“Fuck Safe, Shoot Clean”

An analysis of how to implement programs providing wider syringe access for local communities in California

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"Fuck safe, shoot clean," has adorned the walls of various Syringe Exchange Programs (SEP), all over the country, for years. It is the most basic way to describe the principles of harm reduction philosophy, and all programming that happens at an SEP is filtered through the principles of harm reduction. More explicitly, harm reduction is an ideology that, "accepts, for better and for worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them," (Harm Reduction Coalition). In other words, people have always been and will continue to engage in behaviors that carry risks, such as casual sex, prostitution and drug use, so it is important to make sure those behaviors are as safe as possible.

Harm reduction, as a practice, manifested in the form of syringe exchange when injection drug users (IDUs)[1] organized themselves into unions, affectionately called "junkie[2] unions," in order advocated for their rights to health care and prevention tools. For IDU's clean syringes and other safe injecting supplies are the most important prevention tools to prevent the spread of blood-bourn diseases such as Hepatitis C and HIV, and with the arrival of the AIDS epidemic along with the "war on drugs," harm reduction was theorized into an actual health practice. Today, the Netherlands, UK and Australia have adopted

[1] IDU is formerly, and often still widely misconceived as being an abbreviation for "intravenous drug user." Within the context I'll be speaking of IDU's, however, I'll be speaking about drug users who many inject drugs into their muscles and skin, as well as veins, thus the importance of defining IDU as injection drug user.

[2] Junkie is usually a derogatory term describing heroin addicts (and sometimes users), but in some instances, the word can be reclaimed to empower a drug using community.

Harm Reduction as an official public health policy, while the United States is still reluctant to favor harm reduction as a universal health policy for fear of seeming soft on drugs and drug users.

However, there are still harm reduction programs functioning all over the country, and the most common approach to IDU harm reduction in the US is through SEPs. While SEPs vary by state and county, all work in the same basic way: IDUs bring syringes that they have already used, dispose of those syringes into a county regulated biohazard, and then are given clean syringes in exchange[3]. While some programs have been known to distribute, the Santa Cruz County Syringe Exchange Program (SCCSEP) is a specifically one-for-one program, meaning an IDU can only get back as many clean syringes as they have used. The mentality behind an *exchange* program is that operating on a one-for-one basis places a value on the used syringe, and encourages that the syringe is disposed of properly, as opposed to being left on the ground, or other inappropriate places through out the community.

Other facets of the SCCSEP include extensive services for participants[4] of the program that range from offering other safe injecting supplies[5], to nurses, to drug treatment referrals and health information. While SCCNEP staff and volunteers are happy to share any information that will have optimal benefits of

[3] As of March 16, 2007, "There presently are about 200 needle-exchange programs in the U.S.," ("Funding Woes Slow Spread of Needle Exchange Programs").
[4] Clients who frequent the SCCSEP are referred to as participants.
[5] Which include alcohol wipes to clean the skin, cotton to filter 3d particles out of drugs, distilled water to cook or dissolve drugs with, sterile tins to cook or dissolve drugs in, bleach to sterilize and clean syringes after use, and tourniquets or ties to ensure a good hit while injecting.

reducing harm, they are careful about only sharing information when participants are interested, or when the information is absolutely necessary. For example, in a case of an IDU who likes sharing syringes with her partner who she knows to be Hepatitis C positive, we would not condemn her action, but instead help her learn how to bleach the needle before she shares with her partner, or remind her to shoot up before her partner does. The exchange of information is an important component of the SCCSEP because it creates an open dialogue between health practitioners and participants, which engages a community of disenfranchised people who had historically been shut out.

So, while attempting to never minimize or ignore real harms associated with drug use, one working with the SCCSEP is always practicing and keeping in mind a harm reduction ideology to recognize drug use as a complex issue that involves, “realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people’s vulnerability to and capacity for effectively dealing with drug-related harm,” (Harm Reduction Coalition). Thus, the SCCSEP works hard to recognize conditions of use, rather than place all “blame” of partaking in an illicit act on the user himself. While there are obvious risk to ones mental and physical health regardless of the conditions surrounding risky behavior, the conditions surrounding illicit drug use greatly affect ones chances of not contracting a deadly virus.

Luckily for the SCCSEP, the political culture of Santa Cruz has also expressed sentiments recognizing conditions of drug use. While some individual law enforcers do not understand the importance of the SEPs place in the

community, either because they do not agree with drug use, or don't know syringe laws, the Santa Cruz City Counsel, along with most Santa Cruz community members, have been historically supportive of the SCCSEP, or at least left alone the program to do what it needs to in order to reduce harm for IDUs in the County. And with, "injection drug use [being] the second leading cause of HIV transmission and the leading cause of hepatitis C (HCV) infection in California," ("Summary of Senate Bill 1159), keeping resources available for the SCCSEP is extremely important.

Unfortunately, while the IDU population has only grown in Santa Cruz[6], resources have diminished greatly for the SCCSEP, and past experiences have shown us that users are often left for dead when programs like SEPs are cut in cities across America. So, while SEPs are perhaps the best way to reduce harm in the IDU community, it is important to look at other ways for IDU's may be able to acquire syringes because everyone has the right to access information, materials and services that could potentially save their lives. Denying the IDU community social services is denying their right to live, so in this paper I will discuss legislation and recommendations regarding syringe exchange and pharmacy sales, in order to create a blueprint for how an individual county may be able to help allocate resources for their IDUs.

[6] However, while the IDU population has grown in Santa Cruz, there are not necessarily more people starting using needles, and despite the IDU population growth, rates of infection are going down.

History of SEPs

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While drug use can be traced beyond written history[7], syringe exchange programs earliest beginnings weren't until the 1970's. And while we know syringe exchange activities were happening during that time based on reports from IDU's, there's no definitive year or location where syringes were being exchanged. The reason there is no written record for the definitive start of syringe exchange programs is because, for the first few decades, syringe exchange activities were underground and masked from the mainstream public. The SCCSEP was underground until they established a physical plant location in 1994.

Patrick Stonehouse, supervisor of the SCCSEP, has been involved with the SCCSEP since the program was still considered underground, and then shifted into a "legitimate" program. In his experience, when the SCCSEP was underground the community felt more uncomfortable with the idea of a program, and participants did as well. He said that, "the important change [from when the SCCSEP transitioned from being underground to having a physical plant site] was the level of comfort of the participants felt because going into a place with

[7] For example; images of opium poppies, which is what opium is extracted from to synthesize heroin, were found in, "lower Mesopotamia as long ago as 3400 BC," (Opium Throughout History).

walls is safer than just going underneath a bridge. It turns it into more of an institution rather than something a few people made happen."

While we are only vaguely aware, based on word of mouth, that underground syringe exchange efforts have been occurring since the 1970's, solid documentation shows that a private pharmacist in Scotland undertook the first organized and in some ways "legitimate" SEP in the world in 1982, "following an epidemic of hepatitis B and hepatitis C (and HIV as discovered later) among injecting drug users (IDUs) in Edinburgh," (World Health Organisation). In response to disease as well as overall harm inflicted on IDU's, the first SEP in the United States began in New Haven Connecticut in November of 1986.

The program was started by Jon Parker, whom was a former injection drug user going to school for a masters degree in Public Health from Yale. He realized the need for an SEP when "one of his professors commented that addicts should not be the focus of HIV prevention efforts because they would not change their behavior," (Lane). Parker knew otherwise, because he himself had changed his behavior, and came out of his addiction unscathed. To start the SEP Parker petitioned private donors for funds, and acquired a van donated by Yale (Needle Exchange: A Primer). And so, the first SEP in the United States was a mobile service provided in large by an Ivy League donation.

Two years later, another SEP was organized, this time in Tacoma, Washington, and was marked by being, "the first needle exchange program to operate with some community consensus," (Lane). The Tacoma SEP was jumpstarted in 1999 by the efforts of Dave Purchase, who later went on to

become the chairman of the North American Syringe Exchange Network (NASEN)[8]. The SEP was operated with some community consensus in that Purchase went through the mayor and other public and political officials to plan the program before actually starting it. After being organized by public officials and funded by private donors, the Tacoma Syringe Exchange Program, "grew into the Point Defiance AIDS Project and now operates under contract with the local department of public health," (Lane).

The needle exchange in Santa Cruz was also formed by a group of injection drug users, similarly to those programs in New Haven and Tacoma. The Santa Cruz Needle Exchange Program (SCNEP) officially began its activities in 1989 (Metro Santa Cruz), shortly after the Tacoma program began. County public health workers also helped to develop the SCNEP, which provided some community census and the SCNEP was largely accepted by the Santa Cruz, though its activities were still officially illegal. As support from the community and private donors grew, the SCNEP was able to open a permanent needle exchange site in 1994 that has been called the Drop-In Center ever since.

Despite community support and the establishment of a permanent needle exchange location, legitimizing the exchange system, syringe distribution and exchange were still against the law. Syringe exchange practitioners were still vulnerable to arrest by police for paraphernalia charges, and faced harassment

[8] NASEN is an organization, "Dedicated to the creation, expansion and continued existence of syringe exchange programs as a proven method of stopping the transmission of blood borne pathogens in the injecting drug using community," (nasen.org). NASEN is where the SCNEP buys their syringes from, and provides other types of support such as grant opportunities to individual programs.

from local opponents of the needle exchange. Proponents of syringe exchange understood that the SCNEP is a result-oriented way to effectively combat HIV in the IDU community, however, and fought with the state and county legislators to allow needle exchange programs to be legitimately run.

It wasn't until 1999 that demands from syringe exchange proponents and exchange practitioners were met, though they were met less than half way. The then-Governor Gray Davis signed a compromise bill[9] that legalized needle exchange programs in counties whose governments declared a "state of emergency" with regard to the AIDS epidemic. An epidemiologist studying syringe exchange programs (SEP) at the University of California-San Francisco, Alex Kral, explained when the bill was passed that, "the law probably helps the most in places where the political environment supports needle exchange but where they haven't yet declared an emergency," ("Some California Needle Exchange Programs Emerge From Shadows as New Law Takes Effect").

Fortunately, the political environment in Santa Cruz did mostly support the SCNEP, so county officials were receptive to the bill, and have consistently declared a state of emergency for Santa Cruz County since the bill was signed[10]. Former executive director of the SCNEP, Heather Edney, explained at the time

[9] The compromise was that of Assembly Bill 518, introduced by Assemblywoman Kerry Mazzoni, D-San Rafael (Davis Offers Deal On Needle-Exchange Bill). The original hopes of the bill would have, "acknowledged the effectiveness of syringe exchange programs in combating the spread of hepatitis C and HIV, and would have allowed such programs to operate without a public-emergency declaration," (stopthedrugwar.org).

[10] In 2005, another bill was passed stating counties only had to declare a state of emergency once per year.

the bill was passed that the SCNEP became, “less vulnerable” and that the level of harassment toward syringe exchange practitioners from police had gone down. On the other hand, Stonehouse explained that, “Santa Cruz County had already declared a state of emergency through placing pressure on the police department,” so in his opinion, the bill had little affect on the SCCNEP.

So, while the compromise bill provided a degree of legal legitimacy for SEPs, it was still less than ideal, and only a first step. An associated press article released right after the passing of the compromise bill explained that, “instead of ‘sanctioning’ needle exchange programs statewide [as the original bill had intended to do], Davis would simply free cities from the threat of legal action for running their own, locally funded and locally crafted programs,” (“Davis Offers Deal On Needle Exchange Bill”). Without “sanctioning” SEPs, the issue of funding, among others, was still left hanging.

Without funding, SEPs cannot function, and the fact that Congress banned federal funding of SEP programs long ago, on top of state and county budget cuts to health programs, has made SEP funding very tight, even for items like employee salaries. "Funding for needle exchange programs in the United States has always been difficult because the governmental bodies have never wanted to support what they see as a morally slippery intervention," said Peter Havens of the Medical College of Wisconsin (Funding Woes Slow Spread of Needle Exchange Programs”). So because, “using state funds to purchase clean syringes is still illegal,” (Hahn), funding for SEPs has to come from funds from private donors and grants.

The SCCSEP accumulates most of its funding from NASEN ($4,000), the Tides Foundation ($40,000), and the Comer Foundation ($30,000). The funding strain that the SCCSEP felt progressively stronger every year became too much pressure in 2004 and was almost forced to close after a series of physical plant challenges. "According to Human Rights Watch, the U.S. is the only country in the world to ban the use of government money for NEPs. Because of the controversy, private non-profits and some state and local governments have been the main sources of funding," ("The Age of AIDS; Needle Exchange: a Primer).

In the past, a small department within the SCCNEP called the HIV Education and Prevention Project of Santa Cruz County did receive state funds, but the funds from that department were not enough to hold up the entire program. The response to save the SCCNEP was for it to become a part of a better-funded, state supported program. So in 2005, the SCCSEP officially became part of the Santa Cruz AIDS Project (SCAP). SCAP has helped oversee finances, follow through with program implementation, and petition the state and other private donors for money to support the program.

SCAP agreed to oversee the SCCSEP because of the fact that SEPs have scientifically been proven to be the most effective tool in reducing the spread of HIV among IDUs, thus falls in line with SCAPS mission, "to enhance the quality of life through powerful support programs, to advocate effectively for the health and dignity of those living with HIV, and to reduce the spread of HIV through results-oriented and measured education and prevention programs that are

tailored to specific at-risk community groups and focused on the health of Santa Cruz County," (scapsite.org). So, the SCCNEP functions more specifically under the Education and Prevention Department at SCAP and is tailored to work specifically with the IDU community.

Another series of issues left hanging by the compromise bill have to do with the IDU community that SEPs serve. While the compromise bill tried to provide more stability for SEP programs themselves, it didn't address any sort of legal protection for participants, or the rights of participants to have access to safe injecting equipment. Because the compromise bill did not legalize any way to carry syringes, the fact that anyone with any number of syringes, new or used, could be arrested and prosecuted for drug paraphernalia still stood strong. So, "due to the fear of community stigma, police harassment and arrest, many IDUs are [still] not comfortable exchanging at an SEP," ("Injection Drug Users and Their Needle-Sharing Partners").

The only way around being prosecuted for paraphernalia is if one had a prescription to use syringes as part of a prescribed medication dose, and was able to go to a pharmacy to purchase new ones. Folks who felt uncomfortable going to the SCCSEP, and did not have a prescription to buy syringes were left with few other options: buying syringes off the street, or sharing syringes with others. So, five years later Senate Bill 1159 was introduced as a response to the above concerns that were ignored by the compromise bill. The bill was introduced to provide IDUs with more opportunities to acquire syringes from a pharmacy and carry them safely without fear of being prosecuted for drug

paraphernalia evidence.

Senator Vasconcellos put the bill in front of California legislature in 2000, and for nearly three-years the Drug Policy Alliance helped to push through the bill, which had already been vetoed twice previously by Gray Davis. The bill was finally passed on September 20, 2004, by Governor Arnold Schwarzenegger, who explained that passing the bill was in order to, "evaluate the long-term desirability of authorizing pharmacists to sell or furnish 10 or fewer sterile needles and syringes, without a prescription," (governer.ca.gov). Prior to the bill being introduced and passed, California was only one of five states (along with Delaware, Massachusetts, Pennsylvania, and New Jersey) in the entire country that did not allow pharmacy sale of syringes without a prescription, ("CA Governor Signs Syringe Bill to Save Lives"). The bill will not sunset until 2010.

The Drug Policy Alliance fought so hard to pass SB 1159 in California because they have, for years, understood the importance of expanding syringe access through pharmacies. Pharmacy sale of syringes without requiring a prescription is so important for the simple reason that, "limited access to sterile syringes contributes to the transmission of infections among IDUs, their sex partners and their children," (Shields). While SEPs in California have done an enormous job at providing sterile syringes to the IDU community, because of limited resources, access to syringes through SEPs is also limited.

For example, the largest complaint about the program by participants at the SCCSEP is that the syringe exchange isn't open nearly enough hours in the day to ensure decent access to syringes. Also, many IDUs don't feel comfortable

coming to the SEP for fear of being pigeonholed into the stereotype of a drug addict. Martin points out that, pharmacy sale of syringes is especially important because it, “can serve [IDUs] in rural, small-town, and suburban areas that might be unable or unwilling to support SEPs and can reach some users who may wish to avoid being labeled as drug users.” So, because of the significance of pharmacy syringe sales, it is important to have a clear understanding of SB 1159.

Senate Bill 1159: What it means for syringe exchange programs in CA

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Upon first glance, SB 1159 seemed like a dream come true because of its goal to expand IDU's access to safe injection materials. And in many ways, the bill has helped a lot of IDU's in various communities across California, but SB 1159 is also very confusing due to its language and variation between counties. So, I will begin with dissecting the bill's language and technicalities to provide clarity in order to understand how SB1159 has changed conditions in Santa Cruz so far, and it's potential for other types of change.

While SB 1159 changes syringe possession law across the entire state, law regarding the purchase of syringes from a pharmacy is changed on a county-to-county basis. The most important universal state wide changes are that SB 1159 allows, "individuals 18 years or older to legally posses up to 10 syringes if acquired from an 'authorized source' and [to] possess an unlimited number of syringes that are 'containerized for safe disposal'," (SB 1159: What Does it Mean for SEP Participants in CA?). Two questions that immediately come up when interpreting even the basics of the bill, however, are, what is an 'authorized source' and what are the requirements for a syringe to be 'containerized for safe disposal'?

According to the State Office of AIDS, an "authorized source" includes pharmacies that are registered to sell syringes to those without a prescription, as

well as SEPs. While this explanation seems cut and dry, the issue of proof that syringes come from an authorized source is still up for interpretation. For example, if a participant had 10 syringes, was stopped by a police officer, and the police officer found syringes, the participant might be asked for proof that the syringes came from an authorized source, depending on the county. Although pharmacies do offer syringe receipts, most syringe exchange programs do not offer receipts, which could cause some difficulty proving the participant received their syringes from an authorized source.

Whether or not provided by an authorized source, a participant is legally allowed to possess any number of syringes that are "containerized for safe disposal." Containerized for safe disposal is another slippery term because the law defines a container as one that, "meets state and federal standards for disposal of sharps waste," (SB159: What Does it Mean for SEP Participants in CA?). However, the state does not have any law that defines standards for sharps disposal, and it's unclear if federal standards would make sense in the case of syringe disposal.

So, instead of defining containerized at a local or federal level, law enforcement is supposed to base their judgments on what is "containerized" based on the definition given by The Medical Waste Management Act, California Health and Safety Code 117750. The safety code describes a sharps container as a, "rigid puncture-resistant container that, when sealed, is leak resistant and cannot be reopened without great difficulty," (SB1159: What does it Mean for SEP Participants in CA?). Under this definition sure ways of containerizing

syringes are with a biohazard[11] or with a coffee can (or any other metal can for that matter), sealed with duct tape. Other methods of containerizing syringes that may be questionable, depending on the county and law enforcement include a thick soda bottle sealed with tape, a cooler or ice chest sealed with tape, etc. Contra Costa County Health Department explains that, “those [containerized] syringes cannot be used as evidence of possession of drug paraphernalia,[12]” (Disease Prevention Demonstration Project; Senate Bill (SB) 1159 Project Description).

While SB 1159 affects and changes state law having to do with syringe possession, it also affects county-wide policy having to do with the sale of syringes through pharmacies. The sale of syringes through pharmacies is only addressed on a county level in SB 1159 because the bill, “allows cities and counties to approve syringe sale without a prescription in their jurisdictions by authorizing a Disease Prevention Demonstration Project (DPDP),” (State Office Of Aids). In other words, the county is able to choose whether they wish to enact the DPDP or not, leaving full discretion for planning up to individual counties and cities.

A number of counties in the state of California, including Los Angeles, Santa Barbara, San Francisco, Contra Costa, Yuba, Marin, Santa Cruz, Alameda, Yolo, San Mateo, Solano, Sonoma, Humboldt, and Santa Clara, as well

[11] Which are acquired by the county and distributed by the SCCSEP. Many other SEPs around the country and state also provide biohazards at their exchange.
[12] This portion of SB 1159 is a permanent change in California state law and will not change after the bill’s sunset in 2010.

as the cities of Los Angeles, West Hollywood, and San Francisco have authorized syringe sales by adopting the DPDP, (Sterile Syringe Access). However, a technicality that is particularly important to dissect with regards Santa Cruz is that, “SB 1159 is not clear on the scope of authority granted to the city, but the statute does not contain language preempting local control and, in fact, gives counties and cities discretion to adopt such programs. The legislation does not address the circumstances in which a county adopts a DPDP despite opposition from a city in that county,” (SB 1159: What Does It Mean for Syringe Exchange Program (SEP) Participants in California?)

Santa Cruz county is the only county, so far, where the county *has* adopted the DPDP, but the city has interpreted the DPDP legislation in such a way where pharmacy sale of syringes can only be implemented in areas of the county that do not include the City of Santa Cruz or the City of Watsonville. So Santa Cruz or Watsonville aren’t allowed to sell syringes without a prescription, other areas in Santa Cruz County such as the San Lorenzo Valley and Aptos are allowed to authorize the DPDP. City counsel is responsible for interpreting the DPDP in that way, and while they have not disclosed any specific reasons why they have, there are several points of criticism to explore in order to understand any opposition against the DPDP.

DPDP Criticism and Opposition

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The most prominent point of criticism toward the DPDP is the possibility that if needles are sold by pharmacies, IDUs will have such easy access to sterile syringes, that they will have little to no incentive to bring in used ones. Thus, the worth of the used syringe would deplete, and there would be a greater chance of IDUs getting rid of their syringes in public places like parks and beaches. And we already know that if there are used syringes stashed in public areas, there is a chance of anyone in the community being stuck by one of those used syringes, that could possibly be contaminated with a blood-borne disease. However, I argue that if IDUs are allowed to become active agents in changing their own behavior, they will be more likely to take ownership of their lives and make responsible decisions about discarding syringes properly.

Opponents also fear that legal issues would become complicated, by allowing access to syringes through pharmacy sales. Some believe that authorizing the DPDP, "will encourage continued illegal drug use and make it more difficult for law enforcement to apprehend and convict illegal drug users," (http://folsom.ca.us). In addition to making it more difficult for law enforcement to convict illegal drug users, opponents suggest that criminal activity will also be increased, especially in the vicinity of participating pharmacies. However, the facts are that illegal drug use will continue no matter what the law

is, and if pharmacies are allowed to sell syringes, there is a more likely chance of used syringes being discarded into proper containers. This is because of the fact that in most cases where syringes are discarded in public places, it is due to the fear of arrest or other legal repercussions.

While the above criticisms are mostly concerns that come from a public arena, a lot of DPDP opposition has come from the actual logistics of SB 1159. While enacting the DPDP means that its okay for pharmacies to register to sell syringes, there is still a long process that the pharmacy must take upon itself to sell syringes without a prescription. A pharmacy that wishes to sell syringes without a prescription must first be a pharmacy that is licensed with the California State Board of Pharmacy. If the licensed pharmacy chooses to register to sell syringes, that pharmacy must:

> "Register with the health department;
> Certify that the pharmacy will provide the purchaser with written information or verbal counseling on how to access drug treatment, how to access testing and treatment for HIV and HCV, and how to safely dispose of sharps waste;
> Store hypodermic needles and syringes so that they are available only to authorized personnel and;
> Provide for the safe disposal of hypodermic needles and syringes," (Disease Prevention Demonstration Project; Senate Bill (SB) 1159 Project Description.)

Once the following steps are completed, pharmacies have a series of information they are required to have on-hand and provide to customers. A lot of the information would have to be presented to the pharmacies, so pharmacists

would require extra training about local resources to be able to sell syringes. Also, after pharmacies register, they may be asked later on to take part in a DPDP evaluation, as led by the State Department of Health Services.

Because the application process seems somewhat intimidating, pharmacies may need extra support to want to register with the DPDP to sell syringes. Also, in some cases, individual pharmacists may not want to sell syringes without a prescription because of personal issues such as feelings about illicit drugs. So, even after a pharmacy chooses to participate in the DPDP, there may be internal opposition, and a pharmacist never has to sell a product without a prescription, if they don't want to.

The final opposition to the DPDP has more to do with opposition to supporting any type of program that supports IDUs. Many believe that supporting IDUs is supporting an illegal drug industry, and aids criminals. While the notion that IDUs are criminals don't "deserve" access to supplies to keep them healthy and safe will be looked at in depth at the end of this essay, it is important to note the financial burden of IDUs who do contract a blood-borne disease. Regardless of how one feels about illegal drugs or drug users, the fact is that keeping IDUs safe from disease ensures less tax-dollars and government funds being spent on health care once a person does contract a deadly disease.

Responses to DPDP Criticism

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While opposition toward the DPDP stems from some legitimate concerns, the importance and effectiveness of syringe access through pharmacy sales overrides any criticism. As mentioned earlier, other countries, like Australia, have already been authorizing the sale of syringes in pharmacies for decades. Looking at syringe sales in Australia is particularly important because of the fact that during the 1990's pharmacy syringe sales combined with SEP efforts, "resulted in the avoidance of 25,000 cases of HIV and 21,000 cases of hepatitis C," ("Sterile Syringe Access"). In Southern Australia, specifically, there are approximately 55 SEPs, along with hundreds of pharmacies. These programs, "served about 1.2 million drug users, [and] no new HIV infections were reported for three consecutive years." (Martin).

The dramatic number of lives saved through syringe access programming in Australia is especially apparent when compared with statistics based in America. In the year 2000, according to Dr. Wodak, "there were 14.7 new AIDS cases for every 100,000 Americans compared to just 1.1 new AIDS cases for every 100,000 Australians." For those concerned more with financial burden of health care over compassion for IDUs, results were equally as impressive. In Australia, "an investment of more than $130 million (Australian) in such programs

results in a savings of somewhere between $2.4 and $7.7 billion[13]," (Martin).

More locally, New Haven, Connecticut is an important case study to look at when investigating the effect of prescription syringe sales on a city. New Haven has reformed paraphernalia laws and allowed pharmacy syringe sales since 1992. Since 1992, rates of IDU's who share syringes has dropped by nearly 40 percent, ("Sterile Syringe Access). The rates of accidental needle sticks have not changed in the above studies, though there's no conclusive statistics relating needles being left in community spaces.

Also an important fact to note is that allowing syringes to be sold in pharmacies doesn't detract from folks taking advantage of syringe exchange programs. In other words, if the Longs in Downtown Santa Cruz, which is 2 blocks away from the Drop-In Center, started selling syringes without a prescription, we are confident our participant base would not diminish. It might in fact grow stronger based on referrals the pharmacy would be able to make to our program, since pharmacies under the DPDP are required to provide information about safe syringe disposal and other community programs to help with injection drug use.

Because there are ample statistics and case studies supporting both pharmacy syringe sales and SEPs, it is important to dig deeper and identify obstacles specific to the community that affect syringe access. Many obstacles specific to Santa Cruz County has had to do with misinformation about the

[13] Converted figures from Australian to American currency leave the figures of, "approximately $71.8 million and $1.3 to $4.1 billion," (State Approaches to Expand Access to Sterile Syringes Through Pharmacies).

effects of SEPs and pharmacy sales on the county. On top of legal complications and legal technicalities, many members of the Santa Cruz community, and even Santa Cruz residence specific to the IDU community, accept the view that all IDUs are abusive, dangerous, morally-corrupt criminals deviating from morals and societal norms.   This view of IDU's is stereotypical, yet common, thus placing a negative, and often false, stigma on IDUs through means of academia misinformation, lack of research, and the media, which "others" drug users from mainstream-society.

Stigma and Stereotypes Affecting IDU Syringe Access

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To understand specific stereotypes about IDU's specifically in Santa Cruz County, I ethnologically collected the opinions of several Santa Cruz residence in ages ranging from 17 to 35, who are *not* IDU's. While the sample group is not large, for my purposes the sample provides a basic understanding of some common stereotypes about IDU's. The most common way people think about people who inject drugs, heroin specifically, are in terms of the label, "Junkie." So I phrased the question, "what do you think of when you hear 'Injecting Drug User'? Do you see a specific person? What do they do, look like, etc.? It doesn't have to be detailed at all, it could even be one word."

For most people, there was no clear difference between the terms Injecting Drug User and Junkie, which is a common misperception that I will debunk later on in this essay. The common theme between all samples was that IDUs and Junkies are addicted, and/or abusive**.** One sample explains that their view of an IDU/Junkie is a person who's, " addicted to some hardcore shit and possibly a little dirty or scabish." Approximately 70 percent of those samples painted the picture of a disheveled person, often unhappy, and unable to function in mainstream-society. The sample most completely representing this percentile describes a Junkie as, "waft out...sitting in an alley ...hopeless...wants life to end, but is not courageous enough to end it ...but is brave enough to stick a needle in their arm and feel the numbness ...temporary suicide..."

Only 15 percent of the sample commented that the word 'Junkie" doesn't have to be associated with drugs, while IDU obviously is associated with drugs. One sample suggested that a Junkie could be, "someone who's addicted to something, be it religion, drugs, sex, etc. (and usually desperate)." Only one person in my sample placed a personal connection with IDUs, explaining that although he tries to avoid stereotypical views of what an IDU looks like or is, he thinks about, "all of [his] friends who have destroyed themselves in their addictions. It's like they have removed their hearts and replaced their dreams with heroin." Interestingly, however, even when referring to personal relationships with IDUs, not a single sample showed any awareness that IDUs could be functional, or perhaps injecting legally for medically prescribed purposes of pain relief, diabetes, or other physical problems.

While it is no surprise that a majority of the Santa Cruz community think negatively of IDU's and "Junkies," it is more surprising that people who are IDUs themselves also have negative stigma and stereotypes of others within the IDU community. While I was not able to conduct formal interviews with a sample group of IDUs, due to confidentiality contracts involved with my research, I was able to I received permission to use some casual comments in this essay as a case study.

On April 13, 2006 I participated a home delivery at the SCCSEP, which consists of bringing clean syringes from the Drop-In center to exchange for used syringes in a persons private home. When I arrived at the 3-story beach front home, I was interested to see who would be inside… perhaps a chronic pain

patient, as many IDU's are. In reality it was a woman and her husband who had been injecting street heroin for 25 years. They lived with their 27-year-old sun, and, at the time of my visit, they were also living with two of their grandchildren. No one other than herself and her husband was aware of their recreational heroin use.

After greeting us at the door, and explaining the importance of a speedy interaction (her grandkids were coming home from soccer practice 15 minutes later), she seemed completely mortified to be exchanging needles. The woman kept saying things like, "Really we're trying to quit again, I mean, we're not like that; we have a nice house, we have good kids, a really normal family. We're not like those people, you know? We have a comfortable life." Her comments implied that in her mind there was no place for IDU's in mainstream-society. While I gently tried explaining to the woman that we see a variety of clients at needle exchange, she was insistent in correcting me, "No but we're not like that."

At the SCCSEP Drop-In Center there is an eclectic group of IDU's who come in ranging from the homeless and mentally unstable, to teachers, EMTs, grandmothers, business accountants and children of Santa Cruz County. During women's hours there's a woman who comes in every Friday when the Drop-In center is the least busy, and she feels as though this is the safest time for her to come in. She has expressed concern that she feels unsafe being around "crazy junkies" during other times the Drop-In is open. I asked her of any instances that had happened that made her feel unsafe, and she replied that it, "doesn't take an instance to occur to feel unsafe around junkies," even though she, herself, is an

IDU heroin user who came to the Drop-In.

It is clear that the negative stereotypes associated with IDUs run so deep that even members within the IDU community stigmatize IDUs as "junkies" who are addicted, disheveled and scary people. While we know that the IDU stigma is probably rooted in stereotypes that came about based on a few people in one specific segment of IDUs, it is important to explore how these stereotypes are perpetuated. Based on my experience with the SCCSEP, as well as academic research, I argue that there are a few contributing factors to the perpetuation of negative stereotypes of IDUs.

The first factor is academia misinformation, namely with regards to properly labeling drug use. Much of academia and the health care industry agree that heroin and other such drugs when injected are so highly addictive by administering directly into a vein, that anyone using heroin is dependant on it. As one sample reported, their understanding of an IDU was, "Someone whose whole life is dedicated to their next hit," thus implying that with use is an addiction that impairs the ability for one to function in every day life.

There are many varieties of people who inject drugs, and one who is a user of needles is not necessarily an addict unable to function. Many IDUs are able to lead productive lives, contribute to society, or others who inject drugs for medical or recreational purposes; these are all cases where a user may not be dependent on the drug they are injecting. Some IDUs may also use very little amounts of drugs (once per week, once per month, etc.), as opposed to the common perception that, people who inject drugs are constantly on drugs, with

no ability to quit or regulate their use in site. While recreational heroin IDUs far outnumber those who are dependant on injecting a drug (Rowe), the stigma of drug use implies that it is not possible to be a casual IDU without being addicted. This places the "out of control" label on drug users, which threatens the "norm" of society.

One of the reasons academia fail to differentiate between IDUs who are users versus addicts is the fact that there is such little research on functional users. This lack of research can be attributed mainly to the fact that because functional users generally go unidentified as drug users in society, it is difficult to distinguish a sample group. In the context that I have met functional IDU's, it is easy to identify them, but impossible to conduct any cohesive research without breaching the contract I had sign.

James Rowe also points out that another limitation in the research of users is *where* researchers look for their samples. He explains that, " treatment centers offer access to those whose drug use has reached problematic levels. [Needle and Syringe Programs], particularly identifiable shop front services, are frequented by those prepared to be identified as injecting drug users," (www.onlineopinion.com). These factors, presented in lieu of the lack of funding given the issue, proves to be problematic in identifying functional IDU's for research, and so the lack of research on functional IDU's is often ignored.

Although there are plenty of ways to debunk stereotypes through a simple explanation of academia and research methods and funding, the media continues to verify limited and often false information on drug use and represent

it as truth.   Furthermore, the media latches onto the most extreme cases of violence and labels these violent acts as the fault of drugs. By taking a few cases and creating a synonymous relationship between drugs and violence, IDU's are further stigmatized as "out of control," and even scary, individuals. One sample I collected suggested that he viewed IDU's as, "desperate, alone… people who are more 'normal' looking in the sense that you can't really tell that they are junkies. Those are the ones I'm most afraid of, and fear for."

While it is *not* typical that the sample recognized IDU's as "'normal' looking," it is very unsurprising that there is a sense of fear toward IDU's in the response.   While in reality there is no reason to fear IDU's more than those who are nonusers, the media produces fear through many stories on a daily basis representing the most problematic IDUs.   And because IDUs are not often allowed to offer relevant opinions and participate in discussions about drugs, the way the mainstream media presents stories about IDUs falls in line with society's politics and laws, relying on expertise from those in law enforcement. D.C. Des Jarlais and S.R. Friedman explain that, "From the perspective of most law - enforcement officials, drug distributors and often drug users themselves are considered to be immoral and antisocial," (www.unodc.org). Thus, the mainstream-public is frightened into stigmas that discount IDUs as moral insightful members of society.

Many "normal" members of society believe so fully in the negative stereotypes about IDUs that they don't feel as though stigmatizing them as "bad" is an issue; further more, they feel IDUs *should* be stigmatized in such a way to

keep "normal" people safe. However, stigmatizing IDUs leads to consequences affecting all members of society. Legislative policies that criminalize IDUs have forced IDUs to use unsafe practices when injecting, such as reusing dull syringe or sharing syringes with others.

Because IDU's are considered to be criminals, and criminals have less access to resources, supplies to inject safely are often limited. One way to remedy lack of new supplies is for an IDU to reuse a dull syringe. When someone is forced to reuse a dull syringe the chances of missing a vein and contracting an abscess is much higher than when using a sharp, fresh needle. An abscess may lead to a number of other infections which can be life threatening. When this occurs, an IDU will be instructed to see a doctor, often times accessing health care paid for by taxes, as those labeled as criminals do not have access to health care like other citizens might.

IDUs are often forced to share syringes, due to lack of resources for the IDU community, as well. In Santa Cruz County a majority if IDUs contracted Hepatitis C, and HIV and AIDS are also huge problems among the IDU community. Diseases like these being passed from IDU to IDU must also be a huge concern for non-users due to the fact that many such diseases can be spread through sexual activity, as well. So, even someone who is a non-IDU may be affected by the actions of those who are if programs are limited. In other words, by stigmatizing and criminalizing IDUs, programs to aid users are cut short and in some cases non existent, thus increasing transmission of diseases both within the IDU community, as well as into non-IDU communities.

Recommendations

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To conclude this essay, I have four suggestions that push in the right direction to remove the negative stigma attached to IDUs. To begin with, through my research I have encountered a report pushing to develop the term "addictionphobia." While the term has potential to be problematic by excluding "users" and referring to "addicts," it is important to develop a theory that would, "give a short, recognizable name to the complex of these stereotypes, stigmas and negative attitudes," (Abstract 316). Historically, by identifying key words such as "racism" and "homophobia," important social commentary has surfaced about the issues of race and sexuality/gender politics. Thus identifying a key word might open up important conversations regarding IDU issues.

The second suggestion would be to increase a campaign already in action at the SCCSEP. As part of a harm reduction philosophy, a huge portion of education both in the community, and at the SEP should specifically address the stigma placed on IDUs. This is important not only to improve conditions for IDUs but also for an audience to truly understand the importance of harm reduction programs whether the audience is volunteers, community members, or other IDUs. An entirely separate program to address the *politics* facing the IDU community may also be necessary in order to truly represent and understand the negative stereotypes against IDUs. In other words, increased education that debunks the negative stereotypes about IDUs is an important first step in combating "addictionphobia."

The third has more specifically to do with prescription sales and legislative issues surrounding it, by allowing the pharmacy sale of syringes without a prescription in Santa Cruz County. The first step in Santa Cruz County, specifically, is to pressure the city counsel to interpret the DPDP in a way where the city of Santa Cruz is allowed to take advantage of it. Once pharmacies are allowed to register to sell syringes to folks without a prescription, they will need help registering.

So, much like Contra Costa County did, it is necessary to put together registration packets that outline what the pharmacies would be required to do, as well as the applications to be filled out. Brining as much information to the pharmacies as possible is an important step in legalizing the pharmacy sale of syringes. And if pharmacies are behind syringe sales, syringe use will be more legitimized, thus helping the issue of IDU stigma and minimizing the risk of harm associated with syringe use.

The fourth is an option that exists in very few states because it is so controversial, and would take significantly more time to implement. That is, proposing legislation to permit doctors to prescribe syringes to their patients directly. In this case, pharmacy syringe sales without a prescription wouldn't be an issue, but is in some ways more optimal than allowing syringe sales without a prescription in pharmacies.

It's a more optimal way to allow access to sterile syringes because of the fact that participants in states that *have* legalized doctor prescriptions for syringes have reported feeling more legitimized and less labeled as a drug

addict. So, in addition to providing syringe access, allowing doctors to prescribe syringes is also helping to combat addictionphobia and a lot of the prevalent stereotypes that exist in the community. Another advantage to allowing doctors to prescribe syringes is that, “physician prescription of syringes, much like needle exchange programs, can provide a vehicle through which injection drug users can access health care services and referrals to drug treatment programs,” (“Sterile Syringe Access”).

So, providing access to sterile syringes is not enabling “junkies” to partake in criminal activities – it’s providing users with the tools they need to lead healthy, functioning lives, not only for themselves but for their sex partners, children, and fellow members of the community. In other words, “whether driven by compassion, fiscal prudence, or self-defense, rational public policy will seek to reduce the incidence of HIV/AIDS, hepatitis, and other blood-borne diseases that are spread by the behavior of some IDUs,” (“State Approaches to Expand Access to Sterile Syringes Through Pharmacies”). By allowing access to proper health tools, individual lives are saved, as well as providing for the wellbeing of the entire community. To deny proper health resources is to deny a persons right to live, and the only way to provide proper health care for IDUs is to accept a universal harm reduction health policy in Santa Cruz County.