3rd National Harm Reduction Conference Miami, Florida October 22 - 25 2000

what was discussed and how Vancouver could benefit . . .

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National Harm Reduction Conference
Miami October 22nd - 25th 2000

Page 1 — **Opening address by Dr. Clyde McCoy**, who speaks of the '70s when Miami had treatment programs and developed a heroin maintenance program all under the auspices of Catholic organisations.

Keynote by Lynn Paltrow, who is a national drug advocate for pregnant women. Current research shows that crack cocaine alone, i.e. without alcohol, has a similar harmful effect on the body to that of tobacco.
*She said that the life of a drug dependent person these days develops people into either rogues or heroes because they are so isolated
*There has to be a movement that includes all people who use drugs for pleasure and easing pain.
*Harm reduction is about passion and telling the truth.

Page 2-3 — **Rapid Assessment Response & Evaluation (RARE): HIV & Communities of Colour**
*presenters developed a fast and effective evaluation
*changed the delivery of services to nighttime to meet the need
*held press conferences explaining what was required and members of the public stepped forward to provide funds
*where outreach workers felt unsafe at night - were accompanied by a police officer out of uniform

Page 3-4 — **Drug Overdose**
*Santa Cruz made a video with users called "Dope Opera" which shows people how to take care of a friend who overdoses
* All services are piggybacked on to needle exchanges - natural progression
*San Francisco needle exchange publishes "War on Sleep" leaflet to be distributed to educate about overdosing

Page 5-7 — **Drug Policy - Creating Change**
*San Francisco - medical outlets have been added on to needle exchanges
*SF identify frequent emergency patients to offer services to
*SF developed San Francisco Harm Reduction Resolution - used to educate health workers
*SF have vans that dispense on wheels: needles, medical, methadone

*SF "Bridging the Gap" conferences that integrate harm reduction into current medical practices. Next one Jan/2000
*SF attendees of Bridging the Gap express relief that there is an alternative to the abstinence model, which doesn't work for everyone

Luciano Colonna from Salt Lake City:
*writes grant proposals for abstinence based organisations, offering to help them get more money in return for accepting harm reduction driven methods
*uses "enhancement" instead of "alternative" to describe harm reduction
*when he sees a problem - he forms a task force
*speak softly, never say no, never make them look wrong & look for common ground

Page 7-11 **Getting People On Your Side With Training and Peer Education**
*Hartford, Ct: steps to train users as peer educators
*peer educators are referred to as advocates and get $20 a day
Dave Martineau from Hartford, Ct:
*harm reduction coalition addresses two issues: dialogues & training
*discover people are hungry for new info and frustrated with old
*make distinction that harm reduction is not legalisation
*taking user groups to talk to medical students, law students, police, prisons

Page 11 **Carmen Vazquez keynote address"Creating Communities Effectively"**
*it is better to learn how to fish than to catch one
*activism is not spontaneous, it is organised and needs funding
*be mad without leaving the room - groups have to do things together

Page 11-16 **Ethan Nadelmann: Drug Policy Reform/Drug Policy Reform as Harm Reduction**
*Harm reduction and drug policy reform overlap substantially both conceptually and politically, but they are not the same. Harm reduction is explained in terms of four complementary perspectives: harm reduction as needle exchange; harm reduction as a generic fallback strategy; harm reduction as a framework for analysing and assessing drug policies; and harm reduction as moral imperative.

Page 17-21 **David Lewis, M.D.: Physician Leadership on National Drug Policy**

*Dr. Lewis assembled 37 of America's most distinguished physicians, representing virtually every medical specialty (and political viewpoint) and agreed on a consensus statement. They stressed the need for a medical and public health approach to national drug policy, which has formed the framework for their activities.

Page 22-23 History

*Australia introduced needle exchanges in 1987 - nothing since

*in 2000 Australia called for 8 safe injection rooms and heroin trials and John Howard, their prime minister, unilaterally stepped in and banned them

*"Users News" is a peer education magazine in NSW Australia, with regular contribution from users with their stories and poems of their lives

Page 23-26 International Lessons: Eastern Europe

*"harm reduction brings us closer to the scene, rather than bringing the scene to the health care workers, which keeps the users marginalised"

*OSI (Open Society Institute) actively funds the development of harm reduction in Eastern and Central Europe and the former Soviet Union

*in 1995 Krakow in Poland had 25,000 users and 1,000 detox beds - which forced them to ask the question "how shall we care for the other 24,000?"

*Krakow is establishing a safe injection room in 2000, which will be housed in an existing residential health centre, slightly out of the city centre. People will be taken there by shuttle bus.

Page 26-27 Criminal Justice - International Response

*Chantal Plourde, Montreal: surveyed 317 inmates in 10 prisons and presented results from a questionnaire she completed during individual interviews.

*Danica Stanekovia, Bratislava, Slovakia: reports findings from a pilot study of risk behaviour and voluntary HIV counselling and testing among inmates in prison.

Page 27-32 Criminal Justice in the USA

*Deborah Small, Lindesmith Centre, Drug Policy Foundation, New York spoke about de-escalating the war on drugs and records the current (pre-US election) political climate of the US drug policy.

*She talks of Gary Johnson the governor of New Mexico, who has introduced successful harm reduction measures in his state, amidst great opposition, and a year later is very popular in the opinion polls of the people of New Mexico as a result.
*She spoke of the need to organise 'average' people - the PTA, Rotary Club, Veterans, Chamber of Commerce. Appeal to their particular interest, using economic analysis in order to garner their interest.
*Taxpayers money is wasted when it should be invested into communities.

*Carol Shapiro, Family Justice, La Bodega de la Familia, New York addresses the issues that the judicial system has on families who have been robbed of their power to help. There are distinct benefits from partnering families with the justice system:
*people regain responsibility for their lives
*an opportunity is created to incorporate prevention into treatment
*treatment is matched to need
*enhancement of public safety/public health and how we think of them

*Ricardo A. Bracho works in a program called Centreforce at San Quentin. CA. His piece "I am a nightmare walking" was a performance art-piece, and he addresses reducing individual harm with young straight men of colour, who have experienced a collective increase in harm through state prison incarceration.

*Mary Cotter, "God's Love We Deliver Society", New York spoke about women in prison in New York and harm reduction principles.

Page 32-36 Criminal Justice - Drug Courts

*Corinne Carey, The Urban Justice Centre, New York noted:
*all the data we know about addiction and the affect it has on people's lives is collected from the small traceable group who get into trouble and there is no data on the people who successfully manage their drug use. (nb alcohol metaphor - some people are chronic alcoholics and many others are able to manage their use).
*Her concerns about drug courts are:-
*mandatory urine testing is the only yardstick for success
*mandatory urine testing has rippled through the system and a person has to be "clean" to access many social programs and assistance.

*compulsive treatment makes people more compliant
*people only have access to treatment if they commit a crime
*still remains a control issue
*poor use of resources
*leaves the individual unmotivated
*Daniel Abrahamson, Lindesmith West Drug Policy, San Francisco, CA discusses the proposed Proposition 36 in California which calls for treatment for non-violent drug offenders in a community-based treatment model, rather than an AA or NA 12 step program. Judges do not make the decision over treatment - a health professional makes that assessment.
*Proposition 36 funds $120,000m for the next 5 years, per year. 30,000 people in California will be affected and taxpayers will save $150,000m a year by not putting them in prison, and not building two more prisons would save $500,000m.
*He discusses different guidelines used in drug courts throughout the U.S.

*Angela Gerritsen, Intermountain Harm Reduction Project, Salt Lake City, Utah, describes her experiences as a participant in the Salt Lake City drug court program.

*Urine testing is a good tool if used in confidentiality between the doctor and the patient. An example of harm reduction in treatment would be a man who is on the street injecting heroin for 20 years and is now smoking cannabis. This is success even though he would still test positive.
*Successful drug courts needs good training and good judges.

Page 36-37 The North American Opiate Medication Initiative (NAOMI)
*A research doctor from Yale University talked about the first heroin maintenance trial in the US, held in 1918 in New Haven. It was the idea of the police chief and operated out of city hall. The average age was 33, 20% were women and there was a small fee per dose. It was very successful as the crime rate went down and the police chief was pleased as the participants proved to be key informants about the dealers. Closed down after two years for political reasons.
*He also spoke about the history Europe has had with heroin maintenance trials, and noted that Holland, Germany and Spain are

all set to start with trials of their own. So was Australia, until the current prime minister vetoed the program.

*Dave Marsh from the Addiction and Mental Health Centre in Toronto talked about plans for three cities in Canada to initiate heroin trials and they will follow the Dutch model. No information as to when they will start.

*Ethan Nadelmann from Lindesmith Centre for Drug Policy Reform in New York discussed the pros and cons of doing a joint North American initiative for heroin maintenance trials.

Page 38 **Closing Keynote: The Reverend Ed Sanders II** infused us with enthusiasm, and stressed the need to not give up, work together and work things out.

***don't be afraid to think a new thought**

***don't let circumstances hold you back**

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Page 1-7 **Suggestions and Thoughts for Consideration in Vancouver**

Page 8-11 **Drug Courts Essay**

National Harm Reduction Conference
Miami October 22nd- 25th 2000

Sunday October 22nd

POLITICAL

The conference began with a welcoming address by **Dr. Clyde McCoy**, who is with the department of Epidemiology and Public Health at the University of Miami School of Medicine. He wanted to remind the audience of a man who had worked extensively in Miami during the early 1970's to develop heroin maintenance and a variety of treatment programs - all under the auspices of Catholic organisations.

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POLITICAL

There was a keynote address by **Lynn Paltrow**, who is a national advocate for pregnant women. She said that the life of a drug dependent person these days develops people into either rogues or heroes because they are so isolated. There has to be a movement that includes all people who use drugs for pleasure and easing pain. Harm reduction is about passion and telling the truth.
She spoke about the furore that was created about crack cocaine in the late 1990's, and showed us slides of articles in the media telling dreadful stories about "crack" babies. She referred to current research which tells us that crack cocaine alone has about the same harmful effect on the body as tobacco, and is way less harmful than alcohol. ****SEE LINDESMITH HANDOUT****
In South Carolina, they have voted in laws, under the guidance of a man called Robert Condon, which consider the fetus as a viable person. Consequently, women who are using drugs and are pregnant are arrested for child abuse, therefore creating a powerful war 'frontline' of fighting drugs and abortion. In California there is a program called C.R.A.C.K. (Children Requiring A Caring Community) which offers drug using pregnant women $200 cash to be sterilised. There is a federal

Adoption and Safe Families Act which allows for the permanent termination of parental rights if a mother doesn't get "clean and sober" within 15 months. There is an impending decision by the Supreme Court next term on drug testing pregnant women for the purpose of criminal prosecution.
These initiatives have obvious and menacing underpinnings, because of the fact that the majority of people targeted happen to be poor and people of colour.

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HEALTH

Rapid Assessment Response and Evaluation (RARE): HIV and Communities of Colour

Richard Needle, US department of health and human services
Evelyn Uilah, Health Department of Miami/Dade County Fl.
Harry Simpson, Lead Ethnographer, Detroit RARE Team.

In regards to risk behaviour patterns and the provision of services, the research findings that all three presenters stressed was that the highest activity was at night, and therefore it is a mistake to make most services available during the daytime.

In Miami they held press conferences to announce the findings of RARE and twice members of the public stepped forward to provide funds.

In Miami also, they have a police officer out of uniform accompany the outreach workers on the streets at nighttime.
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In Detroit they used a team of recovered users to do the research for the RARE report, because they are the ones who people will talk to and they are really in touch with the street scene.

They came up with the following findings:

a) have to take the services to the streets
b) have to include users who really know what is going on
c) funding has to have "buy-in" from funders to take the research and put the recommendations it into practice.

It was noted that in Philadelphia they are training people in the user community to go out and educate on the streets.

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All three presenters mentioned that the foundation of providing services to the community was their needle exchanges. As the needle exchange was the first contact with users, they built from there, adding as many harm reduction measures as they can. There is a federal ban on funding needles exchanges in the US and in many states it is illegal to have them, which results in many underground needle exchanges, where the organisers risk the chance of being arrested.

Question: How to get departments etc. to act?
Have policy makers in at the start of research. Also need private sector. Miami consolidated different policy makers to form planning bodies, which always included users. Remember - one size does not fit all.

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HEALTH
Drug Overdose
Joshua Bamberger, San Francisco Department of Health
Heather Edney Meschery, Santa Cruz Needle Exchange
Ro Guiliano, San Francisco Needle Exchange
Sheigla Murphy, Community Health Works Inst. for Scientific Analysis, San Francisco

In California they are faced with resistance to users calling 911 if a friend overdoses for fear of retribution and arrest. Santa Cruz presented a video which was jointly made by the people running the needle exchange and the users, called "Dope Opera". ****HAVE REQUESTED COPIES TO BE SENT**** It is a cool and informative education video, featuring the users as themselves, dealing with an overdose situation. It was completed the day before the conference started, and is the first one of a series.
In California, the services are all piggybacked on to the needle exchanges, so for instance, both Santa Cruz and San Francisco have drop-in centres for exchanging needles as well as street units. These drop-in centres are far more than a place to exchange needles, and appear to be friendly environments where you can connect with people and be directed to other services and get a cup of coffee.

Methadone is not available for people under 18 years in California.

They educate users in rescue breathing and CPR, and there was a lot of discussion about a drug called Noloxon (narcan) which apparently counteracts the effects of heroin in the system in 45 minutes. The paramedics carry it in their vehicles and sometimes people have been known to help themselves to a kit or two to carry around for emergencies. Apparently it is a not a drug you would want to take on its own as it makes you feel bad! They also educate outreach workers on how to deal with overdoses. The San Francisco needle exchange publishes a leaflet called "War on Sleep" ****HAVE REQUESTED COPIES TO BE SENT**** to be distributed in order to educate about overdosing.

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POLITICAL

Policy - Creating change

Joshua Bamberger, San Francisco Department of Health
Alice Gleghorn, Department of Public Health Division of Mental Health, Substance Abuse and Forensic Services, San Francisco
Luciano Colonna, Intermountain Harm Reduction Project, Salt Lake City, Utah
Maureen Rule, Health Care for the Homeless, Albuquerque, NM.

Joshua Bamberger presented the Harm Reduction Resolution in San Francisco. ****SEE HANDOUT****

Services San Francisco provides are:
a) needle exchange and medical outlets
b) training peers to deal with overdoses effectively
c) identify frequent emergency unit visitors, in order to provide them with contact and services

He has presented the resolution to many community groups and health workers - with practical steps as to how to apply it in the public health setting. It is a tool to promote discussion. He went to see health providers first of all, and then people started asking about how to apply it to family violence or custody cases, and he also talks to STD and addiction health workers.

They have vans that are dispensaries on wheels: needles, medical, methadone.

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Alice Gleghorn talked about a series of conferences they have held in San Francisco to educate substance abuse workers in harm reduction. The first one was called "Bridging the Gap", and was so successful that they held a second one called Bridging the Gap: Integrating Harm Reduction with Regular Methods of Treatment" which included hands-on workshops teaching people how to work with staff who see harm

reduction as a personal threat to themselves. They are broadening the view of how to help people.
The third conference is called "Bridging the Gap: Harm Reduction Research, Policy & Practice" **SEE HANDOUT**
The feedback she has received from working with the treatment providers in this way, is that they have expressed an overwhelming relief to know there is a beneficial alternative approach to abstinence.
Another benefit from bringing groups together for these conferences is that they start to treat each other less like enemies.

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Luciano Colonna used to work in Western Massachusetts where they have a needle exchange. He moved to Salt Lake City because his wife was offered a great job there, and made some enquiries about harm reduction when he arrived, and before too long found himself Executive Director of the Utah Harm Reduction Coalition. He created two separate agencies, one for an underground needle exchange, called the Needle Exchange Agency and the Harm Reduction Coalition.
He also realised that calling harm reduction "enhancement" rather than "alternative" met with less opposition.
He was working in a rather unfriendly environment, totally controlled by the Mormon Church, and came up with an innovative approach to befriend them. He approached them and promised them he could get them more money (funding) because he was good at writing proposals for grants. All they had to do was to agree to the grants being harm reduction driven.
For instance, the Volunteers of America - the Salvation Army - had the largest public detox in Salt Lake. He wrote successful grants for them and they in return backed his two agencies.
He has written grants for other places and has successfully brought them more funding, and they in return support him.
He suggested that you speak very softly, never say no, never make them wrong and look for common ground.

The Women's Relief Society is the largest women's group in the world, and is part of the Mormon Church. It turns out that Mormon kids do drugs, and he wrote a proposal that they found acceptable to help them out.
He has used the same strategy with a "Women At Risk" group for sex trade workers, has introduced harm reduction into the "John's" course, and has led the way for dealing differently with overdoses. When you see a problem, form a Task Force
Be a good harm reduction driven grant writer for other agencies! Include money for users to participate in program, write in a consultant fee. Find common ground. He mentioned harm reduction training for police.

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Maureen Rule spoke about homeless in New Mexico which has a population of 1.5 million and they have 8,000 homeless.
They have needle exchanges, including methadone. They have six harm reduction centres including baths and showers for the homeless. She is always collecting empty plastic water bottles, because for people on the street who don't have access to water, they give it out as a harm reduction measure.

She referred to the "Weed and Seed" federally funded program which is about removing 'bad' people and replacing them with 'good' people.

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<u>Monday October 24th</u>
COMMUNITY
Getting People On Your Side With Training and Peer Education
Maria Martinez The Institute for Community Research, Hartford, Ct.
Michael Wilson Chicago Recovery Alliance, Chicago, Il.

Dave Martineau Connecticut Harm Reduction Coalition, Hartford, Ct.

Maria Martinez - Steps in Training Active Drug Users as Peer Educators

* active users know what's really going on
* establish a series of focus groups to find what the outreach workers had missed - not seen
* decided to change the name from peer educators into advocates
* held an open forum to discover the barriers to becoming an advocate
* asked what are they willing to do - let them see themselves as already doing
* have them do interventions and hand out:
  a) image cards - make them fit the area ****REQUESTED SAMPLE OF IMAGE CARDS****
  b) detergent kits - instead of bleach
  c) fit pack - hard plastic case for used syringe
  d) sterile syringe, to mix dope with instead of needle
  e) teach them to cook dope because it is safer

* Practice Weekly Cycles
  a) 6 people - 1 week cycle
  b) 4 men 2 women - heroin and cocaine users
  c) 3 days in house, 2 days site outreach

The issues that came up were transportation, partnering of staff with peer health advocates one on one, flexibility in time - maximum 2 hours, plenty of coffee, doughnuts and pizza for lunch.

* Selection of Health Advocates
  a) high risk sites and outreach recruitment
  b) identify 2 contact referrals and recruit them for baseline, follow up with two more interviews
  c) commitment to program

d) willingness to engage
e) willingness to team up with a staff member and participate in site visits

*Opportunities for Advocates
a) identify own issues and work to address them
b) meet local representatives from agencies that are related to group issues
c) post advocacy and educational/prevention materials in sites at other locations
d) create own image cards
e) write own newsletter or design web site
f) use SHARPS containers
g) in order to let them become training assistants in other cycles of program, must have finished the entire cycle

They are paid $20 a day at the end of each day.

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Michael Wilson from the Chicago Recovery Alliance spoke about the absolute importance of having users on planning groups. Their city community process calls for planning groups, with 15 people on a particular focus group. The Alliance have 3 users on the city planning group, 3 on the county planning group and 3 on the state planning group. Originally their project was not funded and they started by having a focus group for the users to voice their needs. The choice of location for these groups to meet is important because it must be accessible and convenient. He spoke about regular meetings where people identify themselves by what they do, and what a sensitive issue that could be for a user attending a planning group. He spoke about the hard time African American homosexuals have in their own communities - being gay and black is not acceptable by many black people.
Michael handed out a Model for Recruitment of Intravenous Drug

Users for Community Planning Groups.**SEE HANDOUT**

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Dave Martineau talked about harm reduction outreach in the larger community. Two years ago he formed a Harm Reduction Coalition to address two issues: dialogues and trainings.
The first time they met with 100 people and discussed how to spread the words and decided on education. They wanted to make the distinction that harm reduction is not to legalise drugs, but to give more tools to active users to keep safe and improve the safety of the communities.
They have started in 4 cities already and are mapping out the whole state of Connecticut. They advertise by distributing flyers to agencies and are finding that people are hungry for information, and very frustrated with the old rules and regulations which they don't experience as working.
They are talking to state officials about harm reduction and some are changing their thinking. They are getting money for users. As a result of their efforts in the city of Hartford, a small group asked how to take it out to the rest of the state. He said that it is dangerous to inject in SRO's or on the street, and there too many drug overdose deaths.
They have taken user groups out to speak to target audiences:

* medical students
* law students
* police - one idea to help them buy in is for the user to voluntarily show them their card and clean syringe to assuage fear of being stuck by dirty needles when searching
* prisons

They are currently building their 34th prison in California. Once safe,

users have time to think about how they can make their lives better. Quantify the dollars it costs for prison vs housing and services per person. Don't talk drugs, talk pain and suffering. Ask where they are now and where they want to be - empower them because you cannot force. "You can do this because I need you" "You can do it if you want to do it".

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POLITICAL

Keynote Address: Carmen Vazquez, Director of Public Policy, Lesbian and Gay Community Services Centre, New York NY.

HAVE REQUESTED TRANSCRIPT

Some points she raised:

*the need to create community effectively
*it is better to learn how to fish than catch one
*go for success and not victory, because success has no failure attached
*activism is not spontaneous, it is organised and needs funding
*respect for diversity and the freedom to express
*build constituencies of people who lives are being destroyed
*organise communities with community building and advocacy training
*be mad without leaving the room - groups have to do things together

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POLITICAL

Harm Reduction as Drug Policy Reform/Drug Policy Reform as Harm Reduction

Ethan A. Nadelmann, JD, Ph.D. Director, The Lindesmith Centre, New York, NY.

Today we are facing a monumental struggle, a 100 year war, involving deep seated fears found only in the US, and perhaps similar to those in Scandinavia. It is big, bad and driven by some who know what they are doing, those who don't and some who are just caught up.

Is there a drug policy reform movement in the US today? It is similar to other political reforms that we have seen, and seems to be in the same place right now as the gay movement in the '60s, civil rights in the '40s, women getting the vote earlier in the 1900's and slavery in the early 19th century.

Although economic analysis favours reform, there are vested interests in retaining the old system. This appeals to fears about the safety of women and children and playing on that fear wins the middle road. It is really all about social justice. Even though it looks frightening, lots of people are 'mostly' still on side.

In the emerging drug policy reform movement, there are four types of interested parties.

Constituents - have only one issue, eg cannabis, methadone, safe injection rooms, legalisation, heroin maintenance. There is a growing number of groups. How do they relate to ending the war on drugs? They are increasingly identifying with the bigger picture and that will bring about reform. The paradox is that for any one issue to advance politically, the group has to disassociate with overall drug reform. Sometimes they are right to do so because being linked will cause more resistance. However in the long run, a success for the interest group will bring the whole movement along as well.

Core - key people in constituent movements, as well as people who connect the dots, that is those who see all the ways that the war on drugs affects people's thinking, the subtle places it affects. Need to develop a generic strategy a) insist on saying drug prohibition is the major problem -the core part, and b) work on constructive things that can be done today. In order to work together you don't have to agree on the end result.

Coalitions - outside the 'drug' area eg African Americans groups with

racial profiling, pregnant rights, the hemp issue. Building coalitions have the opportunity to begin to educate about other things we face, eg the regulation of pain management which can be related to the dispensing of methadone. Cannot achieve success without others seeing their issues are ours.

Coalescence - an emergent movement for political social justice in the US.

Drug Policy Reform and Harm Reduction have overlapping interests in the core and each includes separate elements.

Harm Reduction is a range of issues, housing, welfare, outside of drug policy. It has much greater breadth. It is associated with a left outlook that may also embrace the redistribution of wealth. Drug Policy Reform is only concerned with drug issues, such as asset forfeiture reform, the right to use psychedelics, hemp, prison sentencing and the rave scene.

Harm Reduction - needles exchanges: when they were introduced in order to stop the spread of HIV it was a pivotal moment. It was the first time authorities had looked at addicts as potential partners. The priority was given to reduce disease over stopping users.

Generic Fallback Strategy: safe injection rooms for heroin overdosing, seatbelts for car accidents, bic pens now have a hole in the piece at the top that clicks a pen into action - they used not to have a hole and occasionally people would swallow them and choke to death.

Public Policy Reform: overlapping definitions of harm reduction. The European model defines it as reducing the harm that users may cause to themselves and reducing the harm they may cause to their communities. In the US there is the European definition plus reducing the harm that is caused by prohibition. It has to be acknowledged that both are likely to exist for the foreseeable future. People say that harm reduction is on the slippery slope to legalisation. First of all the slope isn't all that slippery and the US has to come to terms with harm reduction strategies first. The legalisation debate should be just that - it is one of the answers to discuss. There is no all or nothing in

regards to prohibition or legalisation. There are many potential answers in between. eg prohibition of barbiturates may be good. An ideal policy is a public health approach, legalise cannabis and concentrate on human rights.
Should the term "harm reduction" be dropped? No and there are other terms that are useful eg "minimise risk" or "minimise harm".
In New Mexico the Governor, Gary Johnson has a new bottom line strategy. The evaluation should be "has the drug policy succeeded in reducing disease, death, crime and suffering?" Need to establish a middle ground. Cannot have a sensible dialogue about legalisation until harm reduction is accepted. In Europe in the late '80s they were talking about legalisation and decided to stop and stick to the struggle at hand, which required harm reduction. Two years ago at the U.N. they were able to discuss legalisation because harm reduction is now part of their culture. In the late 20th century the left wing became more middle of the road, and were able to establish their objectives without being so extreme. This phenomena could easily transform the drug policy movement. Leaving cannabis aside in the legalisation debate, change the language to a prohibition debate. The public need to understand this distinction and this issue.
Ethics: a core part of harm reduction is meeting people where they are at. There is the moral viewpoint - we say put real morals back in. The principle is that people should not be punished or discriminated on based on what they choose to put and not put into their bodies. The long term target is sovereignty over our bodies and minds. Need to keep this up front when talking to governments, and it will keep us honest. The paramount principle is 'the right of people to get high'.
Life objective is freedom of consumption melded into the constitution, which translates into having control of our own bodies, with limits as to how it affects society, as with other rights in the constitution. Need to alter drug policy to reflect this principle, and the rest of the drug policy reform has to accommodate this core principle.
As an aside, we are looking at a trend of increased coerced treatment

by the state, urine testing, and criminal sanctioning. How do we deal with drug courts - is it three steps forward and two steps back? How does harm reduction relate to this? The key criteria is that harm reduction cannot accept a program where people are obliged to report 'dirty' tests. This is a diversion and reporting should only be on attendance. Therefore if the courts reverted from the criminal justice system and did not report dirty urine results, that would be an avenue to move forward on. It is not harm reduction, if you have to report with sanctions.

The following are the strategies for the Lindesmith Foundation and the Soros organisation.

Medium term: 2005-2010 - to bring the US close to where Europe is now. Harm Reduction is the official national policy. Needle exchanges are standard, methadone and heroin maintenance, policing under harm reduction methods and a safer approach towards prostitution. Decriminalising cannabis has reduced drug dealing. In Switzerland they are talking about legalising and the Dutch are looking at the doing the same. It could be described as backing into policy.

Longterm - embracing the core principal of no punishment for what we put into our bodies.

Short term: 2001 - lots of progress. There are ballot issues going on in Nevada, Colorado. There are asset forfeiture reforms going on in Oregon and Utah. There is proposition 36 in California which calls for treatment instead of jail - they have worked out that if there are 25,000 fewer people in jail it will save $1.5 billion in the next five years. In state legislature there are lots of wins.

The greatest nightmare in the future would be to see the expansion of urine testing and other forms of surveillance. Sanctions may include the consumption of an antagonistic substance forced into people, to reverse the effects of the drugs they have consumed or to make them physically ill. This would be a totalitarian form of drug control - control over people's bodies.

A harm reduction strategy won't win unless parents in the US really believe that it will protect their kids better.
Who is the new group to lead the movements? The elderly! They have seen it all, they are gentler to their grandchildren than they were to their own kids, they have taken lots of drugs. Nobody wants to lock up gramma - we want them to ***feel good*** -god bless them.
ANSWERS TO QUESTIONS:
1) Coerced treatment is not the same as drug treatment. The fallback in respect of abstinence programs is harm reduction can help them with the people who fall off.
2) In regard to the 'concern' of speed becoming more popular, it would be the same as what happened with cannabis which turned into reefer madness in the past and more recently with crack cocaine. Most people who played with cannabis are not addicted, and most people who played with crack are not addicted five years later. The more people understand that you cannot eliminate drugs, they will see that harm reduction is at best a smart response and at worst drug testing with sanctions.
3) In regard to society using the users as scapegoats, why not find a new one - what about environmental bad guys?
4) Who benefits from prohibition? Well it is complex, but on the one hand there are people in treatment and law enforcement, which can turn into a force of it's own fuelled by parental fear and racism. Somebody once asked the drug czars in Colombia if they would agree with legalisation. The older established ones were in favour. They had made their money, they may have come from middle class families, and saw themselves as the new Bronfmans or Kennedys. They saw their children and grandchildren as benefiting. The newer ones, like Pablo Escobar is from a very poor background, and didn't feel they had made enough yet. Saw themselves as Al Capone, eventually dying of syphilis in prison one day.

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POLITICAL/HEALTH

Physician Leadership on National Drug Policy

David C. Lewis, M.D. Project Director for PLNDP
Centre for Alcohol and Addiction Studies Brown University, Providence, Rhode Island.

The following is taken from the PLNDP's Position Paper on Drug Policy:

Physician Leadership on National Drug Policy (PLNDP) was started in July 1997 when 37 of the nation's distinguished physicians, representing virtually every medical specialty, met and agreed on a Consensus Statement. This statement, which stresses the need for a medical and public health approach to national drug policy, has served as the underlying framework for all of the project's activities. "Despite the best intentions of government policy makers and law enforcement officials, the current criminal justice driven approach is not reducing, let alone controlling drug abuse in America", quoted by the past President of the American Medical Association. "Our profound hope is that this group of distinguished physicians. because of their professional accomplishments and objectivity, will be able to help move us to a new national consensus", David Lewis. The 37 PLNDP members are physicians of high national standing and many have health policy responsibilities at the highest federal and state levels. Because of their wide range of backgrounds, there is no particular ideological or political perspective that dominates the group. In March 1988 the PLNDP presented its first research report "Addiction and Addiction Treatment". The report contained a review of more than 600 research articles as well as original data analyses that conclusively demonstrated that drug addiction is as treatable as other chronic medical conditions, such as diabetes, asthma, and hypertension. The report also found that treating drug addiction is an effective anti-crime measure and is less costly than prison. Some of the most positive outcomes of treating drug addiction include: greatly reduced medical costs to society; returning drug addicts to their families,

communities, and jobs; major crime reductions; and a reduction in funds spent on law enforcement. From this research, the PLNDP developed a videotape report *Drug Addiction: The Promise of Treatment*, released in November 1998. ****I HAVE A COPY OF VIDEO AVAILABLE**** In November 1988 the PLNDP presented a second research report "*Health, Addiction Treatment, and the Criminal Justice System*". The report was made up of a series of research studies on drug courts and drug treatment programs for prisoners, parolees, and teenage drug users and found that the best new programs reduce drug use, crime, and re-arrest rates. In analysing this new level of success, a core component cited in the studies is the need for close collaboration among the criminal justice system, the community, public health agencies, cognitive and behavioural counsellors, drug treatment specialists, health care providers and employment specialists. The PLNDP's second videotape report, *Trial Treatment and Transformation*, was generated from this research and was released in April 1999. ****I HAVE COPY OF VIDEO AVAILABLE****

The PLNDP has also expanded its efforts beyond the PLNDP members by inviting physicians and medical students from across the country to become associates of the PLNDP. To date, there are nearly 6,000 Physician Associates and several hundred medical student associates who have indicated that they are in agreement with the Consensus Statement and that they are interested in further educating themselves on drug policy.

In June 1999 the PLNDP leadership met at the Aspen Institute in Aspen, Colorado. An important goal of this meeting was to facilitate dialogue between various disciplines in order to arrive at shared goals and to articulate the necessary steps in national and local research and advocacy efforts. To this end, representatives from law, the enforcement community, business leaders, legislators, community coalition leaders, and experts in addiction medicine and addiction psychiatry were present. The meeting was successful, with participants responding positively to the idea of working together to

develop new approaches to drug policy.

Position Paper on Drug Policy

Drug addiction is a medical and public health problem that affects all Americans, directly or indirectly. This report by PLNDP demonstrates that a medically-orientated, public health approach to dealing with the problems of drug abuse will help improve the health of individuals as well as the health and safety of our communities and of our nation.

The focus of PLNDP has been on illicit drugs, although many of the policy recommendations in this report apply to all forms of substance abuse. This focus on illegal drugs was chosen by comparison to tobacco and alcohol policy because illicit drug policy is the area where there has been the least input and influence from medical and public health leaders.

The medical and public health oriented treatment policy recommendations in this report are based on evidence that:

* drug addiction is a chronic, relapsing disease, like diabetes or hypertension
* treatment for drug addiction works
* treating drug addiction saves money; it helps people return to work, reduces the burden on emergency care, and decreases crime rates and incarceration costs
* treating drug addiction restores families and communities
* prevention and education efforts help deter our youth from substance abuse, delinquency, crime and incarceration

Key Policy Recommendations

* reallocate resources toward drug treatment and prevention
* parity in access to care, treatment benefits and clinical outcomes
* reduce the disabling regulation of addiction treatment programs
* utilise effective criminal justice procedures to reduce supply and demand
* expand investments in research and training
* eliminate the stigma associated with diagnosis and treatment of drug problems

* train physicians and students to be clinically competent in diagnosing and treatment drug problems

Consensus Statement - PLNDP

Addiction to illegal drugs is a major national problem that creates impaired health, harmful behaviours, and major economic and social burdens. Addiction to illegal drugs is a chronic illness. Addiction treatment requires continuity of care, including acute and follow-up care strategies, management of any relapses, and satisfactory outcome measurements.

We are impressed by the growing body of evidence that demonstrates that enhanced medical and public health approaches are the most effective method of reducing harmful use of illegal drugs. These approaches offer great opportunities to decrease the burden on individuals and communities, particularly when they are integrated into multidisciplinary and collaborative approaches. The current emphasis - on use of the criminal justice system and interdiction to reduce illegal drug use and the harmful effects of illegal drugs - is not adequate to address these problems.

The abuse of alcohol and tobacco is also a critically important national problem. Alcohol abuse and alcoholism cause a substantial burden of disease and antisocial behaviour which require vigorous, widely accessible treatment and prevention programs. We strongly support efforts to reduce tobacco use, including changes in the regulatory environment and tax policy. Drug addiction encompasses dependency on alcohol, nicotine, as well as illegal drugs. Despite the gravity of problems caused by all forms of drug addiction, we are focusing our attention on illicit drugs because of the need for a fundamental shift in policy.

As physicians, we believe that:

** it is time for a new emphasis in our national drug policy by substantially refocusing our investment in the prevention and treatment of harmful drug use. This requires re-allocating resources toward drug treatment and prevention, utilising criminal justice

procedures that are shown to be effective in reducing supply and demand, and reducing the disabling regulation of addiction treatment programs.

** concerted efforts to eliminate the stigma associated with the diagnosis and treatment of drug problems are essential. Substance abuse should be accorded parity with other chronic, relapsing conditions insofar as access to care, treatment benefits, and clinical outcomes are concerned.

** physicians and all other health professionals have a major responsibility to train themselves and their students to be clinically competent in this area

** community-based health partnerships are essential to solve these problems

** new research opportunities produced by advances in the understanding of the biological and behavioural aspects of drugs and addiction, as well as research on the outcomes of prevention and treatment programs, should be exploited by expanding investments in research and training.

PLNDP will review the evidence to identify and recommend medical and public health approaches that are likely to be more cost-effective, in both human and economic terms. We shall also encourage our respective professional organisations to endorse and implement these policies. ****I HAVE A COPY OF THE PLNDP POSITION PAPER ON DRUG POLICY****

Dr. Lewis is very interested in Vancouver and how we have dealt with our epidemics and our drug issues. He has more copies of both videos and the position paper available on request. He made a comment about drug courts and urine testing. In his opinion testing is only justified when there is harm being done to society, i.e. driving while impaired. He was equally cautious about the Integrated Family Court System in the US, which he says has a negative effect on the rest of the court system, particularly for juveniles.

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POLITICAL

History

Jo Bracato, Florida International University, College of Urban and Public Affairs, North Miami, FL.
Andria Efthimiou-Mordaunt, John Mordaunt Trust/Users Voice, London England
Timothy Moore, Redfern Legal Centre, Redfern, NSW, Australia
Stephen Wye, NSW Users and AIDS Association, Newton, NSW, Australia.

Jo Bracato talked from a social worker's perspective, including the challenges of moving from an abstinence based model. It requires seeing the bigger picture and a shift from consciousness is necessary.

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Andria-Efthimiou-Mordaunt is an ex-addict, counsellor and now an activist. She strongly believes in user participation.

**

Timothy Moore talked about the history of drug prohibition in Australia. The first laws were enacted in 1895, prior to which everything was legal, and was covered under the poisons act. The first to be prohibited was the sale of smokable opium, which targeted Aboriginal and Chinese people, and in 1909 opium was banned altogether and the restricted drugs were expanded over time, although there was opposition to these moves. Australia signed up to global agreements written at international conventions on drugs. Australia banned everything, even cannabis which at the time of signing the ban, was not available in their country. Being a commonwealth country, they were automatically signed on to international agreements by Britain, and since World War II they have sided with the US.

In 1985 their prime minister of the day cried on national television because his daughter was a heroin addict. This resulted in a national drug summit, where they recognised that alcohol and tobacco were the major killers, and that they were not able to do much about that, and focused their attention on illicit drugs instead. There was a blanket prohibition. Australia is often hailed as a harm reduction mecca, and indeed they did introduce a needle exchange, which was widely used and HIV peer based, however since 1987 there have been no new strategies introduced.
In year 2000 there was a call for 8 safe injection rooms to counteract their high rates of overdoses, and heroin trials were also slated to begin, when the current prime minister, John Howard, unilaterally stepped in and banned them. Hepatitis C and overdoses are up, and HIV levels are level.

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Stephen Wye talked about his work over the last decade as editor of User's News ****I HAVE SEVERAL COPIES**** which is a peer education magazine of users in New South Wales, Australia. He read many entries from the contributions published over the years. One of the most important, regular, and popular features of the magazine has been the stories and poems of using contributed by the users. They give a varied and sometimes, brutally honest portrayal of how users see their drug use. ****I HAVE A COPY OF THIS PRESENTATION****

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<u>Tuesday October 24th</u>
Anonymous quote *"harm reduction bring us closer to the scene, rather than bring the scene to the health care workers, which keeps the users marginalised".*

HEALTH

International Lessons

Katarina Jiresova, NGO Odyseus, Bratislava, Slovakia.
Kasia Malinowska-Sempruch, International Harm Reduction Development/Open Society Institute, New York, NY.
Marek Zygadlo, Monar Krakow Drugs Project, Krakow, Poland.

Katarina Jiresova discussed a program called "Protect Yourself" in year 2000 which is a pilot outreach collaboration of different professionals working together. They are targeting female sex workers and intravenous drug users. The aims are to mediate better access to a lawyer, a social worker, a psychologist and a gynaecologist for the participants, which also enables the professionals to have direct contact with IDUs and FSWs for better understanding of the problems related to drug use and prostitution. The program provided for participants to have the chance to get to know the experts, one per week and to establish relationships. Frequent barriers for participants are that they don't trust unknown people and don't have financial resources to pay for services.

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Kasia Malinowska-Sempruch works for the international harm reduction development in the Open Society Institute (OSI) and they are funding the development of harm reduction strategies in Eastern and Central Europe and the former Soviet Union. Their strategies are based on human rights, common sense and public health. They currently support 100 projects in the following countries: Albania, Azerbaijan, Belarus, Bulgaria, Croatia, Czech Republic, Estonia, Georgia, Hungary, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Macedonia, Moldova, Poland, Romania, Russian Federation, Slovak Republic, Tajikistan, Ukraine, Uzbekisktan, and Yugoslavia.

Additionally OSI also funds regional, populated-based and topic-specfic initiatives. These include work with street kids, HIV in prisons, ethnic minorities (Roma) and sex trade workers.

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Marek Zygadlo spoke on the treatment available in Poland. Over 20 years ago, the first re-hab centre in Poland was established. It was part of an enforced treatment after detox. Their philosophy was that if you use drugs you are a drug dependent person, and you have to go to detox and then after that you go to re-hab. It was an "I know what is good for you" attitude.

In 1995 in Krakow there were 25,000 drug dependents and 1,000 detox beds. They started talking about what to do with the other 24,000. They altered their criteria for success from abstinence to safer usage. There were needle exchange programs established in a few cities. Polish law changed in 1997 and accepted methadone as a legal medication useful in substitution therapy. There is a methadone maintenance program available now in 5 cities.

He believes that there is no conflict between Harm Reduction and Rehabilitation. Harm Reduction, respecting clients' needs and rights can support clients in finding the way to a safer use or to a drug free life. The Monar Krakow Drugs Project has combined harm reduction with rehabilitation and their clients choose what they need from their services.

They have a drop-in centre, where they provide medical and psychological counselling, establish the individual's level of dependency and direct people to services.

Their harm reduction services include methadone maintenance, which is provided by their public health system and since January 2000 is available through the city hospital. They have a daily needle exchange - their outreach entails taking a big bag of needles to the park and distributing them. They have a Monar Newsletter. There are two

prison projects. Their plans for a legal injection room are underway, and this will be incorporated into an existing house/shelter. They have abstinent (dry) housing and user (wet) housing. They have faced community opposition to establishing these houses, and tend to have them in less desirable locations. They are also located away from the centre of town, and are planning to use a shuttle bus to transport people to use the injection rooms.

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JUSTICE

Criminal Justice - International Response

Chantal Plourde, Montreal University, Trois-Ribieres, Quebec.
Danica Stanekovia, National Reference Centre for HIV/AIDS, Bratislavia, Slovakia

Chantal Plourde spoke about alcohol and drug use in Quebec penitentiaries. She surveyed 317 inmates in 10 prisons, and collected data using a questionnaire completed during an interview. The average age was 37. They explored the kind of drugs used, the motivations and the difference between those before and during custody. They also questioned inmates on perceptions of officer tolerance on different types of products. A large proportion of inmates change their use pattern during custody. Cannabis usage by the inmates is popular with the staff. She spoke about the official denial of drug use in the Quebec prison system, and the consequent lack of awareness around HIV and Hep C. When canvassed the inmates admitted that the source of their drug supply was often the prison guards.

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Danika Stanekovia reported her findings from a pilot study of risk behaviour, and voluntary HIV counselling and testing among inmates

from prison in Slovakia. 32 inmates voluntarily tested for HIV and none were found positive. In a group of 75 inmates involved in a sociological study about the mode of protection against HIV , out of 47, 6% of females preferred to trust their partners, while 75% of adult males and 50% of adolescent males did not protect themselves at all. Intermittent homosexual behaviour related to being in prison appeared mainly with females. The study provided information about first experiences as well as difficulties linked with HIV prevention in prisons.

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JUSTICE/POLITICAL

Criminal Justice in the US

Deborah Small, The Lindesmith Centre, Drug Policy Foundation, New York, NY
Carol Shapiro, Family Justice Inc. La Bodega de la Familia, New York
Ricardo A. Bracho, Centreforce, San Quentin, CA
Mary Cotter, God's Love We Deliver, New York, NY

Deborah Small: De-escalating the War on Drugs - the Current Political Climate of the US Drug Policy
In 1999 the debate changed. Up until then, anyone who questioned the status quo was defined as having a legalisation agenda. This has changed as a result of news articles all through the written media challenging the notion that harm reduction means legalisation. As a result more elected officials have come out against the current drug policy, and some of them are Republicans, Libertarians and African Americans. The governor in New Mexico went public one year ago about supporting legalisation, and the initial reaction was that he was crazy, and that he was bound to fail. People in government and health resigned their jobs. Lindesmith Centre sent someone to live in New Mexico to coach Governor Johnson. After becoming more educated, his drug

reform philosophy changed, and he toned down his talk. He travelled all around the state explaining his position and in the most recent polling, his approval ratings were up from when he was elected and the public were more in favour than not of decriminalising cannabis and introducing harm reduction. New Mexico had one of the highest levels of heroin overdoes per capita, and the Governor looked at that and developed harm reduction approaches. The people liked that their government was acting responsibly. This is what happens when you combine political rhetoric to social action.
In California, Republican Tom Campbell is running in the November 2000 election for senate with drug policy reform as a major platform. He is running against Diane Feinstein who is the popular incumbent and he probably won't win. He has been running political ads on network tv talking about the failure of the drug war, and it has not been political suicide.
A mayor in Utah called Rocky Anderson evaluated the drug prevention program and pulled it from the schools. He fashioned it into a more realistic approach which gives information that gets the students to question their thinking. This has been controversial, but has not been majorly opposed. There is no good alternative to the programs they use for prevention in schools, and there is a need to develop a new one.
It is essential to talk about connecting the dots - needle exchange, prison reform, mandatory drug testing. During the election race, there have been shadow conventions, where elected officials spoke out for drug reform. At the LA Convention Maxine Walters and Jesse Jackson were among those who spoke. People seem to be reaching out to get this information.
Need to expand and build coalitions - let politicians know there are vocal citizens who will lobby, talk, write letters.
Who needs to be organised? Not only marginalised people, but average people - the PTA, Rotary Club, Veterans, Chamber of Commerce. Appeal to their particular interest. Use economic analysis, why should be they interested? Taxpayers money is being wasted - when it should be

invested into communities.

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Carol Shapiro talks about addressing the issues that the judicial system has on families. She talks about a family-focused approach to treatment which engages and supports families. The family's natural resources are mobilised in order to work in partnership with government. As a result, out-patient drug treatment is improved, families are more likely to seek help in dealing with the struggles they are having, and the government will rely less on stigma and sanction. Including the family increases political viability. People don't demonise mothers and grandmothers. Poor people don't have constituencies. Need to involve families to help Families have been robbed of their power to help. How can we help people in and out of jail? Jails stigmatise entire neighbourhoods and affect the economic underpinnings. Communities that used to be centred around agriculture are now reliant on the local jail.

Why include families?

* often victims of loved one's substance abuse
* often first to recognise signs of relapse
* often have more than one identified substance user in the criminal justice system
* a substance abuser's natural support

Work closely with police, probation and parole

* engage the families prior to the release of an inmate. Often they are the last to know and are not prepared. They should meet with the parole officer, who should ask them what their needs are. The parole officer will then see parolee as someone's son or brother, etc.

Get government agencies to think differently - how can we work with them to strengthen families.

Benefits

* partnership

* regain responsibility for their lives
* opportunity to incorporate prevention into treatment
* treatment matched to need
* enhance public safety and public health - can change how we think about it

Ricardo A. Bracho: "I am a nightmare walking". Reducing individual harm with young straight men of colour who have experienced a collective increase in harm through state prison incarceration: a hip-hopist approach
(NB: this young man's talk was so captivating, moving and brilliant - he turned it into a performance-art piece, that it was impossible to write anything down. Instead, I am providing excerpts from the abstract he submitted to the conference.)
"This practice track workshop will detail the convoluted application of harm reduction within a California State Prison context. It will also be the story of a street-seasoned harm reductionist going into an institution based on the increase of harm, the state prison system. I work on an intervention/research project focused on men, 18 - 29, doing short time in San Quentin prison and being released to the Bay Area. I will discuss the specific modes of HIV risk within the prison (tattooing, consensual sex, rape, blood mixing through fighting, needle sharing) and relate what the rubric of the overall harm institutionalisation can mean for young men, the majority of whom are of colour, poor and heterosexual. I will focus on the pressures that prison, correctional officers, the parole system, families, researchers and educators put on these young men that increase their harm and social disfigurement as well as the social raptures and joy they attain through community, hip hop, sex and substances. Furthermore, I will deploy a theoretical/critical lens honed by reading Ruth Wilson Gilmore, Mike Davis, Christian Parenti, Luana Ross and Angela Davis. Discussion will be generated about creating effective, grounded harm reduction for persons serving time inside or re-adjusting to the street.

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Mary Cotter: "Don't You Forget About Me: Women in Prison and Harm Reduction Principles" New York City.

Over the last ten years there are 50% more women in prison, 400% more on drug charges, and 2/3 of the women in prison are African American and Latino.

Why is harm reduction needed in female corrections? Women are more quickly addicted, more psychologically affected, and multi-use.

Harm reduction must be user centred and women centred. Includes condoms, bleach, needles etc. Also means medical, nutrition, health, exercise, violence prevention, recovery from physical and sexual abuse. Recovery for women in prisons involves a lot of trauma work.

Relationships are so important to them, jail is harsh. Many women have unwilling relationships with the staff. They have to be educated in how to protect themselves. Seven out of ten have kids, and 1.3 million kids are small and they have little or no contact. Once out of jail the women are prohibited from contact with each other.

They have introduced educational programs - keeping a journal, art courses. The ACE program which is counselling for AIDS has been introduced into a maximum security prison for women because they were fed up with seeing them dying and left alone. It is inmate run and gives back - they are empowered. There is only one methadone maintenance program in the country and it is in Rikers Island. In Springfield, Massachusetts all the inmates in the jail are grouped by zip code and assigned health groups, which are followed up after release. Provides good quality health education and sex education.

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Wednesday 25th October

JUSTICE

Criminal Justice - Drug Courts

Corinne Carey, The Urban Justice Centre, New York NY
Angela Gerritsen, Intermountain Harm Reduction Project, Salt Lake City, UT.
Daniel Abrahamson, Lindesmith Centre West Drug Policy Foundation, San Francisco, CA.

Corinne Carey
In June 1998 there were 430 Drug Courts. They started in Miami in 1989 and exploded all over the world after an international harm reduction conference, where many countries adopted the idea of using a threat in coerced treatment. In 1998 $38 million was budgeted for new ones and existing.

Concepts of Drug Courts

* drug use is epidemic - can be dealt with
* drug use is a disease - can be treated

All the data is collected from the small traceable group of people who get into trouble and there is no data on the people who successfully manage their drug use. Substance abuse treatment has ripples all through the system. i.e. you have to be abstinent to get help from public housing, parenting, methadone programs, and public assistance. Compulsive treatment is essential for access to all these areas too. Compulsive drug treatment makes people more compliant.

Warning: people only have access to treatment if they commit a crime and have to plead guilty. It is still a control issue - looks better when compared to prison, however it is still linked to the judiciary. Must not ignore community based treatment, and the two strategies could go together. However substance abuse treatment is cost effective versus drug courts. The drug courts are a poor use of resources and leaves the individual unmotivated, whereas community based treatment is empowering and leaves the individual motivated.

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Daniel Abrahamson - Legal Direction for Drug Courts
Drug courts give increasing access to people wanting treatment and help society by getting treatment established. They have contact with social workers and doctors. Proposition 36 in California calls for drug treatment for non-violent drug offenders. Although there are criticisms to be made of drug courts, there are some good ones. They can be good and observe the principles of harm reduction. They are very successful in talking the talk about treatment but not so successful in walking the walk. If you scratch the surface you would not find good treatment.

How can they be improved?

1) a relationship with the treatment provider needs to be established. They should collect history and gain knowledge and figure out what is needed - give them an individualised treatment

2) if not working, treatment should be modified if necessary between the two of them; what does work - adapt to patient's needs

3) principle includes chronic relapse, therefore dirty urine is not a crime, and highlights that they need to adapt to keep the person as healthy as possible

However in drug courts, treatment is defined by the judge or prosecutor's office, and is assessed by what the court deems successful. They only use A.A. and N.A. programs, and don't use any others. Immediately there is no alternative and no individual treatment. The decision is made by the probation officer or the judge, and they may have 10 - 20 hours of training at most. There is no physician with treatment options. Most drug courts don't allow methadone. They prohibit it as it is not considered successful. Often heroin addicts ask for methadone and the judge says no and sends them to jail or prison, which leads to a cycle of deeper addiction. There is major resistance to methadone and the California Drug Association opposes it completely.

It seems that coerced treatment works about as well as voluntary, the success rates seem equal. Researchers define coercion as pressure from schools, work, family, friends, probation officers and judges. There is coercion to stay in treatment and the ultimate coercion is the threat of jail in drug courts.

The US need to provide treatment centres which is a non-criminal justice with no jail option. Take the medical model approach, as earlier defined. Modify - do whatever it takes. Many judges use a flash incarceration in response to a 'dirty' urine sample, to 'teach them a lesson', and it can be 24 to 48 hours or up to 2 weeks in jail. The cost savings of keeping people out of jail are used up by flash incarceration. It is not right to go against the medical model and put people in jail with no treatment.

In California there are drug courts in many counties and each has it's own criteria eligibility. Only able to treat 5% of eligible - 95% have no access. Some take first time offenders and others refuse first time offenders. In San Diego you cannot access a drug court if you have been affiliated with a gang. There are other examples where you cannot have access if you have a learning disability, or are not a longtime resident of the county. No uniform rules - leaves it all up to serendipity. The Department of Justice did a study of the California drug courts and discovered that a) there was a disproportionate amount of people with colour arrested and prosecuted, and b) white people are disproportionately represented in drug courts.

Proposition 36 in California is a levelling mechanism. All people convicted of simple possession only, get the benefit of not going to jail or prison and receive community based treatment as broadly defined above, not N.A. or A.A. It funds $120 million for the next 5 years, per year. In California 30,000 people would be affected. Even then, taxpayers will save $150 million a year by not putting them in prison, and not building 2 more prisons would save $500,000 million. Judges do not make the decision over treatment - a health professional assesses treatment. Although judges have power, there is no flash

incarceration. This point creates great opposition to Proposition 36. It all comes down to the ability to flash incarcerate, which is considered the reason why drug courts are successful. In Arizona, a similar proposition was passed with no flash incarcerations, and the numbers of success rates exceed those of nationwide courts with the flash incarceration ability. There are 15 counties in New York that are similar to Arizona. New York State are calling for drug courts to be offered to all non-violent drug offences and first time offenders.

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Angela Gerritsen was a participant in a Salt Lake City drug court. She stayed at Odyssey House for treatment, which was run like Amway. In pre-treatment, they worked all day. The people who run it also run 12 step groups. She was taken from jail by a man who was staying there, who told her that he was abstinent, and shortly thereafter died of an overdose. It was a punitive program, for instance they were allowed 5 pieces of gum a day and were held accountable for them. It was humiliating. Treatment was totally confrontational, they tore you down, and she did not respond. It is called 'rational' recovery' and costs $1 million annually to run. Even though she was eligible, she was not interested in treatment, but took the offer in order to escape jail. In Salt Lake City they have an invasive procedure in order to take a urine sample. They watch you pee and hold you open and make you cough. Acupuncture is a big part of the program, and she still takes it now, and it is offered for free. Methadone is allowed and you can graduate from the drug court program while on a maintenance program. You can choose electives, and she chose poetry writing. They expect you to use and you have several options to deal with that. Even though incarceration is available it was rarely used. In 1999, 140 graduated and 15% ended up back in prison. Several people died after graduating from the program, as they immediately took a drug, and could not tolerate it.

Drug courts can be harm reduction driven. The after-care, after detox, should be whatever the individual wants. You have to have a really good judge, as they have in Salt Lake City, and if so they can do good things.

Urine testing

- is a good tool, if used in confidentiality between the doctor and the patient. An example would be a man who is on the street injecting heroin for 20 years and is now smoking cannabis. This is success even though he would still test positive.

Need good training and need to pick great judges.

An article on drug courts by a Judge Hoffman in Denver was referred to. ****WILL ASK FOR COPY TO BE SENT****

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HEALTH

The North American Opiate Medication Initiative (N.A.O.M.I.)
A substitute research doctor (did not get name) from Yale University
Dave Marsh, The Centre for Addiction and Mental Health, Toronto, Ontario
Ethan Nadelmann, The Lindesmith Centre, Drug Policy Foundation, New York, NY

The man from Yale talked about a heroin maintenance program which operated in August 1918 in New Haven. It was the idea of the police chief and was actually operated out of city hall. The average age was 33, 20% were women, and there was a small fee. The crime rates went down and the people proved to be key informants about the dealers. It was closed down after two years for political reasons.
He gave a short synopsis on the heroin maintenance trial program in Switzerland, which shows drastic reductions in criminal activity within

the group. There is a minor technical issue with how the program was run. They were not broad enough in their scope of people who were picked, and during the trials, the people who were given methadone had an allergic reaction to it, and dropped out. Even though the conclusions appear that it was successful in stabilising the health of the participants and reducing crime, because of these irregularities, they are doing it all over again. Holland, Germany and Spain are about to start with trials of their own. Australia was all set to go when the program was vetoed by their prime minister.

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Dave Marsh talked about the plans for three cities in Canada and gave some, and described a utopian version of Canada's harm reduction response to drugs. They are not sure when the trials are going to take place, but they will follow the Dutch model.

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Ethan Nadelmann spoke about the idea of combining the Canadian initiative with the US, the concept being that North American sounds less threatening than either Canadian or American. In any event the Canadian trials are far more likely to happen sooner than the US. He stressed that the final decision is political and not health driven.

A discussion took place about Vancouver and Ethan Nadelmann commented on our good fortune to have a mayor who understands the complexities and was willing to push ahead with a harm reduction plan. There was talk about the need for education and discussion at the grass roots level of communities in order to influence the politicians.

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Closing Keynote Speaker
The Reverend Ed Sanders II, First Response Centre of Metropolitan Interdenominational, Nashville, TN.

Black and beautiful, the Reverend presented a powerful talk on working together, not giving up, and working things out. The two things that I wrote down were:

don't be afraid to think a new thought

don't let circumstances hold you back

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Suggestions and Thoughts for Consideration in Vancouver

Richard Needle, the representative from the US Department of Health discussed the behaviour patterns of users and the provision of services. The highest activity is at night, and therefore it is a mistake to make most services available during the daytime.

Suggestion: *that all necessary services be delivered throughout the night to meet the health and needs of the users and the community. eg the operating hours of the resource centre.

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In Miami they held press conferences to announce the findings of their assessment of their situation and what they proposed as solutions. On two occasions, members of the public stepped forward to provide funds.

Suggestions: *similar presentations to the community
*actively search for financial partners in the private sector - provide benefits/incentives for doing so

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In Detroit, they noted that any funding has to have "buy-in" from funders to take the research and put the recommendations it into practice.

Suggestion: *identify projects and set up individual task forces to include the funders and users, with a budget and purpose that they can see through from start to finish

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Throughout the conference everyone who presented said that the foundation of providing services to the community was their needle exchange. As this is the first contact with users, they build from there, adding as many harm reduction measures as they can.

Suggestion: *build on our existing needle exchange in the city and throughout the province with drop in centres, and access to entry level health services

*has to be low-key in smaller neighbourhoods, so that people can maintain anonymity (perhaps part of an already existing health facility

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Santa Cruz presented a video which was jointly made by the people running the needle exchange and the users, called "Dope Opera". It is cool and informative, featuring the users as themselves, dealing with an overdose situation.

Suggestion: *pass on to VANDU

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The San Francisco needle exchange publishes a leaflet called "War on Sleep" which they distribute in order to educate about overdosing.

Suggestion: *pass on to VANDU

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The San Francisco needle exchange train their users to deal with overdoses effectively

Suggestion: *establish a peer-training program for VANDU members

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In San Francisco they developed a harm reduction resolution and presented it to many community groups and health workers - with practical steps as to how to apply it in the public health setting. It is a tool to promote discussion. They spoke to health providers first of all, and then people started asking about how to apply it to family violence or custody cases; they also talk to STD and addiction health workers.

Suggestion: *currently a member of Addiction Services who works out of the Kerrisdale office is doing similar work in isolation and of his own volition. Suggest he expand his education program, perhaps recruiting more advocates to cover the region, using the San Francisco model of where it should be delivered.

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San Francisco have vans that are dispensaries on wheels: needles,

medical, methadone.

Suggestion: Look into the feasibility of this program for the city and the region

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The representative from the Department of Public Health (Mental Health, Substance Abuse and Forensic Services) in San Francisco talked about a series of conferences they have held to educate substance abuse workers in harm reduction. The first one was called "Bridging the Gap", and was so successful that they held a second one called Bridging the Gap: Integrating Harm Reduction with Regular Methods of Treatment" which included hands-on workshops teaching people how to work with staff who see harm reduction as a personal threat to themselves. They are broadening the view of how to help people. The third conference is called "Bridging the Gap: Harm Reduction Research, Policy & Practice, and takes place in San Francisco in January 2001. The feedback they have received from working with the treatment providers in this way, is that they have expressed an overwhelming relief to know there is a beneficial alternative approach to abstinence. Another benefit from bringing groups together for these conferences is that they start to treat each other less like enemies.

Suggestions: *the VR/HB send representatives to attend the conference in SF in January 2001
*the ministry begin to offer similar conferences for the province

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In Salt Lake City, the director of their harm reduction coalition found himself working in a rather unfriendly environment which was not open to new ideas. He approached them and promised them he could get them more money (funding) because he was good at writing proposals for grants. All they had to do was to agree to the grants being harm reduction driven. It worked.

Suggestions: *look for similar opportunities in Vancouver and the

region
*be collaborative, inclusive, speak about enhancing already existing programs
*include money for users to participate in programs
*find common ground.
*harm reduction training for the police

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Deborah Small from Lindesmith spoke about the need to expand and build coalitions - let politicians know there are vocal citizens who will lobby, talk, write letters. Talk to average people - the PTA, Rotary Club, Veterans, Chamber of Commerce. Appeal to their particular interest. Use economic analysis. Why should they be interested? Taxpayers money is being wasted - when it should be invested into communities.

and

Ethan Nadelmann commented on Vancouver's good fortune to have a mayor who understands the complexities and is willing to push ahead with a harm reduction plan. There was talk about the need for education and discussion at the grass roots level of communities in order to influence the politicians.

and

In Connecticut, they formed a Harm Reduction Coalition to address two issues: dialogues and trainings.

The first time they met with 100 people and discussed how to spread the words and decided on education. They wanted to make the distinction that harm reduction is not to legalise drugs, but to give more tools to active users to keep safe and improve the safety of the communities. They have taken user groups out to speak to target audiences:

* medical students * law students * police * prisons

They organise communities with community building and advocacy training.

Suggestions: *copy this model and empower communities to work

out solutions together
*bring disparate groups within community together to establish common ground i.e., don't we all want safer communities . . .
*find funding to support the co-ordination of this process either in the public or private sector
*work on constructive things that can be done today

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Ethan Nadelmann said that a harm reduction strategy won't win unless parents really believe that it will protect their kids better.

Suggestion: *start talking to parent groups, engage in conversations, not confrontations

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Ethan Nadelmann said the fallback in respect of abstinence programs is harm reduction can help them with the people who fall off.

Suggestion: *this approach be used continually in order to direct the debate - it is not about wrong/right, it is enhancing what is already existing

Physician Leadership on National Drug Policy (PLNDP) was started in July 1997 when 37 of the nation's distinguished physicians, representing virtually every medical specialty, met and agreed on a Consensus Statement. This statement, which stresses the need for a medical and public health approach to national drug policy, has served as the underlying framework for all of the project's activities.
They acknowledge the most positive outcomes of treating drug addiction include: greatly reduced medical costs to society; returning drug addicts to their families, communities, and jobs; major crime reductions; and a reduction in funds spent on law enforcement. From this research, the PLNDP developed a videotape report *Drug Addiction: The Promise of Treatment*, released in November 1998. Dr. Lewis is very interested in Vancouver and how we have dealt with our epidemics and our drug issues.

Suggestions: *circulate copies of the video to key members of Federal and Provincial Health, the VR/HB, and the College of Physicians and Surgeons
*invite Dr. Lewis to visit Vancouver and talk to the above with the purpose of establishing a similar process of calling upon physicians for leadership in reviewing drug policy

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Stephen Wye talked about his work over the last decade as editor of User's News, which is a peer education magazine of users in New South Wales, Australia. One of the most important, regular, and popular features of the magazine has been the stories and poems of using contributed by the users.

Suggestion: *establish a similar publication in Vancouver, and ask Bud Osborne to be the editor

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Marek Zygadlo spoke on the treatment available in Poland. Their plans for a legal injection room are underway, and this will be incorporated into an existing house/shelter. They have abstinent (dry) housing and user (wet) housing. They have faced community opposition to establishing these houses, and tend to have them in less desirable locations. They are also located away from the centre of town, and are planning to use a shuttle bus to transport people to use the injection rooms.

Suggestion: Look into the feasibility of this idea for the city and the region

The governor in New Mexico went public one year ago about supporting legalisation, and the initial reaction was that he was crazy, and that he was bound to fail. People in government and health resigned their jobs. Lindesmith Centre sent someone to live in New Mexico and coached Governor Johnson. After becoming more educated, his drug reform philosophy changed, and he toned down his talk. He travelled all around

the state explaining his position and in the most recent polling, his approval ratings were up from when he was elected and the public were more in favour than not of decriminalising cannabis and introducing harm reduction. New Mexico had one of the highest levels of heroin overdoes per capita, and the Governor looked at that and developed harm reduction approaches. The people liked that their government was acting responsibly.

Suggestion: *invite Governor Gary Johnson to Vancouver to talk about his experiences to the Legislature, Vancouver City Council, the Mayors of the lower mainland, the Chamber of Commerce and the Community Alliance

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A mayor in Utah called Rocky Anderson evaluated the drug prevention program and pulled it from the schools. He fashioned it into a more realistic approach which gives information that gets the students to question their thinking. This has been controversial, but has not been majorly opposed. There is no good alternative to the programs they use for prevention in schools, and there is a need to develop a new one.

Suggestions: *form a task force including kids and users to develop a realistic and effective prevention model
*find a partner - eg The Boys and Girls Club

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The first heroin maintenance program in N. America opened in August 1918 in New Haven. It was the idea of the police chief and was actually operated out of city hall. The average age was 33, 20% were women, and there was a small fee. The crime rates went down and the people proved to be key informants about the dealers. It was closed down after two years for political reasons.

Suggestion: *the mayor and the police chief form a task force to explore the feasibility of this program

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Drug Courts Essay

I was fortunate enough to spend a morning at the Miami Dade County Courthouse, in the company of Judge Jeffrey Rosinek, who presides over their drug court. This model, which looks similar to Seattle is one where an energetic, compassionate and charismatic judge is the central focus. Judge Rosenik is a dedicated man working within the definitions of harm reduction in a generally harm promoting judicial system. His hands are tied by the legislation in Miami which is conservative and restrictive. He works with a team - a prosecutor, defence attorney, court clerk and a liaison officer who links the court to treatment and support staff. Their purpose is to encourage the convicted user to take the program in the first place, and if they embark on it the team tries to work together to keep the bumpy road to graduating from the program as smooth as possible. The participant who has been convicted of a drug related offence is given the option of going through the drug court system, with the goal of abstinence for a prolonged period of time, after which he or she is eligible to graduate and their conviction is expunged from their record.

The good judge develops a relationship with the 1100 or so individuals who are in the program. He cajoles, befriends, teases, banters, pleads, threatens and generally relates in whatever fashion is appropriate in the moment to keep the participant committed to the program. He takes care in helping them see that only they are responsible for their actions. There is an interestingly casual atmosphere with a few things going on at once. He addresses each individual directly without going through the defence counsel, except when an interpreter is required. Extensive notes are taken so that, once in the program, there is a continuum of relationship in place when each person attends the court. The participants initially attend on a monthly basis.

The team are all working in assisting the participant to win. Judge Rosinek pushes the edge as much as he sees appropriate with giving chances to succeed, even after the 'failure' of relapse. It is

recognised by the realistic treatment programs that along the way a person will re-use and that is to be expected in the process. Judge Rosinek seems to understand this piece of the puzzle and takes great care to encourage the person who has used to acknowledge that they are responsible for their actions. He stresses continually to them that it wasn't an "accident" or "fluke" or "mistake" but a choice they made in response to their circumstances.
Judge Rosinek is also responsible for introducing the HART program. This came about because in order to join the drug court you have to give an address, i.e., not be homeless. He developed a county funded program to house these people so that they could join and begin to stabilise their lives. This program works in conjunction with the drug court, and also by itself to support people who are homeless and are arrested for non-violent and non-drug related crimes, such as trespassing (sleeping under cover in someone else's building) or hanging around (sitting down I believe) for more than 10 minutes in a public place. This bylaw is particularly handy when a dignitary is visiting and they want to clean up the streets of Miami.

The aspect of the US model of drug courts that is most difficult to integrate into a Canadian model is one of drug testing. As the reader may be aware, testing urine for signs of drug use is almost a national pastime in the US these days. It is problematic for three reasons:
1) People who are in fear of the discovery that they have "used" have previously found creative ways to substitute another's urine for their own. The uniform practice of taking a urine sample now has become invasive and humiliating for the donor. He /she is watched and their bodies are actually handled by the tester to make sure the urine is their own.
2) The fact that the samples are regularly routine and mandatory take away the opportunity for the person to be in control of their body and removes the opportunity for them to become responsible and accountable of their volition.

3) The fact that the test carries with it negative and punitive consequences under the law reinforces the ingesting of a substance as being unlawful rather than a cry for help; a search for escape or simple pleasure; or an addictive physiological response. One harm reduction modification of this aspect of the drug court would be to eliminate urine testing completely and empower the individual to choose for themselves. Another alternative would be to have the result of the testing be confidential between the physician and the patient.

A scenario presented at the conference might be where a person had been a regular heroin user for years and with the support of the program becomes a less regular user of cannabis. Under the terms of an abstinence model, this is a failure, however in a harm reduction, public health model, the individual is in charge; they may not be ready to be completely drug free, but have significantly reduced the harm to themselves and there is far less likelihood of harm to the community. By making a choice that is based on their needs at that moment, they are more likely to continue on successfully and lead a more stabilised life.

During the Miami conference there was a session on drug courts and one of the speakers had graduated from a program in Utah. She is a young, well groomed, intelligent and articulate Caucasian woman. She pointed out that unfortunately some people who graduate from the drug court program still choose to use, and they quite often die as their bodies cannot deal with the amounts they were previously used to taking. Why do people take drugs? - one speaker said it is twofold, one as a way of easing pain and secondly as a source of pleasure. If you remove the body's craving, which is an additional and harmful reason because it overrides choice, there are still the first two, which may be as compelling after graduating from the program as they were at the time of their original conviction.

The implementing of drug courts in Vancouver seems to be in opposition to Health Canada's position on drug addiction being a health issue and appears to entrench the issue in criminal justice. In the current

climate of scarce funds, is it necessary to channel money away from providing treatment on demand? Where is the logic in spending money arresting and prosecuting individuals so that they can go for the treatment that is not available through the regular health programs.

I suggest that the funds be better spent on treatment, and empowerment programs, such as peer harm reduction education; including users in discussions which result in decisions concerning them; developing users as health advocates in the community at large; and job training.

Every penny spent on minimising the risk for users, stabilising their lives, and empowering them to take responsibility for themselves is also a penny spent on crime prevention. In the debate about the differences between enforced and voluntary treatment, when people are coerced they have not been given an opportunity to come to the decision themselves which might ignite in them a desire to become self regulating and self motivated. This could lead to an awakening of hope, which seems to be so sorely missing from these people's lives, and an increase in their sense of self esteem and worth.

Perhaps drug courts, or mandatory treatment as an option to prison could be offered to career criminals who also happen to have a substance abuse issue as a last resort versus an initial response.

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Handouts received from Judge Rosinek in Florida, available upon request:

*Miami-Dade County Drug Court Document "A Holistic Approach"

*Monthly report for the HART Program

*"Transferring Serious Juvenile Offenders to Adult Court"

*"Juvenile Sentencing Advocacy Project"

*"Bay Point Schools" brochure - a non-profit, boarding school for non-violent, habitual youth offenders who have long histories of failed schools and treatment programs.