core values. It’s about passion and empathy. It’s about genuineness in advocacy. It’s about always maintaining non-judgmental attitudes, and I’m still working on that one, because the group of folks you never want me working with is male perpetrators of sexual abuse. It’s very client centered and it’s a very pragmatic approach to working with women. For me it’s about the freedom to be creative, of not having to have all of the answers, of not having to be the expert.

The bottom line is that every woman is deserving of services, no matter where she falls on the continuum of use, abuse or addiction. And that holds true to the cycle of violence. It holds true to women that are still actively engaging in sex work on the streets and it holds true to women who are now labeled as ‘non-compliant’ because of welfare reform. The agency that I work for is the largest non-profit in this country. Our mission statement fits in extremely well with harm reduction, because we believe in serving the poorest of the poor. It’s also about dignity and respect, and if we look at the harm reduction programming, at least within Catholic Charities in the Minneapolis/St. Paul area, we have had wet houses for years. Unfortunately they are only single room occupancies for men. Just within the last two years we have built a ninety-bed facility, where the guiding principle is that people are deserving of basic needs (food, shelter, clothing) and don’t have to be clean or sober to access these services.

The harm reduction programming that I began to develop resulted from seeing women that had been in traditional treatment for 15+ times. This sent a very clear message to me: “This is not working.” Some abstinence folks talk about the “bottom out theory”; you have to bottom out before you are going to find the spiritual awakening. But these are not women who have cars to lose, nor do they have houses to lose—they have their kids to lose. As Edith Springer has said, it’s about reaching up and touching the bottom, it’s about walking around with everything you own on your back, not knowing where you are going to sleep that night, and women having to resort to giving up sex in order to provide shelter for their kids. It’s about working with women who have been labeled in the state as non-compliant, resistant to treatment and in denial.

The reality is that this is about the culture of poverty. It’s about the genocide of women and children, which is now known by our politicians, our legislators and our government as welfare reform. It’s about limited educational opportunities and vocational opportunities. It’s about domestic violence. It’s about single parenting issues. It’s about all the other “isms” of classism, racism, ableism, working in an anti-homophobic manner. It’s about losing your kids into Child Protection. It’s about exploitation in the sex industry and it’s about sexual abuse and violence. You can not rehabilitate any-
body that has never been afforded the opportunity of habilitation. We are crazy if we think we’re going to be able to do this in treatment programming.

There are five programs within the unit that I work in, but I am going to describe two. All of our programming focuses on strengths—we don’t look at pathology, nor do we buy into the powerlessness myth. It’s not about removing a primary coping mechanism before we have put another in place, no matter how dysfunctional that appears to us. We have to have a variety of treatment modalities and therapeutic modalities so that we can fit our services to whatever woman walks in the door. One of our programs is Prevention Outreach to Women at Risk. It’s a street outreach program called POWER. We have trained ten peer educators using the indigenous model. We have active women who inject drugs. We have women who may be residing in domestic violent relationships, women who are actively using other chemicals and women who are actively engaging in sex work. Stipends, vouchers, tokens, various things are provided to our ten peer educators. This program has been in existence for four years and during that time we served 3,500 women and children. We completed over three hundred-fifty risk assessments on the street. Street outreach is very difficult to do in the state of Minnesota. We get four months and it’s damn cold and so you have to be very creative in figuring out about a woman using in that group, nor do we support urinary analysis. A woman is never kicked out for her use. And sometimes we’re looking for controlled use. We have another group rule which is not to come to group intoxicated. It’s always facilitated by two group leaders, due to the nature of the issues involved. If someone is actively suicidal or pretty symptomatic of whatever mental health problem, one of the facilitators can step out and address those issues. And the final rule is that you can’t go into labor in my group. We don’t do any 12-step work there. Coming from Catholic Charities it might sound very odd that I believe that 12 step programming is all based on a Judeo-Christian value system. And I find that very disrespectful to certain segments of women, especially our Native American women who may be residing in the state of Minnesota. But its funding was yanked. Once again we have a program that clearly demonstrated its effectiveness in reaching certain populations where the women go to. One of the things that has become painfully apparent to me is the vulnerability of harm reduction programs due to funding. The POWER program was a program that not only met but exceeded every goal and objective that was dictated to us by the state of Minnesota. But its funding was yanked. Once again we have a program that clearly demonstrated its effectiveness in reaching certain populations...
Q Are you looking at her life-complicating issues, such as lack of transportation, such as domestic violence, such as children issues, such as other family issues?
Q Is she “in denial” because you can’t hear her speaking her own truth?
Q What is your need to have rules and regulations that you must follow all the time?
Q How woman-friendly is your program?
Q Is it safe?
Q How are your consumers included in the planning, the developing and the evaluation of programming?
Q Does your staff mirror the diversity of the population that it serves?

If you’re going to create gender-specific programming, I think you must have the following: childcare, and kids have to be included in the programming; it has to be accessible, it has to be on bus lines or you’ve got to provide tokens or bus cards; you have got to be open non-traditional hours, not the nine to five hours, and I worked a long time to get the nine-to-five job and I would be lying to you if at times I said it wasn’t too cool for me as a single parent anyway having to work evening hours; and you must supply treatment on demand; crisis lines, twenty-four-hour access, somebody that can help at least deal with whatever situation that is arising is helpful; when appropriate, include family members in the programming for women; you must be sensitive to the diversity, we’re talking race, creed, sexual orientation; you must have in place home visits and outreach efforts to engage women into programming. And one of the things that has worked very effectively for us is to utilize a team approach. Every woman that walks through that door knows that she doesn’t need to come to me, she may need to go to Colleen, or she can feel free enough to go to Addy. Feeling safe enough with the team also helps with counter-transference issues that happen within the therapeutic arena and it empowers a woman to be able to access other services if she is learning that process of how to deal with different personalities and different folks. As women within this movement, whether or not we’re polarized because of being in 12 step abstinence-based programs, or whether we’re harm reductionists, or whether we don’t know exactly where we fall, we need to band together. It is imperative that we walk this journey together. We need to be united. Thanks. Peace.

Gayle Thomas is a Unit Supervisor of Chemical Health programs with Seton Services, a division of Catholic Charities in St. Paul, Minnesota.

BY HARRY SIMPSON

I am a recovering drug injector, who has wrestled with the issues both personally and professionally inherent in moving from a complete abstinence approach to a harm reduction perspective. I want to discuss with you the ways that individuals and agencies can address the consequent discomforts that are likely to occur when integrating harm reduction approaches into established abstinence-based programs.

But first, let’s talk about these so-called junkies that we’re all committed to working with. They are people like us. They are our brothers, our sisters, our mothers, our fathers, our friends, our lovers and ourselves. I began using drugs during the summer of 1968 as an eighteen-year-old tank crewman in the Republic of Vietnam. When I returned from that country a year later, I had a Purple Heart for wounds received in battle, an Army Accommodation Medal for Valor, and a heroin addiction that controlled my life for the next fifteen years. Every hour, every minute, every second of every day, I was consumed with an overpowering need to feed the monkey that was on my back. It was no longer a matter of just getting high for me, it was about survival. I felt like I would die if I didn’t get that next fix.

My first treatment experience was in a sixteen-week residential treatment program that specialized in treating alcoholism. I had to say I was an alcoholic to get in, even though I didn’t believe it, because they wouldn’t treat you if you were only a heroin addict. I wasn’t an alcoholic, at least I didn’t think I was then, but I said it anyway because I needed the help and there was no where else to go to get it. But the whole time I was there, I felt that none of this applied to me. I relapsed in the sixteenth week and of course they threw my butt out because it was an abstinence-based program. And if you couldn’t stay abstinent, you couldn’t stay in the program.

Many, many more treatment experiences followed for me. I did the methadone maintenance trip, outpatient, in-patient, therapeutic communities, hospitals, medical detox, psych wards. You name it, I tried it, but none of them worked for me, at least not then. I entered treatment for the final time in September, 1984, and today I am the Executive Director of Community Health Awareness group in Detroit, which is Michigan’s oldest and largest minority operated HIV/AIDS service organization. I am also the founder of The Life Points Harm Reduction Outreach, the first licensed syringe exchange program in our city.

I tell you this story so that you can understand how seriously committed I was to a personal program of abstinence-based recovery. I lived my life according to it and I truly believed that every other
addicted person should do the same. I could not recognize harm reduction programs as legitimate public health interventions for preventing HIV among drug users. Harm reduction, as I thought, was just enabling drug use, and all the good people working in harm reduction were just a bunch of crazy damn fools. That is what I thought honestly, as recently as three and a half years ago. Now, as the founder of The Life Points Needle Exchange Program, I can say very proudly that I am also a crazy damn fool.

What led to this amazing change from abstinence to harm reduction? First and foremost, it was education. I had to learn what harm reduction really meant. In October of 1996, the Association of State and Territorial Health Officers published a report entitled “Preventing HIV Infection Among Drug Injectors: The Role of Sterile Syringes.” In this report, the members of the panel on alcohol and other drug treatment as an HIV prevention strategy said “that while drug treatment and successful recovery are the best methods of preventing HIV infection long term, the panel participants view syringe exchange programs as part of the continuum of drug treatment services.” They went on to say that “treatment is incremental—it may not work the first time, or even after multiple attempts.” Most importantly, they noted that treatment does not cure an individual’s addictive behavior but rather it places the disease in remission.”

The urgency of embracing harm reduction and moving on the debate about abstinence and drug treatment had become clear to me. In September, 1994, the U.S. Conference of Mayors said “that unless more effective HIV risk reduction measures are adopted, people will continue to die at alarming rates.” They went on to say that “as days, weeks, months, and years are spent debating approaches such as needle exchange, and other methods of increasing the availability of sterile injection equipment, HIV continues to spread.” It has been more than four years since that dire warning, many lives have been lost and still the debate continues.

Here are some statistics. 42% of our AIDS cases in Detroit are attributable to injection drug use. Our city has more than one million residents, and is the seventh largest city in the United States. But it also has an estimated 30-35,000 active injecting drug users in the city alone and another 12-13,000 or so in the counties surrounding our city. While comprising 22% of Michigan’s population, the greater Detroit area accounts for more than half of our state’s AIDS cases. So you can see that there is a disproportionate impact. Woman account for over 20% of all AIDS cases in our city, and AIDS is still the leading cause of death among Black men in Michigan, the third leading cause for Black women 25–44 years of age. That’s some of the AIDS statistics. When you look at the HIV infection, the disproportionate impact is even more glaring. In fact, two out of every four new HIV infections in Detroit can be traced directly or indirectly to injection drug use. The Detroit area presently accounts for 70% of Michigan’s new HIV infections. African-American child-bearing women now account for 86% of the new infections among Detroit females, a dramatic increase from 34% in 1990. The epidemics of HIV/AIDS and substance abuse call for an approach much broader than those that use total abstinence as the only measure of success or failure. Abstinence from drugs is a lifelong commitment that is fraught with both successes and failures. Seldom does treatment work the first time, and success varies greatly from individual to individual. Drug addiction is a chronic, relapsing disorder and few of us will enter recovery and remain abstinent for a lifetime without some episode or episodes of relapse. Many of us will experience multiple treatment experiences and multiple relapses during the course of our disease.

I came to recognize that access to sterile syringes will always be necessary, even if drug treatment programs are universally available, because relapses are so prevalent among drug users, and because many people in drug treatment continue to inject drugs. Furthermore, drug treatment is not always available to those who need it. I only had to look at my own addictive history to find an example of this. It didn’t require brain surgery for me to move from abstinence to harm reduction. It only required honesty, open-mindedness and willingness, a willingness to learn something new even though it was contrary to what I believed to be the truth. I learned during this process what many of you already knew; that the single most effective way to prevent the spread of HIV among drug injectors was the once-only use of sterile syringes.

Having made this personal transition, it became my responsibility as the Executive Director of our organization to integrate harm reduction programming into our agencies’ array of HIV prevention services for drug injectors. The Community Health Awareness Group is organized to address current health issues and concerns of the Black community and develop effective ways of promoting positive health strategies to influence the overall quality of life of low income Black citizens of Detroit. To that end, we operate several projects including needle exchange, and now we have a Consumer Advisory Group that advises the Board of Directors.

We provide the services for African-American drug users, active or recover...
I came to recognize that access to sterile syringes will always be necessary, even if drug treatment programs are universally available...because many people in drug treatment continue to inject drugs.

How will adding harm reduction programming affect future funding opportunities?

Many organizations, ours included, may have many different funding sources including state, federal and private, all of which could be placed in jeopardy by the federal government’s disgraceful and cowardly failure to provide adequate funding for these life-saving interventions.

Is a harm reduction philosophy consistent with the philosophy and mission of the organization?

Do the long term benefits of integrating a harm reduction philosophy outweigh the obstacles that are inherent in the shift from abstinence to harm reduction?

The barriers inherent in an organizational shift from abstinence to harm reduction also must be recognized and addressed. Such barriers include people—internal and external to the organization—as well as the organizational culture. In our case, this meant an organization whose structure, policies and procedures were oriented around an abstinence-only model that punished staff for any suspected drug use. Overcoming these kinds of barriers requires that we work together, with a common sense of our responsibilities to each other in harm reduction and also to the people that we are trying to serve.

I would like to acknowledge the work of Timothy Walker Perington, because it was his paper entitled "A Program Director’s Guide to Integrating Harm Reduction Strategies into Existing HIV Prevention Services" which informed much of the work described in this article.

Harry Simpson is Executive Director of Detroit’s Community Health Awareness Group, Michigan’s largest minority-operated community-based HIV/AIDS organization, and founder of The Life Points Harm Reduction Outreach program, the first licensed syringe exchange program in the State of Michigan.

In Valuing Diversity (1995), Lent Louis Loew identifies a five-stage process for implementing a diversity plan into an organization. We have used this process and we believe that this process can act as a model to introduce and manage organizational change.

PHASE ONE: The goal is to clarify the needs for change and to set parameters by asking the whys and the hows. For us this meant gathering information about the subject. It meant site visits. We went to Prevention Point in San Francisco, the Baltimore Needle Exchange and the Chicago Recovery Alliance Program. We visited as many programs as we could. We did personal interviews with experts and we attended conferences to become as well informed about harm reduction as we could. These are the kinds of activities that you might be involved in Phase One.

PHASE TWO: This revolves around strategy design, and in this stage we had to develop specific goals and objectives to shape the change process and to identify how the change would happen. For us that meant developing a strategy that moved the entire organization towards the change collectively, recognizing, as Loew states, that no single part of the strategy is as important as the whole. We met with resistance from everyone; staff, clients and board members. Our challenge was to make sure that everyone was moving through this change model at the same rate.

PHASE THREE: This involves the development of specific interventions and strategies to meet those objectives, such as staff meetings, in-services, education sessions, etc.

PHASE FOUR: This is the Implementation stage, at which detailed plans of how to implement the interventions described in Phase Three are made. It answers the questions of who’s going to do what, when, and where.

PHASE FIVE: This focuses on maintenance and developing a plan for continuing to support the change. Lou describes this stage as about insuring that there is broad-based participation, ongoing communication, client feedback, quality assurance and systems of incentives and rewards.
Members of Global Voice—the international network of harm reduction workers—have been active in the United States over the last six months. Representatives from RELARD, the Latin American network; CEE-HRN, the Eastern European network; and AHRN, the Asian network, provided welcoming remarks at the Second National Harm Reduction Conference held in Cleveland this past October. Expressing solidarity with their US colleagues working in the frontlines, Global Voice members recognized our common need to keep up the struggle against the HIV epidemic among drug users, in particular highlighting those emerging flashpoints in Asia and the former Eastern bloc countries—especially Russia.

During the conference, Dr. Fabio Mesquita of RELARD, Dr. Judit Honti of CEE-HRN, and Palani Narayanan of AHRN were joined by Paulo Teixeira, an elected Deputy from the Sao Paulo region of Brazil, in a visit to the leaders of Cleveland's City Council. Their intent was to bring an international perspective on harm reduction to Cleveland's elected officials. Given Cleveland's often perverse attitude to needle exchange, cultural exchanges can only help build bridges to the rest of the world.

Later that October, representatives of grassroots networks from Africa, Latin America, Oceana, and the US were present at a small gathering of international researchers and world health experts to forge a research agenda on injection drug use and blood-borne infections. The group, partly sponsored by the National Institute on Drug Abuse, explored how to rapidly assess developing crises in locations such as Russia and China; how to respond by disseminating the information quickly and coherently; and how to support organizations implementing interventions. This core of individuals will coordinate a larger gathering to meet in Atlanta later in the summer of 1999.

Oceana has joined the Global Voice founding networks. Oceana will bring the wide-ranging experience and expertise from Australia and New Zealand. Welcome aboard.

AHRN has engaged Ton Smits as its new Director and has relocated offices to Chiang Mai in Thailand. Paul Deany, founding Director, has returned to his base in Australia and will hopefully remain involved through Oceana. Paul, as well as being a premiere bloke, did a magnificent job in his time with AHRN. Ton has just returned from Kunming in China where AHRN will be presenting its first harm reduction workshop in April.

AHRN's new address:
Asian Harm Reduction Network
P.O. Box 235, Phrasingha Post Office
Muang, Chiang Mai
Thailand 50200
Tel (66 53) 801494
Fax (66 53) 801495
E-mail ahrn@loxinfo.co.th

—Allan Clear
HARD TO REACH?

BY VICTORIA CARGILL

It’s an interesting experience to have been someone who has criticized bureaucracies and now has to admit to having become a bureaucrat. But before you all get your eggs and start throwing them at me, I want to tell you that there are many people within the bureaucracy who are very sensitive to the same issues that confront other folks in the harm reduction movement. Sometimes in order to change the pond, you have to become the frog on the lily pad so that you can beat up the system from the inside.

I want to look at a phrase and a question that I hear a lot on the inside: how should we work with the so-called “hard to reach?” When I hear this question, my response is always: “Who are you referring to, the provider or the client?” I want to suggest that perhaps there are issues on both sides of this great client-provider divide, and that we need to get to “yes” and stop throwing stones at each other.

What are the issues for providers? “These people have no telephones, they’re not adherent, they use substances” is what I often hear. The provider may have their own racial issues that they are not willing to discuss or disclose. We certainly have enough behavioral data to suggest that this is the case. We also have to deal with gender, cultural and class issues. Everybody comes with their biases. But since we are educable, teachable, reachable and intelligent human beings with frontal and middle cortices, we can learn to work beyond our cultural biases and be user friendly.

What are the issues for clients? It may be that service hours just aren’t convenient, or that staff attitudes are judgmental towards drug use or being HIV positive or are just plain racist, sexist or homophobic. Clients come wanting a menu of options, but instead get a single “just say no” speech. And so often, clients get little respect.

How can we reach out to each other? For providers my message is: Don’t be stubborn. In our office several years ago, when there was concern about women coming into care, we did the easiest thing possible—we saw children and women in the same place. All of a sudden, compliance or show ups were not a problem. Providers need to make the links to expand the support available and there is certainly a place for user advisory groups, substance help use on-site, and ancillary support. If I was discussing radiation therapy instead of substance use, can you imagine a healthcare system that says: “I’m sorry that you have lung cancer, breast cancer and you need radiation therapy. But you have to go down, catch four buses and go back behind this place. And then they are going to intake you so that they can arrange your appointment.” There would be an insurrection tomorrow.

What are the options for clients? Become informed, ask for help, educate the provider. I write this knowing that sometimes a provider cannot be educated. When this is the case, I’m going to be the first to tell them to move on. But not everybody is a bad guy. There are people coming to me and I’m the third doctor they have seen, and the chip on their shoulder is so big they cannot get through the door. I used to have a little sign that said “check your bags and your attitude at the door.” This is a new day. We need to start from scratch. Education does not equal experience and an M.D. is not a mind reading degree. People have to speak.

How do we all get to “yes”? Whether we are providers, or clients or advocates, kindness always works very well first and then we can take it on from there, because anger is an infectious poison. As soon as someone gets pissed off, the other side gets pissed off and then no one’s listening anymore. It is about accepting responsibility, asking questions, becoming interested, being genuine.

Hard to reach, if defined fairly, applies to both clients and providers and I would even say the system, and its consequences are the devastating impacts of HIV and AIDS on poor and marginalized communities, especially communities of color. Becoming easier to reach involves us all in thinking about change. If there is one rule of behavior that I have learned it is this: People rarely change because they see the light; they change because they feel the heat. It is the HIV epidemic that is generating this heat. It is time to get off the damn dime and address the reasons for the epidemic’s disproportionate impact by race and class with all the interventions at our disposal. These comments are mine, not the NIH’s or the OAR’s, and I’m proud to own them.

Vicki Cargill works as the Director of Minority Research and Director of Clinical Studies at the Office of AIDS Research at the National Institutes of Health.

WHAT ARE THE OPTIONS FOR CLIENTS?
BECOME INFORMED, ASK FOR HELP, EDUCATE THE PROVIDER.
FRIDAY, MAY 28TH, 1999 1:00 P.M. – 5:00 P.M.


1:00 P.M. – 2:30 P.M.
SITUATING THE DRUG USER AT THE CENTER TO PROVIDE A CONTINUUM OF CARE

3:00 P.M. – 5:00 P.M.
PRACTICAL APPLICATIONS OF UTILIZING HARM REDUCTION PRINCIPLES WITHIN A DRUG TREATMENT SETTING

At Stern Auditorium, Mt. Sinai Medical Center, E. 100th St. and Madison Ave., New York. For information call 516.979.7300 ext. 202.

American Society of Addiction Medicine’s 30th Annual Medical-Scientific Conference
April 29 - May 2, 1999
New York Marriott Marquis 1535 Broadway, New York, NY
For more information: ASAM 301.656.3920 email@asam.org

“Bridging the Gap: Integrating Traditional Substance Abuse and Harm Reduction Services”
May 3-4, 1999
Radisson Miyako 1625 Post Street, San Francisco, CA
For more information: Alice Gleghorn 415.255.3722

12th International Conference on Drug Policy Reform
May 12-15, 1999
Washington Plaza Hotel, Washington, DC. For more information: Drug Policy Foundation at 202.537.5005 e-mail: taylor@dpf.org

38th International Congress on Alcohol, Drugs and Other Dependencies “Politics and Reality”
August 16-20, 1999
Vienna, Austria. For more information: 011 41 21 320 98 65 e-mail: icaa@pingnet.ch

National HIV Prevention Conference
August 29 - September 1, 1999
Hyatt Regency, Atlanta, GA. For more information: CDC National Prevention Information Network, 800.458.5231 or http://www.cdc.gov/nchstp/hiv_aids/conferences/nhpc99.htm

1999 National Conference on Women and HIV/AIDS
October 9-12, 1999
Los Angeles Convention Center, Los Angeles, CA.
For more information: Womens Conference Meeting Department, 19 Mantua Rd., Mt. Royal, NJ 08061, 609.423.7222 x 350

The United States Conference on AIDS
November 5-8, 1999
Adam’s Mark Hotel, Denver, CO.
For more information: 202.483.6622

Third National Harm Reduction Conference
October 22 - 25, 2000
The Wyndham Miami-Biscayne Bay, Miami, FL.
For more information contact HRC: 212.213.6376 ext 31 or suzie@harmreduction.org
A decision was made in San Francisco in February 1997 that new dollars would not be put into the drug treatment system until some major system changes were initiated. A community advisory board made up of about forty individuals—activists, those who were in recovery, those who were not in recovery—came together in a dialogue for about thirteen weeks to develop a plan to make these changes.

What emerged from this planning process was a stated goal of ensuring access to substance abuse treatment and care by providing appropriate treatment to those in need in a timely manner. One of the first issues that the planning council grappled with was abstinence. Although it was clear that for some folks this model works, the council also knew that there were large communities in San Francisco that were not going to make it through an abstinence model, and that there was a need to change the system in order to allow for a harm reduction practice that could engage with individuals around their immediate needs and their desires. Another big issue for the planning council was accountability, not only accountability from the Department of Public Health to the providers, but also from the providers to the individuals they are serving.

In order to educate treatment providers about the plan and generate support for its implementation, a conference was held in 1997, and another is taking place on May 3 and 4 (see conference announcement on page 23 for more information). A certification program that will create and train around some professional standards in the drug treatment field has been initiated and, more importantly, harm reduction interventions have been incorporated into the curriculum. Capacity in the whole system has been expanded, but has also been targeted at specific communities who have been underserved by drug treatment in the past. A Spanish speaking residential treatment program for Latino adults in the Mission District has just been funded. We have also started new programs that are not abstinence based, especially for the homeless—we now have wet shelters where people can just come out of the rain and nobody smells their breath when they come in. We believe that there are some basic human rights that we have to be able to protect in San Francisco.

Given that San Francisco is one of the most diverse communities in this country, cultural competency—what I would call cultural proficiency—is extremely important. So it is now an RFP demand—when you come in with a proposal, you need to show what your cultural proficiency plan is. We have also stressed the importance of integrating services—for most people, there are multiple issues to contend with, not just substance abuse. One of the greatest needs that we identified was to work with entire families, so we have just opened a family residential program where the entire family is allowed to come. We have also worked extremely hard to open up services for sex workers. We have developed a new program for trauma, including sexual trauma, with women because it is clear that many women in substance abuse treatment services have experience of sexual trauma.

But the most important aspect of all these initiatives has been the community input that gave rise to them. The policy of treatment on demand in San Francisco has been led and pushed by the communities it is intended to serve. Like any other social justice issue, the movement around substance abuse treatment on demand has resulted from community activism. Bridging the gap is up to us.

**SF’s Treatment on Demand Guidelines**

1. Providers of services for those who misuse or abuse alcohol or other drugs shall deliver care in a culturally competent, nonjudgmental manner which demonstrates respect for individual dignity, personal strength, and self-determination. While programs may differ in orientation toward desired client goals or backgrounds, language should not reflect bias toward personal behaviors, experiences, ethnicity, service orientation, or choices. Services and goals should be client-oriented, and provide a variety of options which could meet the client’s needs. Service goals should not be preset, but be determined through a collaboration between the client, the staff, and the program.

2. Service providers are responsible to the wider community for delivering interventions which will reduce the economic, social, and physical consequences of substance abuse and misuse. Even brief contact with a service provider can produce changes in behavior which can reduce the economic impact of substance abuse on the broader community; e.g., preventing HIV infection, hepatitis C, and other chronic diseases. Providers of services for those who use substances should maximize their impact by providing relevant services that meet clients “where they are” and attempt to reduce harm during every contact.

3. Because those engaged in active substance use are often difficult to reach through traditional service venues, in order to reduce risk the service continuum must seek creative opportunities and develop new strategies to engage, motivate, and intervene with potential clients. For many reasons, substance use is generally a clandestine activity, and drug using individuals are not easily contacted by conventional service agencies. Extensive research and clinical experience have demonstrated that substance users can be effectively reached through non-traditional approaches which need to be integrated into a continuum of care.

4. The goal of substance abuse treatment services is to decrease the short and long term adverse consequences of substance abuse, even for those who continue to use drugs. Traditional substance abuse treatment models have focused exclusively on abstinence outcomes. In recognition of the enormous physical toll of substance abuse, the comprehensive model of care relocates substance abuse treatment within the larger public health model which is focused on the broader community.

**BY BARBARA GARCIA**

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But the most important aspect of all these initiatives has been the community input that gave rise to them. The policy of treatment on demand in San Francisco has been led and pushed by the communities it is intended to serve. Like any other social justice issue, the movement around substance abuse treatment on demand has resulted from community activism. Bridging the gap is up to us.

**SF’s Treatment on Demand Guidelines**

1. Providers of services for those who misuse or abuse alcohol or other drugs shall deliver care in a culturally competent, nonjudgmental manner which demonstrates respect for individual dignity, personal strength, and self-determination. While programs may differ in orientation toward desired client goals or backgrounds, language should not reflect bias toward personal behaviors, experiences, ethnicity, service orientation, or choices. Services and goals should be client-oriented, and provide a variety of options which could meet the client’s needs. Service goals should not be preset, but be determined through a collaboration between the client, the staff, and the program.

2. Service providers are responsible to the wider community for delivering interventions which will reduce the economic, social, and physical consequences of substance abuse and misuse. Even brief contact with a service provider can produce changes in behavior which can reduce the economic impact of substance abuse on the broader community; e.g., preventing HIV infection, hepatitis C, and other chronic diseases. Providers of services for those who use substances should maximize their impact by providing relevant services that meet clients “where they are” and attempt to reduce harm during every contact.

3. Because those engaged in active substance use are often difficult to reach through traditional service venues, in order to reduce risk the service continuum must seek creative opportunities and develop new strategies to engage, motivate, and intervene with potential clients. For many reasons, substance use is generally a clandestine activity, and drug using individuals are not easily contacted by conventional service agencies. Extensive research and clinical experience have demonstrated that substance users can be effectively reached through non-traditional approaches which need to be integrated into a continuum of care.

4. The goal of substance abuse treatment services is to decrease the short and long term adverse consequences of substance abuse, even for those who continue to use drugs. Traditional substance abuse treatment models have focused exclusively on abstinence outcomes. In recognition of the enormous physical toll of substance abuse, the comprehensive model of care relocates substance abuse treatment within the larger public health model which is focused on the broader community.
implications of health problems, particularly those that result in significant morbidity or mortality. Therefore, strategies which reduce the negative health, social, and economic consequences of substance abuse are recognized as key intervention strategies in a comprehensive model of care.

5. Comprehensive treatments for those who misuse or abuse drugs and/or alcohol must include strategies that reduce harm for those clients who are unable or unwilling to stop using, and for their loved ones. Substance abuse treatment needs to be re-conceptualized as a continuum of prevention, intervention, and care, not solely as a service that one uses when one decides to get clean and sober. Comprehensive services also address the needs of children and families of substance users and aim to mitigate the negative impact of having a substance abusing parent or family member.

6. Relapse or periods of return to use should not be equated with or conceptualized as “failures of treatment.” As substance abuse treatment providers have always understood, the “road to recovery” is paved with many twists and turns. In the process of recovering from addiction to alcohol or other drugs, immediate, total abstinence is difficult to achieve. Individuals often do not, are not able, or are not willing to abstain completely from substance use. Instead, the recovery process is sometimes interrupted by intermittent periods of return to use of one or more substances. While a given episode of use may be brief or prolonged, the assistance of substance abuse treatment services staff and programs can serve to shorten or reduce the negative impact of these periods of return to use. Harm reduction approaches can also decrease the emotional and physical damage associated with these episodes.

7. Medical services are an important component of comprehensive substance abuse treatment; patients prescribed medications for the treatment of medical and psychiatric conditions, including addiction, must have full access to substance abuse treatment services. Many methadone consumers, patients with serious medical conditions, and dually or triply diagnosed patients are prohibited from accessing services and support from substance abuse treatment programs. As more medications are shown to be effective in treating addictive, physical, and mental conditions, programs must broaden their treatment philosophies in order to provide quality comprehensive care. Patients should never be denied access to, restricted from participation in, or terminated from treatment in a substance abuse program solely on the basis of their use of a medication prescribed for their treatment. Medications include, but are not limited to, methadone, LAAM, anti-depressants, and psychotropics.

8. Each program within a system of comprehensive services will be stronger by working collaboratively with other programs in the system. Each program approach has its strengths and limitations. By honest acknowledgment of these, and through knowledge of the assets of other approaches, programs can more effectively serve the needs of clients. Comprehensive services may be achieved by expanding service options within existing programs, through collaboration with other service agencies, or by creating new services to address specific needs.

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**Drug Research and the Politics of Knowing and Being Known**

**By Kate McCoy**

Thou shalt not sit With statisticians nor commit A social science!

Contemporary social scientists have begun to ask questions about whether the social sciences are in fact engaged in what might be thought of as criminal practices—hence the quote from Auden above, which John van Manan has used to highlight just such questions. Those involved in drug research have also begun to ask these questions, but that doesn’t mean social science stops, and the truth is that I am a social scientist, who, for the past year and a half, has been involved in a government-funded research project on heroin in New York City. This involvement has put me in a difficult position. Am I just doing spy work for the government? That’s about all I can figure social science does for and to drug users, since most research that has challenged the way drug use is regarded and dealt with in this country has been at best quietly ignored, loudly discredited, or condemned by the likes of former Drug Czar William Bennett in 1991 as “intellectually and morally scandalous.”

Some paranoid part of me suspects that critical scholars continue to get funding as “hush money,” which keeps us well-fed, housed, clothed, and safer in academic comfort than we would be as activists who might make a lot of noise that cannot be confined to academic conferences and journals. That aside, critical drug research is censored by academic disciplines’ and misread and misapplied by policy makers who refuse to acknowledge the complexity, difficulty, and partial perspectives that the sciences have to offer.

Worse yet, drug research is selectively and sensationally reported in mass media, fueling drug hysteria that make it nearly impossible for the general public to get anything resembling a balanced perspective on drugs. Consider, for example, Canadian researchers Julie Bruneau and Martin Schechter, who were outraged that their studies of Vancouver and Montreal needle exchanges were used by General Barry McCaffrey, the current Federal Drug Czar, to claim that needle exchange programs have failed to reduce the spread of HIV and may even have worsened the problem. They reported that U.S. Congressional leaders have also cited these studies to make the same claim. Their rebuttal in the New York Times explains more precisely and completely...
what they learned, put simply here, that HIV rates were high regardless of IV drug use among the population they studied due to other risk factors having to do with socio-economic inequality; an issue often glossed over when “the problem” is thought to be those “demon drugs.”

This brings me to a question posed by Edward Said: “[Is it possible for social science] to be different, that is, to forget itself and to become something else . . . [or must it] remain as a partner in domination and hegemony?” I want to be sure that we’re speaking the same language here (another curse of academia)—about hegemony. We all know what domination means and know that it does not usually, in political terms anyway, imply the cooperation and assent of those who are dominated. Hegemony, however, is a way of thinking about how power operates and is produced with the cooperation and assent of those who are dominated—operating much more insidiously, integrated into the scheme of what is taken to be natural and true, scientifically proven and/or thought of as common sense.

This cooperation and assent is secured in many ways, for example, by the generation of drug hysteria, the propagation of misinformation in drug education in schools, and the shaping of public opinion—with all this in close relationship with the processes and authority of the sciences.

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There is a mutually reinforcing relationship between what most people generally think about drug users and what assumptions guide research and policy regarding drug use. This cooperation and assent is secured in many ways, for example, by the generation of drug hysteria, the propagation of misinformation in drug education in schools, and the shaping of public opinion—with all this in close relationship with the processes and authority of the sciences.

Position is said to be hegemonic when it is not seen as a “position”—but it is considered as simply the way things are and should be. Positions that challenge and complicate hegemonic ones are more difficult to maintain. The challenger can be discredited more easily because of the ready availability of commonly accepted ways of thinking. In the following paragraphs I hope to give some idea of how hegemony operates, the difficulties it produces, and what might be necessary to challenge hegemonic positions concerning drug use.

Most “scientific” inquiry on drug use is shaped by a powerful assumption, one that is informed by and continues to reinforce public opinion. What is assumed is that:

Non-medical drug use is very much like a disease—a malfunction, an abnormality, a pathology. It is not “normal” to use drugs outside a medical context; only a drug-free existence is normal. No one uses psychoactive drugs to get high unless there’s something identifiably wrong with him or her. When things are working right, there’s no “need” to take drugs. There is nothing valuable about the illegal drug experience; it is unauthentic, illusory, seductive; nothing but harm can come of it. Drug use should be purged from the face of the earth; it does not deserve to exist. Or so the pathology theory goes. Not only are drug use and abuse caused by a pathology of some kind, they also cause a wide range of serious pathologies—in other words “evil causes evil.” One cannot fool around with drugs and remain unscathed; there is no such thing as “harmless recreation” when it comes to drugs. Recreational drug use violates the proper rules of nature, science, and medicine. It is the job of the drug researcher to find a way to eliminate it.

It is taken for granted by most people that this assumption should guide the work of the drug researcher. This assumption is a curious mixture of disease theory and moralistic sentiment—the drug user is thought to be physically, mentally, and morally diseased. This view of the drug user is wonderful fodder for drug hysteria, creating the unquestionable idea of the drug user as a monstrous “other.” When this assumption is questioned, it is defended with a cult-like denial of academic freedom and any consideration of the complexity of human experience, scientific endeavor, and differing political points of view. Not only is there denial, but careers and reputations go on the line. Consider, for example, the forced resignation of former Surgeon General Jocelyn Elders, who merely suggested in public that we study the possibility that drug legalization might reduce crime rates. She also suggested that debate was possible on other controversial positions that resonate with harm reduction philosophy. The case of Dr. Elders is only one example, and issues of race and gender might be brought to bear in thinking about what happened to her, but it has become clear that the quick and moralistic condemnation by those with investments in the current arrangements leaves no room for challenging prevailing views or opening public opinion to the possibility that these issues are debatable.

When public debate actually does emerge, there is a swift containment effort, which includes, among other things, the recirculation of the monstrous drug user identity. The effort is a moralistic offensive. This offensive seeks to insure that drug users continue to be regarded and to regard themselves among the most de- praved of deviants. The belief that drug users are monstrous deviants justifies current policies and practices—such as the recent unprecedented rates of arrest and incarceration of drug users. This belief also justifies increasingly harsher policies and practices—such as New York City Mayor Giuliani’s July 1998 proposal to
eradicate methadone programs, one of the few precariously sanctioned choices heroin users have for an affordable, and (for some) a better alternative to coping heroin of unreliable quality and purity on the street.

Against the deviance position, if drug users from all walks of life can be shown to be, and can believe themselves that they are, just as reasonable, responsible, human, and “normal,” as anyone else, then those who run things may have to worry that their policies will be revealed not only as financially wasteful and ineffective, but also as barbaric, discriminatory, and inhumane. They may be forced to begin to worry that people who use drugs and those who advocate on their behalf will begin to resist more publically and effectively in ways that can’t be easily dismissed as “deviant” and immoral and that people, in general, will begin to question the way things are and begin to support alternatives to the War on Drugs.

Public debate about needle exchange has brought some attention to harm reduction. Harm reduction promotes new ways of imagining, educating, and assisting drug users. It is an approach that respects their rights and responsibilities as human beings. The aim is to value individual decision-making, with emphasis on reducing drug-related harm, rather than demanding total abstinence—a goal few drug users are ready, willing, or should be forced to adhere to. Though abstinence is recognized as a possible option to some people’s current drug-using practices, it is understood as a personal choice, not as a goal to be automatically imposed by service providers and other authority figures who adhere to the assumption of moral and medical pathology and have decided they know best what the drug user needs, who he or she is, and is capable of.

The difficulties of doing science on drugs was highlighted at the June 6, 1998, International Conference on Heroin Maintenance, which was hosted by the New York Academy of Medicine. Most of the presenters were medical researchers, while the audience was a relatively diverse mix of medical and social science academics and researchers, community health workers and activists, and drug users. A panel in the afternoon addressed the moral and ideological dimensions of drug research and policy. Martin Schecter, whose work I have discussed above, talked about the U.S. misinterpretations and misuses of his study of the effectiveness of needle exchanges. He charged that U.S. policymakers were not concerned with data, evidence, or science, but were in the grips of moral ideology. He then curiously maintained that scientific inquiry into these sorts of issues had to be above reproach, more rigorous, better designed, and flawlessly executed. Alex Wodak, a veteran of the Australian harm reduction movement, countered that, no matter how rigorous the science, it is nearly impossible to challenge prevailing views in a climate where rationality and logic do not reign, where decision-making is done based on fantasy and denial, where it is almost mandatory to imagine drug use and drug users as pathologically monstrous.

Another difficulty of challenging prevailing views and practices was revealed during a question and answer session at the Heroin Maintenance Conference. It became apparent that the concerns of researchers and the concerns of activists were somewhat at odds, even though they share a commitment to harm reduction. Harm Reduction Coalition Executive Director Allan Clear asked harm reduction advocates in the medical profession what they were doing to educate their colleagues about alternative approaches to treatment and ways of thinking about drug users. Allan was pressing this issue to emphasize that the lag time between research and implementation of new approaches was too long and that scientific evidence may not be enough to lead to new approaches. His questions put medical professionals on the spot to exercise the power they already have to change the ways drug users are imagined and treated, to do something now, not to wait for approval while people are dying or trying to live lives made extremely difficult by the War on Drugs and its fallout. Other members of the audience expressed similar concerns, yet panel members were not able to address these issues with the seriousness they deserve.

It may not be enough to do “good science” and expect that it will enable better policy and practice in a timely fashion, if at all. Moreover, the concerns of professional researchers may not address the concerns of activists and drug users. The near impossibility of debate on our ways of dealing with drugs in the U.S. is a matter of what is thinkable, who is thought to be qualified to think and act, and who is qualified to produce knowledge that informs approaches to drug use. Many questions arise from this state of affairs:

- Where, with whom, and based on whose concerns may research on drugs be conducted?
- What can be imagined, known, and said about and by whom?
- Who may speak and be taken seriously? What can be heard? How can what is said be interpreted and implemented?
- What conditions shape the possibilities of imagining, speaking, hearing, making sense, and effecting change?

Academics must take seriously such questions as they relate to the question of change, yet resist what Martin Luther King, Jr. called “the paralysis of analysis.” And drug users might be inspired to challenge the ways they are portrayed, which has much to do with how they forced to live. There are limits to the ingenuity, creativity, and survival skills drug users have long exhibited in the face of punitive prohibition. Of course, this separation of academics and drug users is an artificial one—it can’t be assumed that all academics are non-users, and it is crucial to recognize the near impossibility of “coming out” as a drug user. This impossibility structures and limits, with high stakes, how a harm reduction approach to doing drug research might proceed.

Several researchers, users, and activists set out to address many of these questions and concerns at the 2nd Harm Reduction Conference held in Cleveland, Ohio in October 1998. Paul Cherashore set the tone for this theme throughout the conference with his impromptu opening plenary—getting
quickly to the heart of what Patti Lather calls “the politics of knowing and being known,” especially when it comes to being an “out” drug user in the harm reduction movement. I participated in a panel with Carol Dawson, Paula Lum, Kelly Knight, and Victoria Schneider entitled “Do No Harm: Developing a Research Agenda and Protocol for and with Drug Users.” I attended two other panels that were designed to address these issues. Benjamin Junge and Ricky Bluthenthal spoke about “Utilizing Drug User Experience: Community-Based Research.” And Carol Polych, Sam Friedman, Brent Whittaker, and Paul Cherashore talked about “Researching Drug Users: Towards a User’s Voice.”

In the limited space I have here, I can’t get into many of the details of what went on in these sessions, but I can give an overview of what seemed to me to be the most pressing issues. The most frequent concern I heard raised about drug research was one regarding research on the effectiveness of needle exchange. Activists and users repeatedly expressed their disappointment, disgust, and outrage about the fact that federal funding for needle exchange is not forthcoming, even though study after study has shown that they slow the spread of HIV without increasing the prevalence of IV drug use. Government officials said that this was the evidence they required before they would agree to fund needle exchanges. They got this evidence, yet still have refused to act because it’s “sending the wrong message.” The people who brought up this issue, for the most part, said that it was time to stop doing this “effectiveness” research and move on to something else that possibly can have an impact. Many suggested there ought to be more locally based studies of particular programs designed to increase effectiveness as it is defined by users and those who run programs and studies that will help such programs continue to receive funding from their various sources.

There was also a great deal of talk about the ethics of research with drug users. Many people suggested that users need to be identifying what kinds of questions need to be researched, conducting their own research, taking part in the analysis of the data, and controlling the release of information. Moreover, users must be paid for their work, and issues of authorship and credit must be addressed. Carol Polych and others presented examples of this kind of work already being done. There was much talk of “rape research,” in which users involved in the research are merely “used” by researchers. What is learned rarely comes back to the community, nor does it get released in a manner that directly helps anyone besides researchers advance their careers. Sam Friedman handed out a very interesting document written by Annie Madden with a users’ group in New South Wales (NSW), Australia, entitled “Practical Strategies and Ethical Guidelines for Research Involving People Who Use Drugs Illicitly Within NSW.” This document is a well thought out and thorough treatment of the issues and questions I have raised in this essay. It, or something like it, should be required reading for anyone participating in drug research in any capacity. I also agree with Madden that such a document should be a part of the official structures of “ethics committees, research institutions and funding bodies to assess the appropriateness of research proposals and research practices concerning people who use drugs illicitly.”

It was exciting to me that these issues were being addressed formally at the conference, but it was also brought home that the problematics of drug research must be the subject of a sustained effort, perhaps a topic to be addressed by a working group organized around a commitment to address and pursue these issues as new developments in practice and new questions arise. This group must have a membership that reflects all parties concerned—users, service providers, activists, medical and mental health professionals, and academics. We can’t just continue to have isolated sessions at conferences and articles in journals. We have to take action to have more organized influence on how these issues are made public and how they might more appropriately inform drug education, treatment, and policy. We must also recognize that not all drug users are interested in participating in research beyond supplying data. In fact, most users probably are not interested and have more important things to do with their time. This sense of priority must be respected.

Strategies to address the difficulties discussed in this essay obviously cannot come from academics alone, though there is much to be learned from feminists and other critical scholars who have tried to do research differently, to have it be something other than it is—part of the apparatus that serves the interests of domination and hegemony. Nevertheless, there must be some recognition that, no matter how good the intentions, all research is to some degree surveillance. All of us are to some degree caught up in systems of domination and hegemony. There is never a guarantee that research designed to question and do something about the current complex of power and knowledge will serve the purpose for which it is intended. Furthermore, anything said can and most probably will be used against anyone who is heard questioning the way things are and getting too much attention as they are promoting change. Despite these admissions, however, it is worth trying, given the potential power the sciences have in the public imagination and given the absolute necessity for increasing the available ways of talking and thinking about drugs in all modes of communication in our supposed “age of information.”
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Thanks to Jack Nantz and Travis Wendel for their careful readings of and insightful comments on this paper. Any mistakes, oversights, and shortcomings, however, are solely my responsibility.

3 For example, a study by Koren, G., Graham, K., Shear, H., Einarson, T. (1989), Bias against the null hypothesis: the reproductive hazards of cocaine, published in Lancet [8677:1440-1442] found that “scientific results describing harmful effects of cocaine use during pregnancy were more likely to be accepted for conference presentation and publication than studies of equal or superior methodology showing few or no harmful effects” (quoted in Cocaine & Pregnancy by Phillip Coffin, 1997, The Lindesmith Center).
6 For example, Schechter and Bruneau explain that syringes are available for purchase over-the-counter in Canada, so those who take advantage of free needle exchanges are mostly those who are economically disadvantaged and are already at greater risk of HIV infection. In addition, they note that the number of needles available to drug injectors in the needle exchanges they studied fell far short of the number needed for every injection to be administered with a clean needle.
11 Madden, 1997, p. 6.

![NOT IN MY BACK ROOM!](image)

Preventing Overdose Deaths Among Exchange Participants On- and Off-Site

By Corinne A. Carey

In June of 1998, a 31-year old woman died in a small bathroom in Buffalo Columbus Hospital, right down the hall from the “harm reduction” program. She died of an overdose, and she wasn’t found for several days. The program took several measures in response. It changed its location so that program participants would only have access to one floor of the hospital, and when they came through the door of the program, the door locked behind them. The program made participants exit out the back door into a gravel parking lot behind the hospital. It banned the use of the bathroom, and it gave this kind of warning to each participant: “Shooting up here at the hospital is strictly prohibited. If you do, you will be kicked out of the program and prosecuted to the full extent of the law.”

Many people on the streets thought that the program had closed in response to the woman’s death. Indeed, the program did nearly that about three weeks later when three other participants were found to have overdosed right outside the hospital’s doors. The program halted syringe exchange at that site for about a week. The director of the program maintained that the “harm reduction” components of the program were still available, and exchanges were allowed to turn in used syringes, but the program refused to give any clean ones back. Program staff lectured exchangers on using on or near hospital grounds, but did not attempt to warn anyone that there may be lethal doses of heroin being sold, and outreach workers gave no information about how to prevent overdose when they did their rounds on the streets.

The absence of an overdose protocol at a harm reduction program is the antithesis of harm reduction. Because of the inconsistent quality of street heroin, and the inability of users to know exactly what the drug is cut with, the risk of overdose is ever-present in the life of a user—even the most careful user. It is therefore imperative that harm reduction programs pay at least as much attention to overdose as we do to the prevention of hepatitis and abscesses.

OVERDOSE FACTS & FIGURES

- From 1978 to 1994, drug-related emergency room visits rose by 60% (from 323,100 annually to 518,000) and overdoses increased by 400% (from 2,500 to 10,000).
- The average purity of street heroin increased dramatically between 1981 and 1996 from 6.7% to 41.5%.
- From 1981 to 1996, the average price per gram of cocaine fell by 66%
- While the proportional rate of drug use is essentially the same across the races, African-Americans and Hispanics suffer disproportionately large health consequences.
- Blacks are 3.5 times as likely as whites to die of a drug overdose, and 7.5 times as likely to go to the emergency room. This is attributable to the disproportionate application of criminal sanctions against blacks, who get arrested and incarcerated much more than whites for drugs.

Beyond providing more (or at least some) information about what an overdose is and how to respond when someone exhibits signs of an overdose, harm reduction programs should also begin to think about safer shooting practices as that goal affects and is affected by our almost universal policy: “no getting high on site.” We may be far from the opportunities presented by the Netherlands, Germany, and Switzerland where harm reduction pioneers are reducing drug-related harm by allowing users to smoke, snort, and inject in clean, safe spaces away from the rough-and-tumble of the streets. However, many harm reduction programs provide safe spaces for users to come in from the chaos and cold of the streets to find some peace in lounges and lobbies and when we deny, either implicitly or explicitly, a user’s ability to seek out the safe and private havens of the bathrooms, we relegate them to shooting in alleys, backyards, under train tracks, or—if they’re lucky enough to find a shooting gallery that hasn’t been shut down by the cops—they can pay for a negligible amount of safety and privacy. Is it so surprising, so horrifying and unthinkable, that ever-resourceful users take the safety of our spaces and use them to ingest their drugs in an environment infinitely more safe than the streets?

**PROGRAM PROTOCOLS FOR PREVENTING OVERDOSE**

1. **Teach both staff and participants what overdose is—and how to deal with it.** Overdoses are often misdiagnosed reactions to different ingredients in the cut, or a body’s reaction to other ingested drugs. A medical heroin overdose, however, where someone has ingested too much of an opiate, causes the brain to slowly stop functioning, which can impede breathing. Trouble signs include: shallow and slow to no visible breathing; the inability to respond to others; a limp body with no reflexes. One of the greatest dangers an overdose presents is suffocation, and the most important thing for those around a person who has ingested too much is to keep the person awake until they start breathing again. Just leaving someone to “get over it” is the worst thing someone can do. Unfortunately, there’s not much out there about the risk of overdose. For more information, visit the DrugText website at: www.drugtext.org and search the site for information on “overdose,” or get a copy of HRC’s *Overdose: Prevention and Survival* brochure, the second in HRC’s Straight Dope series.

2. **Offer courses in CPR to program staff and participants.** Local Red Cross agencies offer reasonably priced courses in CPR, and harm reduction agencies should require site staff to attend trainings. You can save the life of a person who has lost the ability to breathe on their own—either by assisting them to begin doing so, or by keeping them alive while waiting for help to arrive.

3. **Adopt a policy of “don’t ask, don’t tell.”** Have you ever been out, and you have to go to the bathroom so bad, you stop at a convenience store and ask the clerk: “do you have a bathroom?” More likely than not, the clerk said “no.” You knew very well that there was a bathroom in there, convenience stores couldn’t make people work 17 hour overnight shifts if it didn’t provide them with a bathroom (well, I guess maybe they could). Maybe the clerk was honest and said: “not for the public.” You were pissed, weren’t you? So what did you do? If you had to go bad enough, you might have begged him, or, you might have stopped by the side of the road. You probably looked over your shoulder worrying when someone would come by. You might have felt humiliated, dirty, undignified.

This is what we do to exchangers when we deny them access to the bathroom. They may be forced to find a bush, or go behind a house when they leave the program. And beyond the assault on their dignities, we expose them to the risk of getting caught by the cops. (You can be jailed for up to 72 hours in New York for public urination). An arrest subjects someone to a search; searching a drug user often leads to drug charges; and a drug charge almost always means time, especially if you’re poor.

Adopt a policy of “don’t ask, don’t tell” when it comes to your program’s bathroom but be aware and caring about its use. If someone is in there “too long,” check to see if things are OK. In conjunction with suggestions 1 and 2, if harm reduction staff and participants are aware and caring—and keeping an eye out for one another—no one needs to die in a harm reduction program bathroom.

4. **Develop relationships with doctors who are willing to train both program staff and participants how to use naloxone (otherwise known by its brand name, narcan)—explore the possibility of procuring naloxone for the program staff and its participants.** Naloxone is what is called a “narcotic antagonist” and works to reverse the effects of narcotics by competing for opiate receptors in the nervous tissue. Naloxone reverses respiratory depression caused by narcotics. Adminis-
Corinne Carey is a Soros Justice Fellow working as an attorney with the Legal Harm Reduction Project in New York City. The opinions expressed in this article are those of the author and do not reflect the policy of any organization with which the author is affiliated.

5. Publicly mourn the dead. I don’t even know the name of the 31-year old woman who died in Buffalo Columbus Hospital. Instead of marking the woman’s death as another casualty in the war on drugs, a life lost to ignorance, and a tragic, untimely, and wholly preventable death, Buffalo’s “harm reduction” program ignored the woman and focused on blame and condemnation. The program did so in the interest of keeping itself open, weighing the harm to many if the program were to be shut down by the state.

We need to truly care about the people we work with in harm reduction programs. To put it bluntly, we need to care about those lives off of whom we collect our salaries. Program participants are not merely liabilities, they are valuable and precious lives, and we must care about them individually, collectively, and actually—not just symbolically. The actions of program participants aren’t what shut programs down—programs are shut down because of ignorance, hatred, bigotry, and malice against drug users. As harm reduction practitioners, we don’t have to buy into that ideology.

If your program is regulated by the state, and its funding or very existence is dependent on its adoption of oppressive policies like one-for-one exchange, persistent and unsolicited referrals to rehabilitation, and intrusive and non-anonymous registration requirements, please feel free to decry my suggestions in public. Call them irresponsible and destructive in public meetings or in a reply letter to this and other publications. But when you’re alone, away from public health bureaucrats, or in closed staff meetings, imagine what true harm reduction would look like and consider implementing these ideas.

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