

NEEDLE EXCHANGE AND HIV PREVENTION IN A SMALL CITY: A GUIDE

Santa Cruz Needle Exchange Program
Santa Cruz AIDS Project
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Introduction

During the mid 1980's, many cities began developing responses to the alarmingly high rates of HIV infection among injection drug users (IDUs). In San Francisco, for example, Bleachman began distributing bleach kits to drug users. In New York, a battle waged over the location of a new needle exchange. In Tacoma, IDUs began exchanging old syringes for new ones. In Liverpool, people started talking about reducing the many harms associated with drug use. From these beginnings, many communities have responded with the same message: Needle Exchange Saves Lives.

As of 1996, there were 113 needle exchange programs in North America. Many of the 113 programs operate illegally and without funding. The small Central California Coastal town of Santa Cruz, for example is home to both a community health outreach program targeting injection drug users and a needle exchange program.

Both the Santa Cruz Needle Exchange Program (SCNEP) and the Community Health Outreach Workers (CHOWS) of the Santa Cruz AIDS Project (SCAP) were founded in 1989. The programs work together to create HIV prevention and broad based harm reduction programs for injection drug users.

At SCNEP and SCAP, we often hear about innovative IDU focused programs in large urban areas, yet it is difficult to hear from smaller programs. The intention of this booklet is to describe how one small city has implemented politically fragile, under-funded, and illegal programming. We also want to show what our successes and stresses have been and continue to be. The goal of this booklet is to encourage people in other California communities to begin life saving work in their small towns and cities. If you live in a community that does not have an effective outreach program, and you want to start one, you do not need to reinvent the wheel. Communities across the state have information and experience to help make your work easier. We hope this is helpful in getting your new program started.

Brief History & operations of IDU Programs in Santa Cruz

The SCAP Street Outreach Program began in 1989. It is based on a realistic understanding of the demographics of the HIV/ AIDS epidemic and the concrete HIV prevention needs of IDUs.

In 1989 a community member came forward with the commitment to reach people “where they are,” with the understanding that many individuals affected by the virus would never access SCAP services without non-judgmental outreach.

The Community Health Outreach Workers (CHOWs) program grew out of the intention to bring HIV, health care, and prevention education to hard-to-reach communities. CHOWs do this via regular street-based interactions with target populations such as IDUs, Youth, Latinos, and sex workers. CHOWS bring safer

sex, safer injection supplies, Needle Exchange referral information and general social service referrals to the streets of Santa Cruz County.

The Santa Cruz Needle Exchange Program (SCNEP) was also started in 1989 as a direct response to the needs of injection drug users who were accepting bleach and condoms from Community Health Outreach Workers in the Santa Cruz area. For the first five years, SCNEP, was run solely by volunteers, who have made needle exchange possible in Santa Cruz.

Currently, the SCNEP staffs approximately twenty volunteers whose jobs vary from staffing exchange sites to filling bleach and water bottles, from fundraising to making fliers and literature for distribution to participants. Volunteers come from all walks of life: U.C. Santa Cruz students, ex-users, current users, and volunteers and staff of the outreach program at the Santa Cruz AIDS Project.

Currently, SCNEP offers exchange sites six days a week at various locations in the Santa Cruz Area. In addition, we offer home visits on Mondays and Thursdays. We exchange between 10,000 and 12,000 syringes each month to approximately 1,500 to 2,000 combined direct and indirect contacts. We see a broad range of age groups, genders, and ethnicities; we place strong emphasis on outreach strategies targeting communities that may not be using the needle exchange.

SCNEP Primary Objectives:

- 1) To prevent the spread of HIV and other diseases such as hepatitis through contaminated syringes and other injecting equipment. This is accomplished through the exchange of injecting equipment and the distribution of information

on safer sex, safer injecting, HIV risks, health care, drug treatment and HIV testing information upon request.

2) To act as an advocacy group and resource for drug users. In advocating for the rights of drug users, our responsibilities range from offering referrals to taking someone to the emergency room and sitting with them. We do our best to make sure that participants are treated appropriately and with respect. We also offer a user's support group in conjunction with CHOWs called "DOPER" (Doing our Part for Education and Rights); as well as a methadone support group, and a Wellness Center which offers free massage and herbal remedies.

It is important to keep in mind that our primary goal must always be to provide a safe place for participants to exchange their syringes. We avoid coming on too strongly about drug treatment, HIV testing, and health care because it might discourage a participant from coming back. We do, however, build trusting relationships with participants in order to support all positive change.

The CHOW program has also operated a Drop-in Center since 1990. In 1996 the Center was opened as a collaboration between SCNEP, SCAP CHOWs, and the County's HIV Testing Program. Volunteers and outreach are coordinated through the Drop-In Center located across the street from Santa Cruz's transit hub which is on a main pedestrian thoroughfare for drug users and dealers. There is more to read about the Drop-in Center later in this booklet.

Volunteers

Both the Needle Exchange and the Street Outreach Program rely heavily on volunteer efforts. Since the inception of the programs, ninety percent of the contacts with participants have been conducted by trained volunteers. Trainings are held on a quarterly basis as volunteer turnover is often rapid. The average volunteer stays with the program only two months, while the core volunteers with the program stay longer than a year and take on a wide variety of tasks which support the program. Both programs have regularly scheduled weekly or bi-weekly volunteer meetings. At these meetings, outreach and site scheduling is conducted and on going training and volunteer support is provided. As volunteers are the heart of the program it makes sense to place a good deal of effort into volunteer development.

Often volunteers come to the program with limited knowledge of how prevention work is carried out within real peoples lives.

Trainings are two-day affairs which incorporate team building, HIV prevention, cultural sensitivity and Harm Reduction pieces. The first day is packed with information. After initially acquainting people, running over the agenda, and setting up the confidentiality parameters of the training and volunteer work staff proceeds to discuss HIV. An HIV 101 presentation is an hour in length and develops a base knowledge of epidemiology, prevention, transmission and social issues related to the virus. Next an HIV positive First Hand speaker, talks about his or her experience. This provides an opportunity for the volunteers to receive subjective information about the complexities of drug use, sexuality and HIV status.

After a break for lunch we conduct a Drugs 101 presentation in which the volunteers share their knowledge about drugs - how they're used, what they do, how much they cost, and so on. Finally, the last two hours of the first day are spent on presentation and discussion of drug policy history and treatment to provide a context for the work we do. Along with this segment is a presentation on Harm Reduction so that the volunteers understand the system through which we provide HIV prevention. While the first day is primarily lecture-oriented we do our best to encourage participation through sharing of knowledge, fielding questions and facilitating discussion.

During the second day, our goal is to involve new volunteers. Volunteers need to "own" the knowledge as soon as possible if they are to become effective and assured outreach workers. We do role-plays and conversation about the work we do and getting support while doing it. Ethics and boundaries are discussed and the harm reduction model is expanded upon.

Supplies

Once people have committed to giving their time, they need supplies for outreach and needle exchange. However, they are often expensive. Clearly, the most important supply is a good stock of syringes. Syringes and each of the other listed supplies can be ordered from either the North American Syringe Exchange Network Buyer's Club or Safety Works. Price lists and phone numbers for both suppliers are in the appendix.

- **Syringes:** Every community has its own favorite "point." The most common syringe is the B&D Insulin 27 gauge 1 CC (often called "hundreds"). The next-most popular is the BD Insulin 28 gauge 1/2 CC (often called "fifties").

Depending on the packaging, syringes run about 9 cent a piece. If you order from NASEN Buyer's Club, this price will usually include tax and shipping. Safety Works also carries syringes, but only Terumos and not the B&D brand. The gauge of a syringe indicates the size of the needle (the smaller the number the larger the point). The CC indicates the size of the barrel (the larger the number, the more the syringe can hold).

- **Biohazards/Sharps Containers:** Sharps containers also come in many different sizes. Often county health departments supply a portion or all of a program's biohazards. Many programs take what they can get from the county, and others buy from Safety Works or NASEN. Think about the size you need before ordering. If you will only be doing home visits you probably don't want a huge bucket to conspicuously carry around...many health departments also will dispose of the biohazards at no charge.

- **Alcohol wipes:** people usually grow to love these relatively cheap supplies. Using the wipe in one downward stroke before injection greatly increases needle hygiene and decreases abscesses.

- **Cottons:** These dental supply cottons are very important. If people do not have fresh cottons, the next resort is often cigarette filters or old bacteria filled cottons. Filters and dirty cottons can easily result in endocarditis a serious infection of the heart valves. Cottons also store bacteria and viruses, especially Hepatitis B and C and HIV. Fresh cottons will decrease infections.

- **Cookers:** Cookers are often shared and used repeatedly. Cookers also can store bacteria and viruses. The cookers are just very simple bottle caps.

- **Baggies:** You can get baggies in many different sizes. They are great for making IDU packs (wipes, cookers, cottons, literature, bleach, water, condoms, antibiotic cream).

- **Bleach and Water Bottles:** There still is a demand for bleach. Distilled water is a better option than toilet water.
- **Antibiotic Cream:** Cream is great for preventing topical infections. Very expensive but people love it.
- **Condoms:** People often get used to a particular kind of condom and may get discouraged when they are not available, so it's important to have a consistent variety.
- **Latex gloves:** Good for safer sex, and/or try to have something available, mint condoms to cut open, saran wrap, or dams.
- **Hygiene products:** Having little perks like shampoo, soap, razors, toothbrushes, and lotion really draws participants into the program, and makes people feel better.

Distribution

Where do volunteers give out all these supplies? Several methods are employed in Santa Cruz. We do needle exchange via home visits and fixed outdoor sites. We also do a lot of street outreach and we utilize the Drop-in Center. Each method has its own strong suits and rules. The following will discuss how we do our work in various locations.

• **Home Visits:**

The following home visit information is adapted from the SCNEP volunteer training manual:

Participants prefer home delivery for various reasons. Often they do not feel comfortable coming to the site for fear of being seen or arrested. Some of our participants have children and cannot take them to the site or do not have someone to leave them with while they come the site. Therefore, our home delivery service is extremely important for reaching participants who would not otherwise be able to exchange, particularly women.

The home delivery team consists of four volunteers who go out in teams of two. Volunteers call the established SCNEP voice mail number to obtain the name and address of the participants who need to exchange and add them to their regular route. When we walk up to the door, we never allow anything to be exposed (Sharps containers, syringe box, and so forth.) When SCNEP knocks on the door of a new participant, we confidentially identify ourselves (“you left a message to come by, we talked on the phone, I’m ___ with the program...”). We never say we are from needle exchange because we do not know who knows about the participant’s drug use. After our initial contact with the home delivery participants, we begin to use our own names when knocking on doors.

Once we’ve been invited, SCNEP establishes rapport with the participant. When the participant is ready, have her/him count their syringes into the sharps container. Sometimes new volunteers are concerned with their safety when beginning home visits. We follow a few rules to stay safe:

- We don’t touch the container while syringes are being counted in.
- We don’t touch used syringes.
- If we ever feel, for any reason, extremely uncomfortable, or that there may be in danger, leave the house.
- We don’t jeopardize our personal safety or the safety of a participant.

Although we have never had a safety problem, it is important to be alert as a situation could escalate in a matter of minutes.

Delivering syringes to participants with young children in the house can sometimes be difficult. The child knows that there is a stranger in the house and

will sometimes react. In order to avoid confusing the child and distracting the participant from exchanging, one volunteer should interact with the child while the other volunteer works with the participant.

• **Fixed Sites**

In addition to home visits, SCNEP also operates fixed sites six days per week. Finding and maintaining sites has been extremely difficult. There can be tension from non-users who don't understand and/or believe in what is going on and from drug users who do not yet trust the program. We have found that a few things help to establish a successful site:

- Because non-IDUs will probably not know what is going on, and may think volunteers are dealing, it is helpful for volunteers to talk to people who pass by.
- Give anyone that is interested (IDU and non-users) condoms and shampoo to help get buy-in.
- The important thing is to be consistent: be there when you say you will be, people will get used to it quickly.
- Try not to be distressed if it is very slow or no one shows up. It is very difficult to build trust in the IDU community.
- Remember that the beginning work of attracting people into needle exchange is the most difficult, least honored, and probably most important. • Try to have a team of regular volunteers staff the site. Or, if the team needs to change, something else recognizable, like a green supply bag.

The following site information is adapted from the SCNEP volunteer training manual

Eventually, many participants will come to the site regularly; some come monthly, and some come only once. Volunteers become familiar with the "regulars" and come to know them by name. It is important for volunteers to be

friendly to the participants and let them know that their needs are important. When possible, volunteers should start a dialogue with IDUs about subjects both people feel comfortable talking about; i.e., their family, job, the drugs they are using or how much they are using, and so on. Reminding people that their well-being is important, they are protecting their lives and the lives of members in their community by utilizing the services of needle exchange.

For many IDUs, needle exchange volunteers are among the only non-judgmental people in their lives. Injection drug users are stigmatized by society and the legal system. Consequently, they may have limited access to other service providers. Therefore, as needle exchange volunteers, we are in an ideal position to do a more effective intervention. Participants will often request information about programs for kicking, HIV testing, housing, domestic violence, and so on. Thus, it is important to become familiar with the various resources that are available to members of this community. It is important that volunteers give correct information and are honest and ethical. IDU programs are there to help, not to buy drugs, have sex, or otherwise confuse the program's purpose. We take the needs of participants seriously. For example, SCNEP asks participants if there is anything they need that we are not providing. We must utilize knowledge of their problems and concerns from their perspective. SCNEP also encourages participants to become active in needle exchange, Many participants have expressed an interest in becoming volunteers. Participants are often better able to reach the IDU community . Their knowledge and input is extremely important and should be utilized whenever possible. Needle Exchange sites are a great way to build community and get to know regulars. A site as more than an exchange assembly line; it is really a gathering place, try to take an advantage of it.

• Street Outreach

Outside of exchange, it is also important to have a presence on the street. Street outreach is both the simplest and hardest thing to do. Since it's hard, we always go out with a partner. Since it's easy, we try to have fun. First, partners do a bit of walking around in the neighborhoods we plan to work in. Which are the busy street corners? Where are the dealers? Where are the Sex Industry Workers? Where are the liquor stores and bars? Maybe we'll meet some people, maybe we'll even find a few people who want to volunteer from that same neighborhood. If not we move to what's called a cold call.

To do "cold calls" on the street CHOWs need is a bag full of goodies. That means whatever is helpful in getting out the inf. and at the same time providing something useful to the people in the streets. Bags usually contain condoms, bleach, cookers, lube, alcohol wipes, needle exchange and HIV info etc. Sometimes when we're flush we have toothpaste, food, and stickers for the kids, too.

We start by just walking around the streets. We get to know some people. CHOWs don't need to get anything "done" the first couple of times out. After awhile people will come to see CHOWs as a regular part of the neighborhood and start requesting things from us and asking questions. That's what CHOWs work for - providing participant centered service. Go back at least weekly to the same neighborhoods. If CHOWs try to go everywhere we'll never get anywhere. CHOWs can only get to know and be useful in so many neighborhoods. CHOWs should be prepared to talk about whatever comes up i.e. - needle exchange, the police, abscesses, drug use, rehab, death and grief, HIV, yourself,

and so on. By doing outreach you will start building trust within IDU communities which may lead them to access needle exchange. Since street outreach requires a lot of stamina and energy, we usually don't go out if our energy is too low.

- **Drop-in Center**

The Drop-In Center was established in the summer of 1990 in response to repeated requests from participants of the Street Outreach program. The community recognized the limitations of doing outreach on street corners, for example, limited privacy, weather problems, and lack of a meeting place. The CHOWs solicited SCAP support for a more comfortable, safe, intimate meeting place. The Drop-in Center is a collaboration between the CHOW program, SCNEP, and the County's HIV testing program. The center is open from about 12-6 Monday through Friday. Two of the days are open to the whole community, Thursdays are Youth hours and Fridays are Women's hours. One day a week there are structured art activities provided for participants.

The Drop-in Center started as a project of the CHOW program. It was a volunteer run, sporadically scheduled, space in a low-income neighborhood a one mile walk from downtown. The Drop-in later moved to a former hamburger shack near the transit center.

Today, the Drop-in Center is housed in a large storefront space. The Drop-In Center is intentionally designed like a welcoming living room in order to encourage participants to self-identify as co-owners and creators of the space. Whether participants use the Drop-In Center for a nap or as a place to develop their social and living skills through participating in the volunteer programming

and training, they become partners in the Drop-in Center community. The Center has office space, and rooms used for the Wellness Program of SCNEP, HIV testing, and a large front room for general programming. The Drop-In Center allows for more in-depth interventions than are generally possible at the street level.

At the Drop-in Center, CHOWS are able to establish continuity and confidentiality while building trust with the participants- elements essential to the case management that these long-term relationships demand. The Drop-In Center allows CHOWs to increase incentives for participation, thereby encouraging outreach target groups to develop more regular and intensive relationships with the CHOWs. Incentives include pizza and videos to attract young IDUs, a public access phone that allows for immediate processing of referrals to shelters or drug treatment centers; and clothes. All these incentives allow CHOWs to make crucial initial contacts under the umbrella of HIV prevention services or, at least, encourage a second visit.

As an extension of services, we also now offer HIV testing twice a week by the County's Alternative Test Site program. This collaboration with the County Health Services has provided us with more funding and legitimacy. The Santa Cruz AIDS Project and Santa Cruz Needle Exchange are co-sponsors of most of the services provided, again helping supply the program with increased resources.

- **Zines**

Along with outreach, needle exchange, and the Drop-in Center, 'zines help inform IDUs and create community. A group of volunteers from the Santa Cruz Needle Exchange began to conceptualize and produce the publication "*Junkphood*" approximately two and a half years ago. This publication has been produced with virtually no resources.

The first phase of *Junkphood* was to come up with a mission statement about the goal of the 'zine. SCNEP began asking participants from the needle exchange program to submit artwork, poetry, or their story about why they use the drugs they use. The first series related to three specific drugs; heroin, cocaine, and amphetamines. Because most of the users did not want to write their experience down, volunteers conducted interviews. The information in the interviews is very personal, very intimate, and sometimes, very intense. While the covers were designed in the spirit of recognizing cultural icons related to injection drug use, the stories differ in that they illuminate both the positive and the negative experiences and injection drug user can have. In almost every situation, we would just set up a tape recorder and talk about whatever the person wanted to talk about. SCNEP wanted *Junkphood* to talk about drug use in ways that could be helpful to others and help lessen the sense of isolation so many users feel.

Needle Stick Prevention & Protocol

Working with a needle exchange program is most often very safe. The chance of getting an HIV infection from even an infected point is very small, about .003. But who wants to be that rare exception? Though needle sticks are rare, it is wise to have a plan in order, should a stick occur. We can prevent sticks and minimize any harm if they do occur.

The following Needle Stick information is adapted from the Alameda County Exchange Training Manual:

- It is important that everyone working at a needle exchange site take the appropriate precautions to prevent needle sticks from happening in the first place.
- All needle exchange volunteers should get vaccinated for Hepatitis B and verify their antibody status for Hepatitis C. Tetanus shots should also be up-to-date.
- Volunteers need to wear sturdy closed-toe shoes and long pants; long-sleeved shirts are also recommended. Anyone counting syringes needs to use a pen or other pointer, NOT their finger.
- Everyone on-site also needs to be aware of where clients with syringes are and not sacrifice safety in efforts to be friendly. For example, if a volunteer is going to give someone a hug, s/he should wait until the participant has turned in their old syringes.
- Finally, the lids to biohazardous waste containers should not be removed under any circumstances once contaminated syringes have been deposited. Syringes should never be collected in any container(s) that are not biohazardous waste containers.
- If a needle stick occurs, everyone needs to stay calm and focused. The person who has been stuck needs to let the site coordinator know what has happened and collect the syringe they were stuck with, if possible.
- The person who was stuck needs to apply generous amounts of bleach to the puncture site immediately.
- Within 24 hours of the needle stick, the person who was stuck should have the following baseline lab work performed: HIV test, Hepatitis B and C antibody status (if previously unknown or negative), syphilis serology, CBC with diff, chemistry panel and pregnancy test (if applicable). The client whose syringe it

was should be referred for HIV antibody testing and have appropriate lab work done.

- A tetanus shot is also needed if it has been 5 or more years since the last one or the person doesn't remember when their last one was; they should also be vaccinated for Hepatitis B if they weren't previously vaccinated.

- In keeping with CDC recommendations, the person who was stuck should follow-up with regular HIV blood tests at 6 and 12 weeks as well as again at 6 months and one year.

- San Francisco General Hospital (415) 469-4411 operates a 24 hour needle stick hotline for any questions or concerns that arise.

- Anyone who has experienced a needle stick needs to make a firm commitment to safe sex for at least the first 12 weeks and up to 6 months after a potential exposure in order to protect their partners.

- Any flu-like symptoms (fever, chills, etc.) should be reported to a medical provider along with information about potential exposure, especially if these symptoms occur 3-12 weeks after the needle stick.

- AZT prophylaxis is recommended if the person whose syringe it was is known to be HIV infected, the needle stick was deep enough to draw blood or if the person who was stuck wants to use AZT.

- Biohazardous Waste or Regulated Waste must be handled and disposed of with special precautions. Biohazardous waste is defined as: 1) liquid or semi-liquid blood or other potentially infectious materials; 2) contaminated items that would release blood or potentially infectious materials which are capable of releasing these materials during handling; and 4) contaminated sharps (i.e. needles). For maximum protection, it is important to treat all blood, body fluids and unidentified waste as potentially infectious and dispose of these materials in the same manner as biohazardous waste.

- Biohazardous waste should never be placed with regular trash or in regular trash containers. Not only is this a violation of state and federal law, it is extremely dangerous.
- Any materials that meet the definition of biohazardous waste must be disposed of in the red biohazardous waste containers. This would include caps, used cotton, used cookers, plastic or paper bags used to transport used/contaminated syringes and any other item that might have come in contact with blood or other potentially infectious materials.
- When in doubt, have clients deposit items in the biohazardous waste container, not the trash.
- When clients drop items such as syringes, plungers, caps, etc. on the ground, the person counting syringes should ask the client to retrieve the item and drop it in the biohazardous waste container.
- Any volunteer who needs to pick up items left on the ground needs to wear latex gloves and deposit both the items and the gloves in the biohazardous waste container.
- Once the biohazardous waste container has been closed, the lid should not be removed under any circumstances.
- Anyone attempting to deal with the contents of the biohazardous waste container (i.e. law enforcement personnel) needs to be informed in no uncertain terms of the dangers involved and the proper way to handle regulated waste.

Funding IDU Programs

In Santa Cruz, we are fortunate that IDU specific programs have become funded. Early-stage IDU work is rarely funded, yet funding is necessary for the long haul the work requires. Establishing a sound financial base for an IDU outreach or Needle Exchange program is a process that can take nearly a decade,

so its best to start now. Fortunately, as of 1997 the data and models which support HIV Prevention services for IDUs exists.

Fund-raisers and major donor support are ways to kick-start a program, but fundraising through events can be very time consuming and major donor support takes some luck. What's needed first and foremost are connections. In 1994 the Centers for Disease Control directed all local areas that were receiving federal and state HIV Prevention funds to form consortia to establish funding priorities, evaluation of programming, and management for these funds. The individuals and agencies in the consortia representing the varied interests of prevention and often care shape the local areas response to the epidemic. It is often the single largest AIDS related community group in the locality. It is extremely important to participate in the local consortium for a variety of reasons. First and foremost to make sure that there is an adequate level of representation from the IDU community and secondly to begin to get to know the players within the local AIDS bureaucracy. Funding cycles for these monies vary from one to three years. Chances are that there are already established agencies competing for these funds.

However, these agencies may not be serving the needs of IDUs adequately. Participation in the consortium process will help see to it that funds are appropriately allocated. If no local agency is competently serving the IDU population it may be time to either talk to one of the currently funded agencies about building an IDU specific outreach prevention program into their Education and Prevention department and proposal or it is time to start doing the work yourselves and apply for funding to support it.

Throughout the consortia process, it is important to educate the consortium about outreach, IDUs and needle exchange. Also, it is crucial to build alliances with other communities hard hit by the epidemic, specifically Gay and Bi men. When it comes time for funding decisions, support from a variety of communities is necessary.

What gets funded? HIV prevention monies need to be spent on direct provision of prevention services. We think of these monies in more abstract terms than just syringes. Most consortium will probably be unable to fund direct exchange but may be able to fund support services such as outreach and prevention to IDUs including education at exchange sites.

To receive funds from many grant sources both public and private it is necessary to have a 501c3 or in other words non-profit status. Research the options. There may be an agency which can serve as the umbrella organization to receive funds for a new outreach program. This is called a "fiscal agent" and is fairly common. Usually, a fiscal agent charges a small fee (5% of the budget they handle). The Board of Directors of the fiscal agent agency usually needs to approve the decision, so it's a good idea to know the Board. Establishing non-profit status may take upwards of a year or more.

Many grant opportunities exist to fund HIV prevention services. There is a regional agency, the Foundation Center, which serves as a grant warehouse where you can look through many grant sources. Additionally, a lot of grant information can be had through on-line services or the public library. There are also classes available on effective grant writing.

Currently, in the State of California, no state or federal funds are available for actual needle exchange, so we rely on private foundations for much of our funding. Funding sources will usually provide you with the grant guidelines which can vary drastically depending on the foundation. The guidelines should specifically outline what program information needs to be included in your grant proposal, the total amount of money you are requesting, and a detailed program budget showing how you plan to use the funds.

When writing a grant, it is important to show how the funds will enable your agency to reach injection drug users, provide the necessary HIV education and prevention information and supplies, and make a difference in your community. The primary expenses of a syringe exchange program are the most important, including syringes, condoms, bio-hazards and syringe disposal, etc. Once the primary services of a program have become established and stable, it is important to take advantage of any opportunity to apply for additional funds to allow for special projects, outreach strategies, supplies (personal hygiene, etc.), and other ways to reduce drug related harm.

A few good places to start looking for resources: the North American Syringe Exchange Network (NASEN) which provides 10,000 syringes as a start up kit to new programs. NASEN also has a yearly grant program, watch for proposal deadlines in May. The Drug Policy Foundation (DPF) also funds needle exchange programs, they usually send out proposals in April. (See the appendix for more DPF and NASEN information.)

Finally, when applying for grant, think collaboration. Here's where relationships with other service providers come in to play. Collaborations can create

programs which encompass larger scopes than those of IDU programs.

Collaboration between agencies is often very attractive to funders and can be a source of strength and legitimacy for IDU programs.

Does funding a new IDU program sound like a great undertaking? It certainly is, but the payoff is huge when you consider the support necessary to slow the HIV epidemic within IDU communities.

Political Obstacles and Community Support

Getting IDU programs funded is a job in and of itself. Another big job is that of dealing with political obstacles. Many people are opposed to IDU work. Police, local officials, business owners, neighbors, and community groups have been known to attempt to block needle exchange. Community organizing is important. New needle exchange programs, rarely, if ever, are met with open arms. It only takes a few key people to protect the program. Think of where you have influential allies: is there a local university with a friendly professor; a director of a big agency; a politician; a health department employee?

•Law Enforcement

Resistance to needle exchange has been an ongoing issue in Santa Cruz. Starting from our inception in 1989, we have had to work with different opposition groups. In many cases we have been able to utilize influential allies to deal with current or potential problems. For example, the founder of both the CHOW program and SCNEP, Richard Smith, solicited help from John Laird (then Executive Director of the Santa Cruz AIDS Project and former mayor) in an attempt to ensure the safety of needle exchange volunteers and participants. Smith and Laird worked together in an effort to promote the importance of a

needle exchange program in Santa Cruz County. They stresses to law enforcement the importance of operating with as little resistance from law enforcement as possible. Laird was successful in that he was able to convince the chief of police to "look the other way" when needle exchange was being conducted. The Chief also agreed to put needle exchange "at the bottom of their list of priorities," which offered some sanction to needle exchange volunteers and participants.

Because needle exchange was operating in the same area that drugs were being bought and sold, there were several altercations with law enforcement. This ranged from officers pulling into the parking lot of the site, sitting in their car, and leaving their siren lights on, thereby scaring away participants and forcing volunteers to quit exchanging for the night, to forcing volunteers to empty out their outreach bags and counting how many syringes they had in their possession. None of these incidents resulted in arrests, probably because of Smith and Laird's work with the Chief. However, it did disrupt the consistency of the program because most participants became nervous about exchanging their syringes.

We have recently had difficulties with the Santa Cruz Police Department due to their ticketing of four needle exchange volunteers for syringe possession. After years of informal sanction, the citations came as a terrible surprise. Both the local health department and SCAP advocated in conjunction with SCNEP to have these charges dropped by the District Attorney's office. We also had national help in fighting the tickets from the Harm Reduction Coalition and the North American Syringe Exchange Network (NASEN). We took comfort in the knowledge that of the many people who have been cited for volunteering with a

California needle exchange, no one has ever been convicted of the charges. After much community and national organizing we were able to get the charges dropped. Although we were successful in our local efforts, needle exchange remains illegal in California, and thus no formal arrangement was agreed upon to ensure that ticketing would not happen again. We are working on training the police department and having regular interaction and discussion with officers. Because we do not have the formal sanction of police, organizing around this potential obstacle remains vital.

- **Declaration of Local Emergency**

Clearly, public support for politically fragile IDU programming is crucial. However, informal sanction is not always enough. Another way to get political support is through a Declaration of Local Emergency.

Declarations of Local Emergency are very important needle exchange tools in California. Declarations are typically used to side-step state law in an event of natural catastrophe. Examples of typical local emergencies include earthquake, fire, or flood. Local governing bodies, cities and counties, can declare an emergency. Declarations can then be used to suspend usual law to prevent further damage of the catastrophe (limitations on city worker time, use of public facilities, quarantine, etc..). San Francisco declared the first emergency in regards to HIV among injection drug users. San Francisco's emergency is very strong and even allows for city funding of Prevention Point. Declarations of Local Emergency have to be renewed every two weeks. Other governing bodies that have declared local emergencies include: Sonoma County, Marin County, San Mateo County, Santa Clara County, Santa Cruz County, City of Santa Cruz, Monterey County, City of Salinas, City of Berkeley, and Los Angeles County.

Organizing your local politicians to declare emergencies requires much community collaboration. County Board of Supervisors and/or City Councils must be lobbied about the importance of, and liability limits, of such an action. If your County Health Officer is supportive of needle exchange S/he may be the best person to lead the lobbying of individual elected officials. Otherwise any HIV Advisory Board member, Education Consortia member, or AIDS Project Executive Director may be a good person to take leadership. Start by identifying supportive Council members or Supervisors. Generally they will want to know that you are not asking for public funds to conduct needle exchange. You just want a way around paraphernalia laws as they relate to HIV prevention/needle exchange programs. Councils and Supervisors are the big boss for their police and sheriff departments; it is important to have the governing body declare an emergency so that the cops can turn the other way.

When the officials have been lobbied, that is, given needle exchange studies, a fact sheet about your program, and the County statistics on AIDS cases, you should then have a feel for your support. The most influential supportive official will be the best person to introduce the measure to the governing body. It is very helpful to have a supportive audience on the day of the vote. Dr. Peter Lurie, author of the major CDC sponsored study "Public Health Impact of Needle Exchange" has testified to many Boards on this issue. You can contact him through U.C.S.F., his expertise may persuade an unsure official or make it politically easier to vote yes.

Also, get good press. Try to find friendly journalists who will carry the story well. Declarations of Local Emergency can bring legitimacy to needle exchange

and highlight the issue in the press. Drug users may also begin using exchange when word is out that it is quasi-legal. Funders also like to see that a Local Emergency has been declared. A Declaration of Local Emergency should make needle exchange staff, participants, funders, cops, community organizations, and elected officials feel confident in their support of needle exchange.

•Neighbors

Working with neighboring communities where syringe exchange takes place, is also very important. Neighbors are a great organizing opportunity. One example of addressing their concerns resulted from a neighbor finding a syringe in her driveway. Her first response was to demand that needle exchange get out of her area. She reconsidered when we wrote letters to neighbors to address concerns about IDUs and syringes in their “back yard” and showed commitment to doing a clean up after each exchange shift.

Working with other agencies

In dealing with needle exchange opposition it becomes apparent who supporters are. As you get to know IDU needs for services more closely, a working knowledge of supporters within service providing agencies is necessary. We have tried to work with service providers through offering trainings to staff and clients. The trainings often include an overview of the harm reduction model, AIDS 101, Licit and Illicit Drug Use Information, a description of the services that SCNEP and SCAP provide, and a compassion based view of drug users (Drug User Sensitivity Training) as it relates to each specific service provider. We focus on providing trainings to law enforcement, teaching institutions, health professionals, halfway houses, alcohol and drug treatment centers, methadone

centers, and juvenile detention centers. In addition, we also train our volunteers and staff on a quarterly basis.

One training model that we are working on replicating is the exchange of trainings for services, i.e. a methadone detox slot in exchange for a Harm Reduction Training for the staff, or a treatment slot for a participant from our program in exchange for an AIDS 101 training for clients in their treatment center. For more information about exchange of training for services, contact the Monterey County AIDS Project CHOW Coordinator. Building an exchange referral system takes good trainings and good relationships with service providers.

Another advantage in providing trainings and in-services is that it is an excellent way to recruit new volunteers. For example, if we do a presentation for a class at a local community college or university, we are often able to make arrangements with the professor so students are able to volunteer with us and receive credit.

The following is an example of a proposed Memorandum of Understanding (MOU) between SCAP/SCNEP and the local methadone clinic to illuminate how the exchange of services can be implemented on a formal level.

Memorandum of Understanding

Participating agencies: The Santa Cruz Needle Exchange Program and Methadone Clinic.

Term of agreement:

This Memorandum of Understanding will remain in effect for one year from the date of signature by the Executive Directors or designees of each agency and can be renewed upon mutual agreement and signature of each participating agency.

For the purposes of this agreement, the contact person for the Santa Cruz Needle Cruz Needle Exchange Program will be :

*Sarah C. Miller, Program Administrator:
Santa Cruz Needle Exchange Program
138 Younger Way
Santa Cruz, CA 95060
(408) 429-9489*

For the purposes of this agreement, the contact person for Methadone Clinic will be:

The participating agencies agree as follows:

The Santa Cruz Needle Exchange Program will provide two in-service trainings each year to the staff of the Santa Cruz AIDS Project at a mutually convenient time and location. Each in-service training will last for a minimum of one to two hours and with topics including but not limited to:

Basic information about HIV and AIDS, including but not limited to epidemiology of HIV, statistics, modes of transmission and prevention, HIV testing, etc.

HIV prevention education as it relates to drug users, their families, and partners.

The Harm Reduction Model as it relates to both methadone and user culture. Drug policies, national and international, as they relate to local issues in drug treatment.

Issues relating to grief and burn-our of service providers. Other relevant informational seminars and trainings as agreed on by both agencies. Trainings will be designed in response to the needs and interests expressed by the staff at the Santa Cruz AIDS Project.

In exchange for in-service trainings, The Methadone Clinic will provide two free slots each month for their 21-day detox program. The terms for the free treatment slots are as follows:

The referral participant's progress and continuation in the methadone program will be the responsibility of the staff of the Clinic.

No effort shall be made on the part of the Clinic staff to collect any fees for these free slots.

Heather Edney, _____ Date: _____

Executive Director Santa Cruz Needle Exchange Program

Miscellaneous Person, _____ Date: _____

Executive Director Triad Methadone Services

• **The Harm Reduction Consortium**

We have found another tool to identify and build relationships with IDU programming supporters. In 1996 we established The Harm Reduction Consortium. The Consortium's purpose is to provide a forum for on-going harm reduction education and, more importantly, to build support for politically at-risk services to injection drug users. The Consortium meets bi-monthly and is made up of health care professionals, drug treatment providers, and other social services providers. The most successful and interactive Consortium meetings are topic focused. For example, we have had meetings regarding health care for homeless people, the link of sexual abuse to injection drug use, sex work in our local community, and health care strategies for injection drug users. We have asked various people to lead these topic focused discussions. For some meetings, Consortium members have led the discussion based on their experience. At other meetings we have utilized outside speakers, mostly from the San Francisco Bay Area via the Harm Reduction Coalition.

Our mailing list for invitations has mostly come from CHOW and SCNEP staff. During a preliminary brainstorming session, staff identified strong allies as well as service providers who could use further harm reduction education. The Consortium list is updated every several months. Individuals on our mailing list receive Consortium meeting announcements. Invitations are sent to approximately fifty service providers. Average meeting attendance is twenty-five. The most supportive members of the Consortium have been asked to help recruit within their agencies and specific fields to help recruit more members.

It has taken about a year of meetings before the Consortium has really begun to feel like an open forum to further harm reduction. Our first several meetings

seemed far from our goal of building support. However, the group grew more comfortable over a year and managed to really achieve an understanding of harm reduction and a belief in our programs.

We have coordinated the Consortium with no funding support for over a year. However, the Drug Policy Foundation has recently granted \$500 to support the meetings. The Foundation's interest in the Consortium is due to the clear goal of the Consortium to establish support for harm reduction in local communities. Local support is what will help harm reducing services gain legitimacy and become protected from attacks.

With all the work required to develop good inter-agency relationships, the hope is that community support will pay off for participants of the program. One common complaint of IDUs is the difficulty of accessing services. Though we are trying to establish MOUs to deal with some of the accessibility problems, many relationships we build with service providers are more informal. Sometimes its hard to know where to start making referral systems that can best serve participants of the program. We started by talking with participants. Needle exchangers are smart. Many know how to access the various social services in the community, just like they know how to use needle exchange. They know what resources have worked for them in the past and may even have good contacts within those organizations.

We started by setting up meetings with people from drug programs, health clinics and social service agencies. We found out pretty quick who's interested in doing the work by who returned our phone calls. We found that it is not crucial to talk to managers or directors, often it is the front line folks that can tell you

the most i.e. Medical Assistants, Case Workers, Eligibility Workers. These contacts serve many purposes - getting the word out about needle exchange, meeting people interested in serving the same participant base, learning about the various services available to needle exchange participants and beginning to identify key contacts for both client and political advocacy down the line.

If you decide to meet with service providers, expect to go slow. Trust has to get built with service providers the same way it does with participants--through consistency and credibility. When you go to the meeting don't expect to jump to the Memorandum of Understanding right away. Agencies need time to get to know one another and build trust. Go prepared to participate in a mutual education session around services. Provide them with written materials about the needle exchange, contact numbers and program overview. Try to get a few of the agencies pamphlets for your files and for participants. By all means get a front line contact with whom you can talk to later. The most important thing is to set up individual successful working relationships. Later through "In-Service" trainings you may be able to offer this same education to all the employees at once. The most helpful and useful agencies may offer to provide a 30-60 minute training session for your volunteers as well.

Once you've identified a few good agencies, start making small resource referral handbills with the names, numbers and descriptions of these agencies available to needle exchange participants. Offer to help contact the agencies with individual participants if they need help accessing the services. Sometimes a few calls from a health service worker can help cut through agency bureaucracy. It is also helpful to have a volunteer within the exchange program that plays the role of participant advocate. This helps with consistency for volunteers, participants

and the agencies with which you are working. By being able to give a participant the name of a specific person with which they will be dealing helps participants feel more confident accessing services and makes the process less exhausting.

Another good way to establish resource referral connections is through various networking meetings. They're called by different names in different communities but some might be the Latino AIDS Coalition, HIV Services Consortium, Youth Providers Meeting, Drug and Alcohol Commission, Homeless Commission etc. But don't worry if this all doesn't happen right away needle exchange in and of itself is an important service.

A Little Closing Encouragement

There are many components of a well established IDU program. Santa Cruz has the good fortune of a long history, many dedicated volunteers, funding, and an increasingly supportive community. If you are thinking of starting a new program, remember that we did not start with anything but a few committed people who wanted to stop the spread of HIV through exchanging new syringes for old rigs. For the first several months, the new points were stolen from a hospital and the old ones were collected in a coffee can. SCNEP and SCAP CHOWs took it from there and now have an eight year history behind us and a future that looks much more secure and innovative than we could have imagined even a few years ago.

Prevention work for IDUs is the right thing to do. HIV rages on among IDUs. It is not easy work but it has been done in many towns, rural areas, and cities of all

sizes. Syringe Exchange and street outreach can be done where you live too.

Needle Exchange Saves Lives!

Appendix: Case Studies in Harm Reduction Dialogue

Outreach workers will often say that what they love the most about their work, and what they feel is the most significant, are the relationships that develop with participants. Because helping relationships are not quantifiable, they were not readily evident in any data. To capture the heart of harm reducing relationships, we began asking volunteers and staff with CHOW and SCNEP to write about their experiences with injection drug users (IDUs). We wanted to capture how far beyond syringe exchange and condom/bleach distribution our work takes us. Volunteers and staff have written about the many ways we become involved with participants, such as, advocating for drug users within the social services/health care/law enforcement arenas; helping participants find ways to use more safely; listening to people talk about their families and loss; and building trust with new participants. The following are excerpts from writings of staff and volunteers

Susan Pratte 3/97

I was sitting under the bridge like I had done for almost two years now, and a guy came up to exchange. I do not know if he was new to the site or town, but I had never noticed him or engaged with him, such that we had any rapport.

The man, fairly non-descript, somewhere in his 30's, white, not particularly scruffy, yet definitely not a yuppie or narc, plunked his syringes in the bio. I figured he was a veteran of needle exchange, because he made sure I was able to see all the syringes he had, and he did not try to hand them to me, rather deposited them himself--two things we as a rule demand of participants.

I, in response, said, "Do you want 'fiddies' or the bigger ones?" He asked me what was the difference. I hesitated; usually I would launch into a scientific spiel, explaining different barrel sizes, different needle sizes, smaller holes in the arms, etc. But this time I said, "Well, I like the 50's, myself."

Immediately, he sort of perked up, and looked surprised, "Oh, you use!?" I said, "Yeah, I've been a speed freak off and on for years now; I only just recently started shooting up because my sinuses can't take it." To this he said, "Wow, I

thought you had to be clean to work for you guys.” I told him no, we in fact have all sorts of people volunteering for us, some who have never used, some who have quit, and some who still use, but it has definitely never been a criteria that a person has to be clean.

We continued the exchange, he decided that he would rather have the bigger syringes which are better for heroin. While I was bagging up all of the other safer injection stuff for him, he started telling me about how he was becoming dissatisfied with his drug use and how he was thinking about kicking. I was able to refer him to a few places locally that might help and told him to not hesitate to hit me up for whatever support I might be able to offer.

He left and I have not see him since. He may be going to other sites or may be out of town, or who knows, maybe he kicked. What continues to live on about my interaction with him is that I got to see first-hand how having users doing the work is appropriate and in come cases a big bonus. I hesitated outing myself as an IDU to him for a number of reasons- I am a novice and do not want to seem more “down” than I really am, and part of me, simply as a natural defense mechanisms, will always feel compelled to lie about my drug use. But the part of me that would have let myself be the “service provider” for this “client” would have missed and opportunity for a great harm reduction intervention.

Heidi Dunbar 1996

I’ve seen him many times, sitting on Pacific Avenue with his guitar, playing dead tunes or his own songs about life in Santa Cruz. He looks about my age, early 20’s. He usually asks those passing by for change, often with clever remark. As we talked, I asked, “Hey, do you know about the Drop In Center?”

“Yeah, yeah,” he answers. “I’ve been down there before, but they were taking pictures of everybody,” he says, slurring his words a little bit and looking slightly paranoid. “I don’t go down there, and I don’t shoot drugs.”

“Oh, well, that’s too bad you had that experience there. It’s actually a very cool place and no one I know down there would take your picture without getting your permission first,” I say. He grunts skeptically and starts telling me about the last asshole who walked by and told him to get a job and the car load of punks who yelled out their window and called him dirt. “The negative energy, man. You know, I don’t expect people to give me their money. I’m just out here trying to play my music. It’s my therapy you know, my art.”

We chat a little longer and I tell him about Youth Hours on Thursdays, the food we serve, the movies we show, and the chance to take a break from the street and hang out on the couch. I talk on about the CHOWs and we agree about how important it is for people to be non-judgmental. I give him a flyer for the Drop-In center and he still seems very skeptical when I walk away, but I was pleasantly surprised to see him there the next week, and the next, and the next.

Now this witty street musician is a regular at the Drop-in Center. He is extremely grateful for the food, loudly expressing his thanks and always emptying the change in his pockets into our donation box. Despite his initial assertion that he doesn't shoot drugs, I notice that he regularly, and discreetly, grabs a needle exchange schedule and other safe injection stuff on his way out. Most importantly, he now identifies the Drop-in Center as a place to talk through his life frustrations with the CHOWs and to get support and information on local resources.

Caroline 3/97

Diane is a local woman who has lived in the Santa Cruz area most of her life. She is in her forties and has four children who are in foster care. My contact with Diane was always at the same place in Santa Cruz, although she also utilizes other needle exchange sites. She was staying with a friend whose house was a refuge for many. Her friends and support system are primarily injection drug users who have joined together as a family network. Although she has not directly told me of her drug using history, through conversation, it is apparent that she has been using for many years.

When I first met Diane, it was through home delivery about three months ago. My first visit consisted of polite chatter and just a basic exchange. My next visit, Diane seemed to light up when she saw me. She said that she remembered me from the week before and liked me right away. I had thought nothing of my visit, and I was glad that I had affected her so greatly. We proceeded to talk that evening and I realized that she was having problems with her children. She had neglected to reply to court orders and therefore was losing her visitation privileges. She was visibly upset, and proceeded to show me pictures of each of her children.

Through the next visits, I learned that Diane's husband was in jail, and he was upset with her for some reasons she did not explain. Her contact with her children was scarce and she was very upset. She was sick of using and felt that her life was hitting the bottom. She was curious about methadone support and wondered if she would be able to afford the treatment. I educated myself on

what was available to her, gave her a flyer with times and dates of a methadone support group, and told her to call me if she had any problems. I told her I would help her with the paper work or drive her to any appointments she had. When I left, I felt that she had gained a better opportunity to make use of the services that were available to her.

I haven't heard from Laura in two weeks. I know that she and her friends were being evicted from their apartment so I can only imagine that her life is filled with stress and turmoil at the moment and that when things settle down she will be in contact with me. I know that people don't change their lives overnight, and I am confident that at the very least, Diane knows that she has my friendship and support no matter what she decides to do.

Timothy 8/96

So, I'm out on the street in the Flats and have already talked to about twenty people for anywhere from 1-10 minutes each and am ready to end my day. I go to look for my outreach partner and continue doing outreach on my way. I run into an Anglo guy about 40. He appears probably drunk and is hanging out with a couple Latino guys who are also loaded. I speak Spanish but am directed to the white guy probably because of his IDU "look" which I can't define but an outreach worker seek out so as to make my work more efficient. I'm right as it turns out.

He says, "Hey, brother can you give me a rig. Just front one cause I ain't got nothing." I tell him I can't but bring up the needle exchange as a possibility. He says, "Yeah, yeah." I tell him it goes on six days a week. He says, "Hey, but, I need a rig right now. I pull out the bleach, band-aids, alcohol wipes, water, and antibiotic creams. I say "Hey, you need any of this stuff?" He says he isn't big on bleach but he'll take it anyway. His girlfriend takes care of all of that. The Latino guy takes the band-aids and creams out of his hand and says they're for his little girls. Competing needs. The blond guy takes off his jacket and shows me some really nasty abscesses. I tell the Latino guy to give him the antibiotics. I go back to pushing the Needle Exchange schedule in his hand wondering if he can make it tomorrow. He says, "I'll take the schedule and give it to my woman. She takes care of all that. But, I know all this already, brother, tell me something spiritual." "Spiritual," I says, "give me a second." "Spiritual?" I say, "It's all spiritual." He says, "O.K. Thessalonians 4.12, 'God this that the other thing. He loves the least of his creations. Loves them so much-blah, blah, blah.'" And I don't mean blah, blah, blah, because the quotation wasn't good or he didn't say it, it's just that I don't remember. He says, "I love God, but Satan's a

motherfucker. When Jesus comes back I hope he gets everything he's got comin' to him."

Why do I consider this harm reduction?

- 1) The discussion was long enough and in depth enough to build trust and facilitate the next entrance/contact.
- 2) We found him and delivered concrete instruments and information for the prevention of HIV.

Timothy 5/97

We often attend health and community fairs. Over the years we've become more discerning regarding which will be the most advantageous for us to attend. At a health fair we set up a table and display our wares upon it. Anywhere from 25-500 people can come by depending on the scope of the event. The table needs to be innocuous enough to attract a wide variety of people and at the same time specific enough so that an IDU will immediately identify the services. A couple of weeks ago at a Cinco de Mayo celebration a heterosexual couple came by our table pushing a baby stroller. The man was Latino and the woman was European American. They appeared to be working class. Since we were in a very public setting our discussion was not readily revealing. The man mostly stood back from the table slowly shuffling from foot to foot. The woman did all the talking. She said, "It is so good to see you. We didn't know if there was one of these in own." She proceeded to take an IDU pack with bleach, water, alcohol preps, etc. She asked for a schedule and the needle exchange voice mail number. The rest of the conversation was very amicable and sort of just chatty. Since we were at the fair for a few hours we had the chance to see them again a little later. This time she took a couple of hands full of condoms and lubes. We talked a bit about which condoms were the best. We offered her a few small boxes of food and they went on their way. Since I was her first contact I made sure to write down my work number for her. I found this contact to be very positive as they had just come to town and we had found each other so readily. I had reason to believe that there were much more things we could have talked about but I was happy just to have them. And hoped they would take me up on the referrals.

Dana 3/97

I first met Pete at the Drop-in Center Youth Hours. I would say "hello" to him week after week in the pizza line until we developed a basic level of familiarity. Like many newer participants, he would usually eat his pizza and then leave the Center fairly quickly without further contact.

One quiet Youth Hours afternoon, Pete and I had the opportunity to talk more intimately about his life. Pete was among a small number of people who were watching a video, and I sat down next to him and said, "what's up?" I asked him how long he'd been in Santa Cruz and did he have an easy time finding safe shelter and cheap food? He responded with a personal narrative about his several month long stay in Santa Cruz. We discussed his good relationship with his parents, who, although they wouldn't send him money in the event that he was arrested, were always willing to let him come home for a while. Pete talked about having left home five years earlier to follow the Grateful Dead and that he'd been traveling ever since. He spoke about how much he loved to travel and we were both impressed by how many places he had visited during his years on the road.

Eventually Pete began to discuss his experiences with the police and his current heroin use. He was on probation and expresses mild concern about the size of his habit, but we primarily talked about the mechanics of his use: how often he injected and how he had been injecting on and off for several years. We ended that discussion with friendly promises to talk again.

I continued to see Pete regularly after that, and we'd have brief check-ins when there was time. One evening, as I left the Drop-in Center at around 8 PM, I heard Pete calling out to me that he really needed to talk to me and would I be there tomorrow? I said, "Yes, will tomorrow at Youth Hours be soon enough?" Pete replied with a yes, but again indicated how important it was for us to talk.

The next day, Pete did not show up early enough for pizza. I finally saw him later that afternoon. He look tired, sick, and yellow. He confided to me that he had Hepatitis and had gone to the hospital for a hepatitis and HIV test. He also showed me several spots of severe cellulitis on his side and leg. Pete wanted to talk with me about how to not spread his infections to other people in his community and was interested in learning about how to care for his hepatitis. But first, he said, he had some business to attend.

When I saw Pete again a few hours later, he was in police custody for probation violation and narcotics possession. He had been picked up and, subject to search and seizure, had been patted down for being in off-limits drug purchasing territory.

The arresting officer allowed Pete to return to the Center before being taken to jail- at Pete's request. Pete had wanted to check-in with me about his arrest and wanted my help in getting his Hepatitis and HIV test results. I spoke with the officers to clarify Pete's charges and connect with them about our mutual interest in his "case." I then told Pete that I would be happy to advocate for him

wherever possible, and that he should feel free to contact me, if only to have someone to call.

A week later, I received a letter and call from Pete, requesting information on accessing his test results and, he asked, could I make it to his court date? He explained his current interest in staying clean and going through a drug treatment program rather than doing a long sentence. I said I would see if a letter of support would help and on the day of his hearing, I presented his public defender with an advocacy letter. The judge sentenced Pete to 120 days in jail and he would be allowed to return to his home state upon release. His public defender let me know that the judge had read my letter and shortened Pete's sentence by six months because of it.

I am currently in touch with Pete by phone and through his letters to me. We still have to solve the problem of his test results, however, his health is much improved and his cellulitis has all but cleared up entirely. He writes me often about how much my support has meant to him.

In all, I feel that I was successfully able to help and advocate for Pete around issues that he had prioritized. My ability to have regular contact with Pete over the course of several months allowed our trust to build naturally and allowed me to advocate for a person whose (drug use, legal, and health) issues I knew fairly well. This contact also "worked" because the compassionate, non-judgmental understanding I offer Pete empowers him to take supported steps towards healthy decision making for himself.

Charles 3.97

Jake is a 45 year old white male. He grew up in Oregon. His father was an entertainer who rarely participated in the family due to an extensive touring schedule, as well as the irregular hours that he kept even when he was not on the road. Jake followed his father's career path and also became a professional entertainer. At 17 years-old, he found himself performing on the road throughout California. This was when Jake first began to inject drugs. He reported that heroin was his drug of choice but that he occasionally injected cocaine and speed as well. Jake made a living in the entertainment industry for 23 years. He reported that his drug use became a problem for him only when his career ended as a result of an accident which caused severe damage to both of his legs.

According to Jake, drugs have become a major problem for him primarily because his life has lost its focus. He was dedicated to his career and now is no

longer able to pursue what had always been the defining aspect of his identity. He lost his livelihood, his medium for artistic expression, and the source of his social connections. His drug use increased, in part, as a reaction to the physical pain that the accident continues to cause Jake, along with the emotional pain that it brought about. The last three years have been absolutely torturous for Jake. He has spent most of that time homeless. He reports several arrests for drug possession and shoplifting. He has sought treatment for help to stop using drugs on a number of occasions, so far with no long term success.

When asked about the failure of treatment, Jake reported that the biggest problem is that when he has gone to agencies for help, he has been placed on waiting lists. He has been told that he would have to wait at least a week to ten days for a detox unit and up to six months to get into a methadone program. The logistics of homeless living make it very difficult to comply with the demands of waiting lists and other bureaucratic obstacles that must be negotiated.

Recently, Jake attempted to stop using heroin by himself. He stayed with family who allowed him to be there so he could refrain from using. He reported suffering through the first four days of withdrawal. He was unable to get past the fifth day however. He felt that it was just too painful, that he thought he was "going insane." In an emotional outpouring at the needle exchange site, he discussed his deep regret for his inability to stop using drugs and how much pain and confusion that his family suffered as a result. He said he felt so weak and really didn't understand what was happening to him. He wants to stop so badly but is unable. He suggested that he might even turn himself into the police for some outstanding warrants, believing that at least in jail he would have to stop. In a conversation that occurred just two days before writing this, Jake said that his illegal acts are becoming so bold, he can tell that he just wants to get caught. He said that he feels his life just slipping away and he is horrified by that. He can't believe what he has become and feels powerless to really stop himself.

I told Jake that he had a few options for getting help to stop using and that I would help him to try any of them. I informed him about the Homeless Person's Health Project (HPHP) and that they could line up several different detox or treatment plans according to what he felt he needed. He said that he was so confused and stressed out that he couldn't decide on anything right then but that he really would consider trying HPHP.

There are several examples of harm reduction in this vignette. First and foremost, is the non-judgmental support that Jake has received from myself and others at the needle exchange site. The evidence of this is in Jake's willingness to

trust us with the difficult facts of his life and the vulnerable emotions that he experiences in association with his situation. Jake has found an understanding and compassionate forum where he feels free to express himself.

Another example of harm reduction is that Jake was given options for treatment from which he could make any choice at all but was assured that when his decision was made any choice at all but was assured that when his decision was made I would fully support it and help to make any of the necessary arrangements. In a subtle way, the participant is shown that he had some power of choice in regard to his drug use, which may help to mitigate the desperate feeling of powerlessness that he has expressed. This is harm reduction because it differs from other approaches which may dictate one specific form of treatment and which may put pressure on a drug user to make the choice to get treatment.

Harm reduction is also exemplified here in that the Santa Cruz Needle Exchange has formed relationships with other agencies that work with us to help participants get the treatment that they need. Referrals are made. participant get treatment and if they manage to abstain or reduce their use of drugs, by definition, harm reduction is accomplished. If Jake decides to seek treatment, he has a good chance of receiving such help through the Needle Exchange. Also, if arrangements are made through the Needle Exchange, our advocacy can help to lessen the difficulty that homelessness presents in keeping touch with the participant during any waiting periods that might occur.

Deborah 5/97

If I could, I would tell you all sorts of things about what it's like to be part of the Santa Cruz Needle Exchange. I would want you to know what it feels like when I sit and talk with individuals about everything from how to take care of themselves when they kick, to how the stars look that night. The knowledge that just sitting there listening is enough to make someone feel like a human being, makes a profound statement. I would tell you how it feels to know that people ask where I am on nights when I'm not scheduled to work. I would let you know what it's like for me to do this work, but I find it impossible to express the feelings that are in my heart and mind.

I don't volunteer with the exchange for personal satisfaction or for recognition. I do it because it's important. It's important to distribute clean, sharp needles, clean cookers, clean cottons, bleach, water, and alcohol wipes to individuals so that they can reduce the risks of abscesses, HIV, hepatitis and other infectious diseases. I am proud to be a part of this organization which is committed to reducing the harms (without judging the user) inflicted by drug use. It wouldn't

do justice to the intense experience of being a volunteer if I were to tell you that it is “a rewarding experience.” It goes way beyond being rewarding. Instead, let me invite you, in the following sentences, to an evening at a site: an hour in the life of a needle exchange volunteer.

It’s Monday night, close to seven and I’m walking down Pacific towards the site. It’s a beautiful night out and as I am walking, I am recognized by a program participant. He strides right along next to me and we engage in mellow conversation. We arrive at our destination to find a few people waiting patiently. We help set up an I take a seat behind the bag of supplies. I hand a fellow volunteer the statistics recording sheet and the night begins with the exchange of safer injecting materials. After about fifteen minutes the site usually slows down and there is a real opportunity to interact one on one with participants. It’s more likely for the regulars who know and trust me to talk about what has been happening in their lives. Soon other participants begin to talk freely.

This particular night, a woman who I have connected with says with great animation that she is going to try to kick heroin. She explains that she visited her doctor today and has collected some pills to ease the pain. I ask her how she thinks her body will react, whether she thinks it will be especially difficult or easy. She responds with an “I don’t know” and I ask her if she knows what she can do to help alleviate some of the discomfort associated with kicking. She nods her head and says she has some medication her doctor gave her. I explain to her that I just created a flyer about how to help yourself when you kick and I ask if she wants to hear what is on it. She says, “yeah, it would help,” but only if I go back to her car. Her son listens from the back seat, and we talk for about fifteen minutes. I mention that keeping hydrated is really important because of the vomiting and diarrhea that sometimes accompanies heroin withdrawal. I explain that eating bananas is a source of potassium which helps with the muscle cramping. I suggest eating other foods like apples, rice and toast because they are easy foods to keep down. I give her encouragement and wish her the best. As I get ready to leave, I let her know that if she needs anything, she can reach me at the exchange’s number. When she thanks me for taking the time out to always listen or spend time with her, I tell her that’s why I am here. We hug good-bye.

Being a volunteer is different for everyone. Each of us willingly contributes a lot of time and energy for something about which we feel strongly: saving lives by educating people about safer sex and safer injecting.