

Legal Advocacy For Injection Drug Users: How that is an aspect of HIV
prevention work

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Chapter 1. Introduction to HIV Prevention and My Social Location

A. Introduction

The structure of HIV prevention work as a social practice entails breaking down many of the social factors that perpetuate HIV transmission. As I will explain further on, social norms, access to HIV prevention items like condoms and clean needles, laws regarding prostitution, marriage, and injection use are contributing factors to HIV transmission. In addition to the laws, the enforcers of these laws hold a place in the prevention model as well. Looking at the idea of HIV prevention as making every prevention method accessible to any individual who needs it, there are barriers in the way. Advocating for the rights of individuals to have access to prevention items is a huge task, and initially we can see that it was no easy task for people in the beginning of HIV prevention work. Gay rights advocates were organized and spoke out against social pressures they face and how that plays a role in transmission. Other groups are not as able to be open and organize in the public view. Injection drug users (IDU's) are illegal and face serious pressures which include things like incarceration, and so remain underground.

B. HIV prevention background

The goal of HIV prevention work is to prevent HIV transmission through any number of processes. The transmission of HIV is often blood to blood contact, mainly through needle sharing, unprotected sex, higher risk is anal sex because the lining of the walls of rectum are only one cell thick and will tear easier which will expose blood to semen during sexual intercourse, unprotected vaginal sex, and breast feeding. Injection drug use, sex and HIV status are all highly stigmatized in our society, thus trying to educate and discuss these practices in a safe manner is changing social norms.

Prevention of HIV transmission needs to be recognized and approached as a very complex issue. Most non profit organizations that focus on HIV/AIDS outreach work understand this; however there are many legal restrictions which create a difficult barrier for state led prevention work. Some of the legal problems involved include syringe possession regulations, over the counter syringe sales, anti-prostitution laws, same sex marriage laws, and already implemented programs such as abstinence only sex education. One argument with abstinence only sex education programs coincides with some struggles of men who have sex with men, Bruner argues, "Even programs that avoid conveying false information nonetheless advocate for sex only within marriage. This implies that heterosexual sex outside of marriage, and all homosexual sex

are morally wrong or dangerous. Such a message excludes from the conversation- and the moral community- many of the very young people who need to be included and engaged...Similarly, current restrictions on federal funding of HIV counseling and prevention programs that 'promote or encourage...sexual activity, whether homosexual or heterosexual,' are barriers to moral dialog and effective prevention." (Bruner, High risk sexual behavior and failure to disclose HIV infection to sex partners: How do we respond? P. 22)

Some of these transmission methods of HIV are stigmatized behaviors which most people do not feel comfortable talking about because of the social values of our society. In Santa Cruz County 83% of HIV transmission among men was due to injection drug use or men who have sex with men (72% men having sex with men, 10.4% injection drug use) and 53% of transmission among women was attributed to injection drug use. (Goodfriend) Injection drug users are treated as something unsightly in our society. In movies we have images of people droopy headed, scraggly hair, unshaven, dirty clothes, irresponsible and stealing from family members to support their habit. In general people think of drug addicts as "street people" and untrustworthy, as junkies. The term "junkie" began in reference to people addicted to heroin, because heroin is often referred to as "junk" in slang terms. As the term gained popularity it became a reference term for people who are addicted to other things as well, for example an "adrenaline junkie".

The stigma around what we consider and categorize as a drug addict is circulated through urban legends, of friends who could not get clean and so were left to sleep the streets and steal to support their habit. The countless movies we have paint a picture of people hopelessly addicted to drugs to the point of no return. Movies such as “Candy” provide us with a couple becoming addicted and how that leads them into a life of stealing and prostitution for their drug using habit. In this movie they start as a healthy looking couple and deteriorate into unkempt and desperate. In other movies, such as, “Trainspotting” a group of people is addicted to drugs and fit the general term of “junkie.” In “Trainspotting” all of the people continue to lose their jobs, have difficulty with the law, and struggle just staying alive. When a couple who is addicted to drugs has a baby and continues using drugs, they get “so high” for several days that they forget about the baby and find it dead several days later. With these images in our minds of what a drug user is, should it be any surprise that the general population responds with apathy and scorn to the needs of the drug using population. Often it will not enter a person’s mind that an injection drug user can have a job, children, and a home. In the media there is a disconnect between “normal” and “drug addict,” and movies dehumanize the people they portray as addicts. While some IDU’s may fit into the stereotype the media creates for our society that is not an explanation to deny assistance to them. On the contrary, as a community of people who are looking for help and asking for it, I would hope people

could recognize that as an obvious fact that there needs to be more support.

A person who is an injection drug user is not necessarily addicted to drugs; “drug addicts” is what they are often referred to, which they may not be, addiction and drug use is different. Though most drugs that can be injected are highly addictive, that is still an assumption. The term “addiction” itself brings up a lot of negative connotations. The laws and beliefs of drug use in our society include people being tested and fired from jobs for being on drugs, they can be arrested for possession, they can lose access to just about everything, convicted felons are not allowed to vote, in our town any homeless person seeking shelter at the main shelter is not allowed to have drugs on them or use them while staying. (Capitanio) Most people in the injection drug using community are afraid of cops, and while at work I have had many conversations with people who say that a police officer beat them or harassed them, or arrested them with out proper legal reason. Equal legal representation of drug users and commercial sex workers is very complicated because social bias works against them. A report done in Philadelphia also illustrates the correlation between increased police activity near syringe exchange programs and decreased use of syringe exchange programs, which can only be a conclusion of increased risky behavior of sharing needles. (Davis)

Harm reduction is the idea that risky behaviors can be safer. Not to change the behavior, because making people feel comfortable can be half of the work. In harm reduction work we acknowledge that people are going to continue doing drugs, but that should not mean that they lose access to health. The Harm Reduction Coalition recognizes harm reduction as, "a set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of strategies from safer use, to managed use to abstinence. Harm reduction strategies meet drug users "where they're at," addressing conditions of use along with the use itself." The trainings and experiences I have had during my internship have changed my view of what problem I wanted to focus on. Previously I thought a large problem was education and outreach, and I wanted to focus mostly on education. While I do recognize the lack of education of HIV prevention is still a large problem, I have now realized I am more interested in access to resources and breaking down the social stigmas regarding high risk groups. During my six months I have done both educational presentations and direct service to the high risk groups, and it was during my time at the drop in center and at the office that I had come in to contact with so many instances of people being denied care or just completely disenfranchised by different institutions. Some of the stories I have heard include people not being able to talk to their family because of their HIV status and/or sexual orientation, people being denied medical treatment because of their drug use, people being denied housing

because of their orientation or drug use, and so many stories that I could not even begin to compile them all.

Of every study done regarding stigma in high risk group category one of the most important factors is the stigma of being HIV positive (Capitanio). Being HIV positive has so many stigmas attached to it that people will not get tested, or not have access to the test itself. The people who are not getting tested will have a higher sero-positivity because they will not be getting treatment which increases the risk of transmission. The reason this happens is because the virus will continue to replicate and without treatment viral levels can get very high, which means that any exposure for someone else to a not knowing positive person is more risky because they will have more viral replicas in their bloodstream. While people may not be getting tested who are in high risk groups there is also the stigma of being HIV positive and trying to share that information with someone. For instance, if someone is about to share a needle because they may be in a county where access to syringes is limited, and they know they are HIV positive, they might not tell the other person they are sharing with because they might not be able to get high. Or being in a relationship and not knowing when to take the next step, there are a large number of people who are afraid to tell their partners what their status is. This stigma is the most dangerous to perpetuate, it is this fear that we have instilled in our society through institutions and media that makes

people not want to get tested or disclose their status, which puts the entire community at risk (Capitano, Des Jarlais).

The social stigma and laws are things that harm reduction workers are seeking to change, which is social change. Harm reduction is the ideas that risky behaviors can be safer, they do that while making people feel comfortable, so that they will be more inclined to seek help for themselves. In harm reduction work we acknowledge that people are going to continue doing drugs, but that should not mean that they lose access to health, or that they may be able to continue their habits in a safer way. The Harm Reduction Coalition recognizes harm reduction as, “a set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of strategies from safer use, to managed use to abstinence. Harm reduction strategies meet drug users “where they’re at,” addressing conditions of use along with the use itself.” This model is a non judgmental approach to working with a community that is used to being judged and treated a certain way in society (Capitano, Lane). A participant once voiced her appreciation for the services at the Drop in Center and the level of friendliness by volunteers, “Thanks for being so nice. You know, even though most of you guys are college students and don’t have much background in using; you’re nicer than other exchanges. I have always been treated nicely at the drop in center. In San Luis Obispo when I went to exchange they used to treat me bad because they were all recovered users, they would try to tell me to get

help every time and be really pushy. I didn't even want to exchange most of the time." (Field Notes, Jernberg 8/13/08) Just as this woman said, she did not even want to exchange, accommodations and friendliness can be a method used to help people realize they can get help if they need it, when they are ready.

C. My Social Location

As a person from this town I have many connections and experiences that have affected the way I have learned to interact with participants at the Drop in Center and the different aspects of this town that I am familiar with. It has been important for me to learn how to interact with participants as a person who might have been acquainted with them and their family. The strict confidentiality policy at the Drop in Center works to protect the rights of our participants and make it more comfortable for them. With the confidentiality policy we are all required to "not know anybody". Even if my best friend comes in I can not acknowledge them until they acknowledge me, and even then once we are outside of the Drop in Center, I can not bring it up unless they do.

The Needle Exchange has been open for years, starting as an underground practice by individual volunteers. Through this time most injection drug users in this county have learned about us, however, outside of the Drop in Center, they face a whole different battle. Outside our front door they face stigma, they face stereotypes, they face the law,

and all of these are factors and barriers for them from society into our front door, and the safe use of injecting substances. These barriers then can be seen as “preventing prevention.” The Needle Exchange seeks to stop the transmission of HIV and Hepatitis C via sharing needles; however, I have come to realize that society views the use of needles very differently. I have heard many people say, “You shouldn’t be helping the addicts use drugs.” And likewise the police see people with needles on them as drug addicts, and people who should be in jail.

Sitting in the chair I wait for people to come in and exchange. I sit by the bags of needles and my partner sits on the other side of the supplies taking down statistics. On my side I am seated next to about over a thousand needles with different barrel and needle gauge sizes. The supply tower next to me consists of labeled drawers with alcohol wipes to prep a shot, cottons to filter whatever you may be injecting, cookers to cook the substance, water to mix in the cooker, tourniquets to tie off, both latex and rubber, and bleach to sterilize any needles a person might share. My partner has a sheet that records the following questions: number of syringes exchanging, size of gauge or barrel size given back, number of people exchanging for, and estimates of age, ethnicity, and gender, the last time they exchanged, or if this is their first time here, and zip code. All of this information is recorded for grants and funding we receive that asks us for information about different things to know where the money is going and what kind of population is being served. On the

other side of us is a chair seated next to a large biohazard container where the participant sits. All of the people that use our services are usually referred to as participants because they are participating in the exchange of needles and finding resources for themselves.

The next participant that comes in is my age and I went to school with him in third, fourth and fifth grades, we used to play on the playground together. He asks several questions, such as, do we have the “big ones.” There are many different sizes that could be, the barrel size or the needle size, so I show him all of the different sizes we have and tell him the larger needles are better for muscling, which is injecting in to the muscle as opposed to a vein. He makes his decision and then comes back to ask us about Hepatitis C testing, what are the hours, how long should he wait before coming back to get a second test. I reply that we have schedules he can pick up or the hours, and that when he comes in he can ask the counselor about the testing and he can answer those questions better. During this whole interaction there was no recognition, I see him fairly often in the Drop in Center, and I knew him as a kid. Our strict confidentiality policy restricts us from ever “knowing” anyone that comes in. I have to be comfortable giving needles to anyone that I might know, and never act on the recognition. I have had good friends of mine come in and I just wait for them to say something or I don’t say anything at all.

Somehow I got lucky enough to be on the side of the supplies instead of the biohazard. I grew up here and often see my peers and people I have known most of my life. That is one of the complications of doing this kind of work, it can be very hard, especially to see a friend you know to be struggling with an addiction but giving them needles and not being able to tell their family you have seen them, or having people ask if you have and saying no. Many of the people that work at the Drop in Center and volunteer are from out of town and moved to Santa Cruz from somewhere else. On my first day I saw a friend of mine and later asked the other people working, "What do you do when you see people you know?" My response from more than one person was the same, "I've been here a long time and that has never happened to me." Well, my first day I saw someone I knew. It was something I have had to deal with and learn to digest, and now I see people I know on a regular basis and I do not feel awkward anymore.

Being a local person creates a very different environment, and learning to be okay with my place as a local and being a provider versus being a participant is something very complex. I have a hard time justifying being as lucky as to have made it to the side of the provider. As a kid I had lived on the streets, I worked full time to support myself as soon as I was twelve, and have since. The frustrations of being lower class and family problems led me to escape the lot I was given by doing drugs and drinking a lot. By the time I was fourteen I had taken a few

different kinds of drugs and at the ripe age of fifteen was in a bad relationship with a man who was a meth dealer. I was on the path to being the participant. I have very intimate ties to living in this town; quite literally, I have slept on most of the beaches. I know what it feels like to run from the police and duck behind a bush because they can cite you for anything, or wake up and hope that all of your stuff is still there. For me, being the provider is the most empowering position I can think of. I have overcome that for myself, and I can now offer services for my peers who are still in that position, of injecting and needing support and resources.

Chapter 2.

A. Santa Cruz History

Santa Cruz County is geographically located on the coast of California, very close to several major cities, San Francisco, San Jose, Oakland, and other California cities are within a days drive. Santa Cruz is a beautiful area, full of forested areas, the Monterey Bay, and these areas are very unique. The Monterey Bay is a marine sanctuary which is protected by the government from exploitation and pollution. The forested areas are also protected by their individual state park statuses. These local wonders are protected mostly by individuals in the area which meet together to make committees that do things like fund raisers, petitions, and rallies to fight against people, organizations, or the government that might

try to break those regulated protections. Partly because of these natural elements and location to the cities, Santa Cruz itself has become a desired and impacted living situation. The living costs here in comparison to income are very far apart. The cost of owning a home in Santa Cruz County is \$699,000, and the median household income with an average of 2.7 people per household is \$52,031 (US census report, updated 2004 stats.). The percent of people living below poverty standards are 10% in Santa Cruz County.

The community of Santa Cruz is composed of approximately 75% white and 27% Hispanic, with very small other diversity (US census also 2004 stats.). With the state of California having a funding budget of \$103.8 billion (Governor's Budget 2007-2008), Santa Cruz has a very good budget piece as well. The County of Santa Cruz and State of California are very areas; however, Santa Cruz also has a very high rate of homelessness. There is an average of over 1500 people sleeping outside every night, and only 700 emergency beds available. In addition to this, the shelter which provides these beds prohibits any person from being in the shelter with any form of drugs or paraphernalia on their person, and a two week wait on average for a bed. (Homeless Issues Task Force Report) Not only is it difficult to access these services, but the people who are left out become criminalized by the laws we have.

There is an estimate that over half of the homeless population have mental health illnesses or is addicted to drugs, therefore, the homeless drug users do not have an emergency shelter (Homeless Issues Task Force). If they are on the streets then they are illegal as well by the ordinances in Santa Cruz County of not being able to sleep in public, or even try to stay warm with a blanket, and homeless people continue to die from hypothermia (SC ordinance 6.36.010). In addition, they added into the ordinance that any person caught trying to sleep, wrap in a blanket or erect any form of shelter in public can be searched, without a warrant, leading to many illegitimate arrests. The attorney representing many homeless in Santa Cruz, Kate Wells, put it simply, "This town used to be tolerant and liberal. Now the city council and law enforcement have become the bullies to our own community." In general our homeless population is criminalized and swept under the rug.

B. SCAP's Background

The Santa Cruz AIDS Project office is located in downtown on Front Street. There is a separate location on Front Street that is the Drop in Center, where the Needle Exchange program takes place. The mission statement of Santa Cruz AIDS Project (SCAP) reads,

"The Santa Cruz AIDS Project was founded in 1985 by a group of dedicated volunteers with the mission to lead a community response to the ever-changing HIV/AIDS pandemic, 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.”

In their mission statement they lay out the kind of work they do, and the programs they offer. The programs at SCAP are broken into two categories, client services and education and prevention. The client services programs are offered to anyone who is HIV positive and include services that are sensitive to the needs of people with HIV.

The client services are provided by case workers which are similar to social workers, but are not licensed, and are not affiliated with the state, and represent the clients as an ally. The caseworkers will assist the clients in filling out paperwork to receive social security, disability and other state benefits that can be difficult to figure out. They will help them with trying to find housing by showing them how to look through the classifieds in the newspaper, looking on craigslist, and then assist them with the process of applying for a housing situation. Caseworkers will also help the clients look for jobs, get medical appointments, medications, or anything they can. If medications are not working properly, or having more severe side effects than normal then the caseworker will ask a doctor for them, go to a medical appointment, or make the appointment. SCAP also offers a boarding house for clients who are sober, in need of housing, and meet a certain financial criteria. Inside of the office at SCAP there is a food pantry program that is offered to any of the clients in need

of food. During the days that I have worked I have seen more than several people use the food pantry, sometimes which is the most food they have access to. The food pantry is stocked mostly by donation, with some help from grant money that the organization uses for whichever program presents the most need for it.

The education and prevention aspect of SCAP has the other half of the programs. Harm reduction can be seen as clean needles, condoms, clean tourniquets, clean cookers, clean cottons, lubricant, and pretty much anything that will reduce the risk of transmission for activities that are at highest risk of contraction. The highest risk groups in the US are men who have sex with men, injection drug users, sex workers, and then various minority groups depending on the location (CDC). In Santa Cruz the highest risk groups are the same except for the Latino population shows up as the third highest risk group (SC HIV report). The educational portion mostly consists of pamphlet handouts, presentations, and educational programs for high risk group members, such as instruction of the risk and use of clean needles.

C. Needle Exchange History

Syringe Exchange Programs (SEP's) became first recognized as established in the late 1980's with the first one in Tacoma, Washington. The SEP became one of the first recognized programs despite the fact that a response had been made previously through underground

distribution and exchange. One of the first places to provide an underground Needle distribution was San Francisco in the early 1970's. These efforts first arose as a way to combat things such as abscesses and yellow jaundice. When HIV first became a known contractible disease in the injection drug using community even more of a response was necessary. Due to the nature of SEP's communities shunned the idea and many political figures were opposed to such a new idea that without background information seems to many to be advocating for drug use.

Throughout the course of establishing Syringe Exchange Programs in the United States, legitimacy was gained, and people began to get familiar with them. Though it has taken decades to gain a certain amount of trust and legitimacy with the government and communities that host SEP's, there is now evidence of effectiveness and countless supporters of SEP's. People can not avoid the facts of SEP's place in a community as a needed health service, and the CDC has this to say, "An impressive body of evidence suggests powerful effects from needle exchange programs....Studies show reduction in risk behavior as high as 80%, with estimates of a 30% or greater reduction of HIV in IDUs." Despite this support there is still a huge amount of work that needs to be done to legitimate these services and provide more stable funding and legal support.

At the Drop in Center alone, there have been volunteers who have been told by law enforcement that they need to have an ID to carry

unused syringes, which is contrary to what SB 1159 says. The communication gap of the laws and of individuals rights can lead to people not being aware of what they are entitled to, and a fear of the enforcing agencies, who also illustrate misunderstandings of individuals' rights, particularly people who are carrying injecting supplies. The citations for paraphernalia then put more than just the users at risk for legal complications, but any person who may be doing outreach for the IDU community. While police are generally lenient on people who are exchanging in the community for a SEP, they are not held to that. The lack of support from the community creates even more of a barrier for people who need to access health services.

The struggle that needle exchange programs went through in order to get where they are is similar to many fights against injustices and the upward struggle that is thrown at any social service. In 2001 a volunteer in Sacramento was put on probation and ordered to stop distributing syringes. At that time there were no laws to protect her, and this was one example of how committed SEP's are. Before there were laws protecting syringe exchange, the practice was still taking place by concerned individuals. One of the first individuals to make a break through in needle exchanging and IDU rights for health access was Jon Parker. He was one of the first people to distribute syringes despite laws, in 1986, in Boston, Mass. He was cited and put on trial for possession of paraphernalia and

distributing injection supplies with out prescriptions, but he was acquitted with the support of the court and a surprising amount of the country.

Throughout the evolution of SEP's the different sites have found ways to provide more services to IDU's. Due to the nature of SEP's they have become one of the most reliable resources for IDU's and in many cases ends up being the only organization where an IDU can feel comfortable. SEP's now serve the community with programming such as, Hepatitis B and C testing, referrals for drug rehab treatments, medical referrals, housing referrals, and can be advocates in the community. SEP's may have started as just exchange sites, but now their importance has been taken advantage of and trends prove that their services are always changing. The CDC reported this, "In addition to exchanging syringes, SEPs provided various supplies, services, and referrals in 2005. Nearly all SEPs provided alcohol pads (117 [99%]), male condoms (115 [97%]), and referrals to substance-abuse treatment 102 (86%). Certain medical services also were offered by SEPs, including counseling and testing for HIV (96 [81%]) and hepatitis C (66 [56%]). Vaccinations for hepatitis B were provided by 46 (39%) SEPs, and hepatitis A vaccinations were provided by 43 (37%). Thirty-four (29%) SEPs offered other on-site medical care." (CDC, MMRW) Through the time that SEP's have been open more services are being offered as more needs arise. When people began to realize that medical care was an important need in the IDU community, medical clinic hours began to take place. A need that has

arisen is legal advice. The IDU community is a constant target of police harassment, brutality and ongoing citations. The people trying to access syringes have the struggle of making it past illegitimate police questioning or stopping in order to access what is proven as an effective form of HIV and Hepatitis C prevention.

Chapter 3.

A. Drug Laws and Other Relevant Ordinances affecting Drop in Center And Needle Exchange Participant

Over the counter syringe sales is something that is still evolving, was approved in California in 2004 (Padmanabhan, "Syringe sales bill still a touchy issue," Sacramento Bee.) and is approved by each county in the state, while syringe sales are still prescription only in many places it is difficult for injection drug users to access them, and syringe possession is a limited law. The law is Senate Bill 1159, or SB 1159 and is temporary until December, 2010, at which point there is a meeting of public health officials who will assess the use of this law so far. SB 1159 states that any individual over the age of 18 can carry up to ten clean syringes from a legitimate source without a prescription, any amount of used syringes as long as they are containerized safely, and the containerized syringes can not be used as evidence of drug residue for prosecution purposes. This law basically is the most dramatic law made to protect the health of drug users. The complications include most people who may have syringes on

their person could have the drug they were using, which then police could use against them, or many police still do not know the law, and continue to penalize b old standards. This law has been in effect since 2004. In Santa Cruz County public officials passed the law saying that over the counter syringe sales would be acceptable except in Santa Cruz “proper,” which turns out to be everywhere in Santa Cruz; leaving the Rite Aid in Aptos as the only pharmacy in the county. I became curious about why this is and who it was who passed this local legislature, so I asked my supervisor. Gina informed me that she had asked County Officials who denied having any authority over it, saying it was City Officials, the City Officials then told her that it was County Officials, who denied it again, so she went to the County Health Department, and they too had no answer.

In the US prostitution is illegal (CA penal code 653.20) and many sex workers are at risk of prosecution, and access to condoms is also limited. In Santa Cruz County the Latino population has 63% of the infection rate but is only 27% of the population, being disproportionately infected (Goodfriend and Van Hon, HIV/AIDS in Santa Cruz County). These risk groups are being targeted for outreach, which has the goal of trying to change their risk behaviors. It is important to offer people who do participate in high risk behaviors information and access to things that can keep them safe from transferring fluids. Because of the high risk groups and the behaviors that are directly associated with them, we can see what the behaviors are for IDU's, MSM's, and sex workers.

Chapter 4. Legal System and Drug User Entanglements

A. Impact of this system- examples

On any given evening at the Drop in Center as a volunteer I will hear many stories of interactions our participants have with the police and other organizations. There was one woman who had so much to share with me that I could only write out some of the whole conversation. The stories that she shared illustrated some of the problems people have within our legal system and even more. As a person she was denied medical treatment and the legal system provided her with little to no support because of her physical appearance, personal background and lifestyle choices. Despite her choices to inject drugs, and be a commercial sex worker, she voices her concern and desire for another life. She shared with me the fact that she wanted desperately to not live on the streets anymore, to have a home, and she was excited about getting treatment, but all of those things were a life out of reach due to the structure of the legal system we have.

As Laurel* enters from the street all she can think of is how nobody will talk to her and where she will sleep tonight. She cannot sleep on the streets anymore because last year she was raped three times, this is only an example of the dangers she faces on the street, not even the fact that it is illegal for her to be out there as well (SC ordinance 6.36.010). Of the

three times, they were all dismissed by the District Attorney because she has previous charges of drug use and prostitution. The charges she has are unrelated to her rape, but are true. The cops came while she was being raped, it stopped the rape, but the person was never charged. Incidentally while she tries to press charges she gets into more trouble with the law, while trying to bring charges against the person who raped her. She had already paid for the hotel room that she was sleeping in; her friends kicked her out though and would not give her her money back. In the event that something happens to Laurel she has no one to call for help. She cannot call the police or she will be the one who gets in trouble. She is exempt from any assistance from the law, but instead becomes the offender. Confused, frustrated and with no where else to go, she comes to the Drop-in Center. She is in her late twenties with light blonde hair, blue eyes, about five foot five, and her name is Laurel.

We have made it to the clothing corner and as she sits down I sit near her. She says, "Oh, well I lost my brush, do you have a brush here? Oh and my socks, I really need new socks." She begins to lift up her pant leg exposing an extremely swollen ankle riddled with sores and abscesses, she winces once they are exposed and because there is so much skin missing. I can only imagine the pain she is in from having exposed flesh. Abscesses are a common physical ailment of injection drug users as a result of their injecting. Once the needle pierces the flesh

it leaves an open wound, and that wound can often become infected and develop into an abscess.

She explains why she needs socks, “Since I don’t have any my feet stick to my shoes and they rub the wrong way. They usually break open the sores I have already and then they start bleeding. See these ones here I get from injecting into my foot. I don’t have any veins anymore so I have to find new places everyday. Socks would be really nice.” The best way to treat abscesses is to first stop injecting into the abscessed site, second keep it clean with antibiotic soap and ointment, and put hot compresses on it as much as possible keep it covered with a band-aid if being active, but give them enough time to breathe with air. Ultimately any abscess should be treated by a doctor because an abscess can be a symptom of more severe illness. I casually try to explain how to treat her abscesses, however, proper treatment of any sores on her feet are going to be extremely difficult to treat. The best advice I can offer her is some antibiotic ointment packets and I tell her to apply them to the most painful spots. We really do not have enough antibiotic to give her that would actually cover the amount of open sores and abscesses she has on her body. She would have to be off her feet, with no shoes on, to give them air, and proper antibiotic treatment, all of these things are not really an option for someone living on the street, she needs her feet. Her feet are her way of transportation, they are the emergency exit in situations that constantly need to be evacuated, like when the police might roll by, or if

someone is trying to steal her stuff, or if someone is just being cruel, which she describes later.

As she talks about these abscesses it reminds her of others. She can tell I would like to help her and that I am listening, so she continues, “How does this one look?” She asks, exposing a large abscess on her neck and then explaining what happened to her head. On her forehead is a wound that looks like it is healing, it is still fairly fresh and the hair won’t grow back she says. The wound on her neck is quite large and still open. I explain to her once again how to clean them and that it is also very important not to pick at them, because they won’t really heal if you pick them off every day. As I am saying this she starts picking at her arms, which is full of abscesses and says to me, “I can’t stop picking at them, they are so gross. I just want to get them off of my body, so I try to rip them off. I squeeze them to get the puss out.” She continues to pick and squeeze at the various places on her body that have lost skin, mostly due to her injection use. I respond, “I know it’s hard to not pick, but they really won’t heal if you don’t. I do it all the time when I get scabs and stuff. You just want to rip it off, but that will make it keep bleeding.”

The idea that her abscesses probably won’t heal is sad to me, because if I have a wound I know I have the option of letting it heal. She does not have the option to clean herself on a regular basis. I realize now that the wounds on her face are from abscesses, and from her need to

continually pick them off. I can think of a modified way to let them heal, but can they heal if she picks at them? Well, anyway, I give her antibiotic ointment and tell her to apply it to the most painful ones as often as she can, and that might help at least relieve the pain. In my mind I am thinking of the other issues this might lead to, an overwhelming, almost epidemic outbreak of MRSA, has been occurring in the injection drug using community leading to death in some cases. MRSA is Methicillin Resistant Staphococcus Aureus, commonly know as drug resistant staph infection. This infection is spread by internal exposure to the bacteria which is on most surfaces. Washing hands, general hygiene, and covering open wounds can reduce the spread of this. Laurels lack of access to hygiene supplies and her case of multiple abscesses puts her at extreme risk for MRSA, which in many cases, if untreated, can lead to death. Necrotizing Fasciitis has also occurred in the area, which starts out much the same way, but leads to serious nerve damage and is commonly known as Flesh Eating Skin Disease. Both of these have the same symptoms, they start out as abscesses or bumps that grow rapidly and are painful.

I ask her if any of her abscesses have grown in size or if they are the same, she knows exactly why I ask and replies. "No, these ones are all the same size, that one has grown a little." She points to one by her neck. "I probably have staph infection. I got drug resistant staph last year and they treated me for it. But I will probably get it again, with all these abscesses." These are all just points of hygiene, I advise her to seek

treatment and tell her about HPHP, the Homeless Persons Health Project.

. Then begins the next story. “Last year I had two strokes and they helped me a lot. [the doctors] I had to have valve replacement and I am supposed to have it again this year or I will die. But when I started looking for treatment no hospital would take me, and one nurse told me I didn’t deserve it because I was a junkie. They all say I am too much of a liability.” She thinks about this for a minute.

The next story she begins to tell me about is that she wants to get methadone treatment and stop using drugs. Once again, she is familiar with the resources in town, or more accurately the lack of resources in town. She had received methadone treatment three times last year, “...I was finally down to ten milligrams every other day, almost clean. And I was looking for housing when the cops picked me up, they found a warrant that was [for] \$5 I couldn’t pay for court fees from something else. After they took me to jail I had missed a couple of my methadone treatments and was going into withdrawals. My dad called when I was in and asked if I wanted to come home, that was so nice of him. I really want to go home...but he wants me to go get treatment and I don’t think they would accept me again. And then when I called him after I got out, he wouldn’t call me back, and he wouldn’t answer the phone. All I want to do is go home, I don’t want to sleep on the streets anymore.” She was almost clean and then the police interaction prevented her full recovery.

The methadone treatment programs in the area have an eligibility requirement that most of the population of injection drug users cannot meet (Question asked on surveys done at the Drop in Center: Have you been denied access to methadone treatment in the past twelve months? Most answer yes.) One of the requirements of methadone treatment include being physically ill in withdrawal upon arrival to a facility. Another requirement may be having financial support for treatment which many people do not have, and one of the largest issues that are debated in methadone treatment programs is the amount of methadone offered to individuals. Heroin addiction can be very specific and differ from one individual to the next, therefore, individual analysis and treatment is necessary. For example, if one person has a regular opiate dose of twenty milligrams every eight hours and another person averages forty milligrams of opiates every four hours it would seem obvious that the two should have different dosage treatments. In Santa Cruz many treatment programs offer a fixed amount that is given to all opiate users seeking rehabilitation. This idea has been deemed ineffective, even by the government, but is still practiced. “Despite compelling evidence that doses need to be determined on an individual basis, that higher doses are more effective, and that doses of 60-120 mg/day are required for most patients, some clinics administer fixed doses to all patients and provide less than optimal doses.” (CDC website. Accessed 3/8/08) The point Laurel had made about being on ten milligrams every other day is clearly

close to full recovery when the CDC recommends 60-120 milligrams a day as effective. The dosage that she was receiving could have been one reason why she relapsed into heroin use. If Laurel was not getting the amount of methadone she should have been receiving she might have been having severe withdrawals making it harder for her to resist heroin.

“I can’t work without using something. I couldn’t imagine doing what I do without being high on something, you know. I think too much, and then I think about why I don’t want to take dates, but I don’t know what else I would do. If I thought about my work I would probably just try to kill myself. I can’t handle doing this without using, and most of the time people pay with drugs. But there are good things about my work too. I know all of the regulars, and some of them are really good to me. The Johns around town will give me like a hundred dollars for a quick blow job you know, but some of the ones I don’t know will try to beat me pretty bad. One of my Johns would buy me diapers and stuff when I just had my baby. Those are the kind of relationships you can build.” Laurel is a commercial sex worker, also known as a prostitute. The term “commercial sex worker” is used in HIV prevention work because it takes away any degradation that “whore” or “prostitute” might have associated with them and tries to make sex work empowering and a choice.

As she left the Drop in Center she had a smile on her face and looked like she had just shed so much weight from herself, she was standing up straight, holding her belongings with strength, and she was

okay with leaving, not like she was holding on to anything, but that she was ready to go on with the night. As she walked out the side door, it was just a casual walk, we both started walking over there, not one leading the other, but she had clearly gotten what she needed. Stepping through the door she had a huge smile on her face, and she looked at me and said, “Thank you so much. I feel so much better. Thank you for listening to me, I really appreciate that.” I smiled back at her and waved from the side door. “Thanks for coming in, I really enjoyed talking to you. If you ever need anyone to talk to you can always come back here. Everyone here is good at listening.”

This woman “Laurel” was living her life the way she knew how. She had recounted more than one story of how she had sought to change her position as a homeless person, and as an injection drug user. Due to her situation she was illegal, as a sex worker, as an injection drug user, and as a homeless person. The laws that restrict her lifestyle from being legal such as, sales of sexual encounters (Federal Code Title 18, CA penal code 653.20), possession of paraphernalia or substances (Federal Code Title 21 USC, CA Health and Safety code 11000, et seq. 11350), and the “homeless” ban in Santa Cruz (Sleeping Ban, Blanket Ban, and Camping Ban, SC ordinance 6.36.010) are the very laws that put her at even more risk of danger. She is in a higher risk group of contracting HIV due to her sex work than someone who is not. Because of state regulations it is harder for her to work safely, if she is in a situation where someone is

attacking her and she needs to call the police, that is not an option. Even her general legal rights to press charges against someone for rape seemed to be taken away from her because of her work.

The most common reason for people not having a syringe to exchange is that the police busted them or raided their house and they do not have anything to exchange because it was confiscated. On certain occasions there have even been stories of police going into individual biohazard containers to retrieve used syringes to press charges for possession with evidence of residue and paraphernalia. In those situations it is illegal to go into someone else's biohazard, and just not a good decision. The police do not know if that person might have a contractible disease or where the syringes came from, and could get accidentally stuck with a needle. All of these encounters are contrary to the law in effect by SB 1159.

The stories I hear at the DIC are mostly in regards to people wanting to change their position, talking about how they want to get into a rehabilitation program, see their kids and live normal lives. Generally our participants are incredibly nice, we have good conversations, and they are thoughtful, insightful people who have jobs, kids and homes. When I talk to people unfamiliar with the people in the IDU community often they are referred to as "junkies" thought of as the homeless person who may be harassing someone like in so many of the movies we see. On the

contrary, IDU's are people just like everybody else, trying to make it through the day. Perhaps their problems are different because many may be in need of shelter, legal advice and rehab help, but they are still people. When participants have offered to tell me their troubles or stories, so far I have not heard the argument that they want to be in that position, though that is also possible. I recently had a conversation with someone about the homeless community and how it can be voluntary. There are some people who may wish to be homeless, but the many of the people I work with so far have not told me how much they like living on the streets, generally people want to live in homes, but just do not have access to that.

Chapter 5.

A. Overall Analysis and Conclusion

What scholars stress in the history of HIV prevention work is how the different demographics have been affected. The history of HIV/AIDS is about each different group struggling to get recognition and access to the information and treatment that is offered and denied to the high risk groups. Because HIV started as Gay Related Immunodeficiency Disease and was thought to only affect gay men, it was first the homosexual community that fought for access to healthcare, research to be done, and a breakdown of homophobia. Leading the way for other health rights, other communities began showing infection rates, and when it was understood how HIV is transmitted, the other communities began to fight

for recognition and a better approach to HIV prevention and education. Many scholars (Stoller, Hunter, Friedman, Curtis, and others) have pointed to the problem of each group struggling with infection rates after they begin to rise. By confronting the issue after the infection rate begins to rise, perhaps prevention could slow the process and keep infection rates down. This idea points to the problem of prevention, why do so many groups not have access to preventative information or outreach? As one result SEP's were created.

When it was first realized that HIV could be prevented by using clean needles when injecting, people responded by providing needles to injection drug using communities. The need for clean needles created syringe exchange programs and studies supported the fact that SEP's were going to be a new form of necessary health programs. Political issues continued to get in the way of operating needle exchanges (Lane, et al), such as, funding, community awareness and support, and laws. The laws that have become a barrier to accessing clean needles and how the police have chosen to interpret these laws has become a problem for HIV prevention work and needle exchanging.

The amount of services and respect that get denied to injection drug users is unacceptable and inhumane. I write this after hearing of a woman who was denied treatment in an emergency situation because she had used heroin. In an emergency room where medical treatment is being sought the people had no problem denying "drug users" care, she then ran

out of the room yelling about how much she wanted to kill herself. After decades of being criminalized and marginalized by society the struggle is now to humanize a population that we have defaced. IDU's are not "junkies" on the side of the road in the dark, where we forced them to be. These are people like you and me, brothers, sisters, mothers, fathers, cousins, aunts, uncles, etc. Most people, no matter how opposed to injection drug use or anti drugs, if their close relative is an addict, or shooting up, they probably hope they are using clean needles, they probably hope they are getting the care they need as a human, not being denied treatment and left to freeze in the cold or die from MRSA, which is where they are now.

A. Further Recommendations

An effort to raise awareness in the community would be ideal, and to get the support of our neighbors to diminish the stigma that currently cut off the IDU community from a normal life. One aspect of equality that we can work on is the law enforcement agencies in town adhering to policy regardless of IDU status. That action has however proved to be something more difficult. In a conversation with the chief of police by SCAP's Education and Prevention coordinator he said he would respond when the community asked for a response, but was clearly opposed to any collaboration with the Drop in Center or SCAP. Our participants are very much a part of the community, and his statement neglected that fact.

That was the response that was just for a request to not harass our participants. Due to this response there needs to be an alternative, if we can not advocate for our participants by the easiest means of just asking the police to follow the law and be cordial, then we should have another form of support for our participants while this continues to take place and make them feel uncomfortable in their own community. While the law does state that people possessing illicit drugs are in defiance of the law (CA Health and Safety Code 11000), under protection of the law as a human we are entitled to the same rights of search by consent or with a warrant (unless limited by probation or parole). If a person is over 18 they are legally allowed to possess up to 10 syringes. Also, the sleeping ban is a violation of human rights in the United States of being able to fulfill a basic human need.

In Los Angeles, the sleeping ban which was similar to the Santa Cruz sleeping ban was overturned in 2006. The lawsuit was headed by the ACLU of Southern California, and was officially ruled as inhumane by the federal court in 2006. Interestingly, the ACLU chapter in Santa Cruz which is mildly involved in the sleeping ban has not taken serious action regarding the sleeping ban. The list of board members of the Santa Cruz ACLU chapter was surprisingly similar to the list of City Council members, many of whom have been historically in support of the sleeping ban. The work that needs to get done is advocacy work, because most of the time when a participant tries to stand up for themselves in the community they

are slandered as a “drug user,” a “junkie,” and sometimes a “bum.” If our community will not provide the resources to guarantee equality to all of our community members regardless of their using or homeless status, then something must be established.

There have been a few lawyers and organizations that have began advocating for the homeless in Santa Cruz, but finding people has become difficult because in the past when people have fought their sleeping citations they have been later targeted by the police for further harassment. Many participants at the Drop in Center complain of being constantly exposed to the police in the streets if they are homeless, or being targeted as an IDU. Many more participants have personal relationships with the police and the police often know and will harass people for possession or even so much as being under the influence in public, without any probable cause aside from knowing an individual is a user. This problem leads to countless citations and recidivism without the opportunity for the individual to get free of the personal stigma and without the right to be in public without getting questioned by the police for legitimate purposes.

If there were a lawyer or group of advocates that could cite codes and laws that would protect our participant’s rights we would be able to raise awareness in the community, and be able to offer support and rights to our participants. In one month if we could record the number of complaints and violations of individual’s rights and publish that in the news

we might be able to get some support from the community or at least get the message out there. Other organizations have been able to lessen stigmas in certain communities by offering legal advocacy and training programs. The Walnut Avenue Women's Center was able to set up emergency response rape advocacy program which supported women who had been raped and were reporting it police. Previously, the police did not have the most comfortable rape response reporting methods. This program is still in effect and offers a legal advocacy program which helps women in the court system file restraining orders, press charges of abuse, and child custody issues. Their program trains individuals in specializing in certain legal issues. Also, they train their advocates in liability and the extent that they can be involved, they too have strict confidentiality policies that they adhere to. With the support of the community and the Drop in Center a legal program similar to that of the rape advocacy could be started for IDU's. With a legal advocacy program local struggles could be lessened and community awareness could be raised. The implementation of a program would make participants of the Drop in Center feel more comfortable, thereby accessing the services they need more frequently which will increase their health. Hopefully there will be this program available soon.

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Ordinances and Laws:

14. Santa Cruz ordinances: 6.36.010. The sleeping ban, camping ban and blanket ban take place between the hours of 11pm and 8:30am. Under this ordinance no person is allowed to sleep in a car or public place, be wrapped in a blanket or use any form of

temporary shelter. Immediately after this ordinance took effect six homeless people died from hypothermia within one year.

15. Title 21 USC with amendments, federal drug possession code. Any schedule I drug is punishable by 1-5 depending on amounts of possession same restrictions are held for cocaine and heroin possession.
16. Title 18 USC with amendments. Federal Prostitution regulation. Sales of any sexual behavior are punishable by arrest and citation.
17. California penal code section 653.20-653.28 prostitution. Official state penal code regulating sales of any sexual conduct, which also include loitering with intent to sell sexual acts, soliciting of sexual acts, and “pimping” or receiving any amount of money for sexual sales.
18. California Health and safety code 11000, et seq. 11350 drug possession. The state restrictions of possession of illegal substances under federal drug schedules. Schedule I drugs have the same amount of time for imprisonment, an average of 1-5 years for under a gram. Over a gram of possession is punishable by 5 years plus in state prison for intent to sell. Also limits the restrictions of possession to harsher penalties if found in certain areas, such as, within 100 feet of schools and public parks.
19. Drug scheduling by the DEA: taken from the DEA website.
<http://www.usdoj.gov/dea/pubs/scheduling.html>