Sharp! The Dangers around Inaccessibility of Sharps Containers and Needle Exchange Programs in San Antonio, Texas

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This ethnography attempts to capture what San Antonio provides with its pilot needle exchange program and how harm reduction advocates have interacted with the complicated legal landscape in Texas. First, breaking down the legal landscape within Texas to build an understanding of how San Antonio is legally allowed to operate a pilot program and then jumping into the major themes presented from participant data to unpack the intersection of identity, stigma, and access to healthcare. I draw upon my own experience volunteering with harm reduction outreach and the experiences of seven participants who live and work as harm reduction advocates in San Antonio. Ethnographic data was gathered following semi-structured interviews conducted over the phone and transcribed. The data was thematically assessed to facilitate the unpacking of consistent themes among interviews which dealt with socioeconomic position, communication and support among the community, nationwide political narratives, and the morality of the drug user.

Positionality & Experience

The purpose of this research project is to describe what the city of San Antonio provided with its pilot needle exchange program and how harm reduction advocates and workers have interacted with the complicated legal landscape in Texas. The community of San Antonio seems to have a dynamic culture of intense community care. I often hear it described as a city that feels like a small town. People know each other, know of each other, and express care about each other. This community of care seems to have existed in San Antonio for a while, which is demonstrated through the community's resilience and persistence in having some form of needle exchange program, regardless of the legality. It's

because of the community culture of care that this topic of harm reduction first came to my attention.

In 2020, I volunteered to clean up a houseless camp in San Antonio located under I-35 and Austin Street. I spent an afternoon working among several other volunteers to pick up trash, needles, and human excrement. On that day of outreach, I became aware of the issues surrounding sharps containers and needle exchanges as we came upon a portion of the camp dedicated to all that was undesired and hazardous, including a massive pile of shit mixed with needles. Having few options, we decided the best way to clean up the area was to shovel this mixture into double-bagged, heavy-duty black trash bags. It was then that I became increasingly curious about what state support was available and who received it. Additionally, as a nonbinary individual who uses syringes for masculinizing hormones, I wondered what my experience would be if I were houseless.[1] How hard might access to sterile syringes and sharps containers be? I am not solely concerned about the trans experience of houselessness, but about the accessibility of sterile syringes for any medical conditions, such as diabetes or immunosuppressants for arthritis as well. Syringes are daily medical necessities for many Americans.[2] What I realized on that day in 2020 was that my experiences had always been on the side of privilege. That heap of waste was a clear manifestation of the experience of the underprivileged who, like me, also utilize syringes. Before me was the evidence that compelled me to ask, what separated my syringe use from theirs? I shoveled and I pondered the stigmatization of syringes until the stench coupled with my own thoughts nauseated me. Henceforth, I set out to understand what circumstances might have brought into existence that hazardous heap of waste.

Methods

Most participants were referred to me through other fellow participants. I became acquainted with my initial participant through my volunteer work with Yanawana Hebolarios, meaning that a majority of my participants knew of each other and/or had worked with each other for years. I initiated contact by emailing each participant an IRB approved recruitment script that detailed the topic and purpose of this project

1 According to Frederick "Homeless sexual minority young people are consistently found to have higher rates of mental health problems, drug use, sexual health risk, and victimization than their heterosexual counterparts". Chpt. 22. Diversity at the Margins: The Interconnections Between Homelessness, Sex Work, Mental Health, and Substance Use in the Lives of Sexual Minority Homeless Young People." In *Handbook of LGBT Communities, Crime, and Justice*, 748-797. Berlin: Springer Science & Business Media, 2013. Epub.

2 According to the National Diabetes Statistic Report 37.3 million Americans have diabetes. CDC. "The Facts, Stats, and Impacts of Diabetes." *Centers for Disease Control and Prevention*. Last modified June 20, 2022.

along with the benefits and risks. Following their response, we would coordinate a date for the interview. I gave each participant a twenty-five dollar Vanilla electronic gift card, delivered via email. I kept no permanent records of their contact information.

I conducted interviews over the phone with harm reduction advocates in San Antonio, recording and later transcribing each conversation. Initially, I had seven interview participants; however, one of the audio recordings came out too garbled to be viable for me to complete a transcript. I was able to follow along with most of the garbled audio using my post interview notes, but most of the interview data was nonviable. Each interview followed a semi-structured protocol with 18 main questions and two to three follow-up questions, as appropriate. The interviews themselves varied greatly in duration of time, from one hour to over two hours. I compiled notes from memory after completing each interview as a means of highlighting what initially stood out to me. Over the next 6 months, I slowly transcribed each audio interview. I assigned each transcript a random number and then created my key for the pseudonyms participants were given. The transcriptions served as paper evidence to allow me to locate and pull recurring themes and compile them into a list which I used to build my outline.

Participants

One location was a rather large, organized camp beneath the highway 37 bridge between 9th Street and Brooklyn Avenue. This was where I was working, among other people, with Balinda. I volunteered with her to work outreach events at those two locations where we went around houseless camps asking folks what goods they needed and if they had any injuries they would like to be seen by a volunteer herbalist medic. Balinda is a charming and confident woman with little doubt of the impact of her actions. She has lived in San Antonio most of her life with a few years in Houston and Floresville. She first became aware of substance misuse and abuse in high school and later became even more intimately acquainted with the topic in her late twenties, due to a partner. Balinda explained she had seen substance misuse and abuse in her community: "I've always recognized [substance misuse] has been a big problem with the indigenous community. So, I mean, I can't really think of a time when, you know, when I didn't see it as a thing in our community." These experiences have informed her sense of community. She regularly provides medical assistance to marginalized

community members throughout San Antonio. She is a strong advocate for the houseless and is well positioned to continue her meaningful work within the community.

João is a retired social worker. She has lived in San Antonio since 1996, when her family eventually settled here. She is kind yet stern in speech with much insight to offer. Prior to 1996 she lived around Texas as well as internationally. She had been in social work since the mid-1980s, and starting in 1996 she began to work in the field of HIV and AIDs with a non-governmental organization. She retired around 2011 but remains an active advocate by volunteering within San Antonio. She has personally been impacted by substance misuse issues. She told me over the phone, "I've known about it since probably 8 years old. We were in Wichita Falls and a guy ran 6 lanes of traffic and hit the van on the front siding. I wore a neck brace and my spine is now fused from that car accident. Thanks to the paramedics that got me out I'm still alive and not paralyzed. And people were saying, 'Don't you just want him to be crucified?' I said 'No, I want him to go to treatment'. This is what needs to happen. They go to jail and as soon as they get out they go right back to the bar. And this guy was 25! He got arrested for alcohol and they plea bargained his case." Her experiences have led her through a rich career and decades of community work within San Antonio that explores the intersections of community support and the legal justice system.

Khoshekh is a lifelong resident in San Antonio and has extensive family ties in the area. While speaking with him I noticed his genial spirit in speech. He knows how to keep a listener engaged! Koshekh maintains a career as a chemical dependency counselor alongside his volunteer service hours working in local harm reduction programs. His experiences living in San Antonio offers a rich account of life within the community. From parties to overdoses, he has history in the city. In part, this is due to his years working in transportation coupled with his own curious nature. He described his first experience with intravenous substance use: "I didn't know anything about IV drug use until I went to a party near Our Lady of the Lake University. I caught someone using IV drugs, we're talking 1971. It caught me off guard, you know, I wasn't exposed but that's how I became aware of it. It happened at an apartment. I went to use the restroom and the guy had passed out. Next thing I did was put him in the shower trying to get him awake. I had no idea what to do with someone overdosing on heroin." He described to me another overdose experience from his

days working in transportation, following up with, "It was a good evolution for me to become a counselor because I don't like to see people getting hurt." Khoshekh channels his concern into educating his community about substances and preventative medicine through his volunteer work within the community and his work as a chemical dependency counselor.

Cecil has lived in San Antonio for 40 years. He served in the Army and settled in San Antonio around the early 1950s. Prior, he was a globetrotter having lived extensively throughout Asia, specifically Vietnam and Japan. He spoke thoughtfully and kept the conversation at an even pace. His career background is in public health, having earned his first bachelor's degree in bacteriology. Later on, he earned his master's degree in archeology from the University of Texas in San Antonio. He applied his bacteriology degree towards community health when he started work at a hospital in Del Rio where their interest was in HIV prevention. This expanded as he began to take up public service at the statewide level, where he became a member of a planning committee that created programs to help slow the spread of HIV. He became an active agent in San Antonio's HIV prevention planning when a group approached the planning committee to ask for support in establishing a needle exchange program in the city. Outside of his professional experience in HIV prevention, he has personal experience with substances. He describes himself as a recovered alcoholic and has been a member of Alcoholics Anonymous for over 30 years. Cecil was influential in advocating for legislation for a needle exchange program within San Antonio, and he is regarded by some as an outstarter.

Jack was born and raised in San Antonio. He lives a busy life–I managed to catch him for an interview between meetings. Jack works as an alcohol and drug counselor with 25 years of experience. Additionally, he maintains his volunteer work in harm reduction on top of his position as a Pastor. Jack started noticing substance abuse at a young age and he noted that "substance abuse is something that you see in the community, and usually it doesn't really become an issue until it starts hurting you." He spoke of aunts or uncles that carried flasks and drank too much starting on the weekends, continuing into the weekdays. As a man of the cloth, Jack deals with the marginalized and uses his position within the city to advocate for housing justice with the city council. He is an active political member in San Antonio who can provide a detailed account of the experiences of gentrification throughout San Antonio. Not only this, he can also recount a detailed history of the rise of HIV in San Antonio

and the portrayal of the disease in popular media. Jack remains connected to his community through political involvement and his volunteer work on the streets. He has been influential in the local political scene, and, like Cecil, he is regarded as an outstarter in San Antonio.

Adi is a lifelong resident of San Antonio. They grew up on the Southside and recalled noticing substance abuse and misuse at a young age. They were personally impacted because their older sibling struggled with an addiction to crack cocaine. Despite the prevalence of substances within their community, growing up, Adi noticed that HIV was not something they learned much about from their community, but rather as an adult from the LGBTQIA+ community and their previous volunteer work around HIV prevention in San Antonio.

Harm Reduction & Needle Exchange

As an introduction into the layers of harm reduction, I present to you a synthesis of my participants' collective input. Firstly, let us establish that harm reduction does not necessarily include needle exchange. Needle exchange is a component to a harm reduction program; however, as often is the case in Texas, harm reduction programs exist without needle exchange. In a broad sense, harm reduction can be likened to an ideology, an extension of faith, a commonplace practice, or advanced preventative care. As an ideology, harm reduction is treating people with compassion and empathy while simultaneously empowering them. Khoshekh described this as, "when you talk to someone and ask them about their experience or share their experience without you judging them… It is an opportunity to get better and that requires education…It's a learning process. Understanding why they found themselves in that situation to begin with." As preventative care, harm reduction encompasses an array of taboo and commonplace topics in American society, like sexual health, birth control, correct condom use, and access to other preventative care services. Harm reduction touches upon essentially all aspects of public health that are difficult to talk about in public spaces. For some, harm reduction is an extension of religious principles. Jack explained: "For me as a theologian the most important thing, as a Christian, is that harm reduction extends grace. It is a theology of grace, the grace of God. The grace to cover me in the height of my addiction, grace covering me. Harm reduction is kinda like grace, it covers me in spite of myself. I have an opportunity to get better… Grace- I don't deserve it but I get it anyhow." For others, like João, harm reduction programs are extensions of everyday logic around

risk assessments. João explains:

> "A lot of people don't realize they practice harm reduction in their own home. If you have a baby, you are very vigilant about putting locks on doors and picking things up off the ground. That is basic harm reduction. You teach your child how to cross the street. I agree that those are simple practices, but the concept is the same. When I was working with SAFE, which no longer exists, we gave out clean socks and sandwiches on the street one day a week. If we give them clean socks once a month or every two weeks, they don't get foot rot. If they go to the hospital, who pays for it? You do. With the sandwich, if they dont wanna eat it, it'll still be okay the next day. It lessens their harm but it also lessens the tax burden. People don't realize that if you lessen the damage to the most vulnerable it also helps you."

As advanced preventative care, harm reduction seeks to educate about social problems that seriously impact a community's health through providing culturally appropriate care. Balinda explains, "For us on the street, medic work might look like patching up a wound or it might look like giving someone a limpia[3] with sage smoke. So, it's really not trying to force all of your clients into one specific, accepted, motive of health care and really trying to personalize it to that individual." Harm reduction brings together all of these logical systems into a framework that seeks to empower, ameliorate, and advocate for marginalized members of a community. Jack synthesizes this unification by saying:

> "This harm reduction model is one that I've found over the years that combines the faith component with the health component where you're looking at the faith piece, you're looking at the government piece, and you're looking at the health piece. If things could come together the harm reduction way, I know that it would be able to stem the seriousness of substance abuse and can be across the board a healthy [solution] as far as changing lives and communities."

Other professionals also describe harm reduction in a similar light. I was recommended several books by my participants, including Drug Use For Grown Ups: Chasing Liberty in the Land

3 A limpia as described here is a practice among curander@s used to spiritually cleanse.

of Fear by Dr. Carl Hart and The Wisdom of Whores: Bureaucrats, Brothels, and the Business of AIDS by Dr. Elizabeth Pisani. Dr. Hart is the Chair of the Department of Psychology at Columbia University and Dr. Pisani is an American Epidemiologist and independent researcher. To Dr. Hart, harm reduction would look like "...implement[ing] age and competence requirements as well as other safety strategies, strategies that minimize harms and enhance positive features associated with these activities."[4] For Dr. Elizabeth Pisani, harm reduction is central to HIV prevention. It is cost effective in the long run by reducing the burden on the healthcare system, and it is most effective when there are educational opportunities made available to the identified at-risk population about preventative care.[5] The additional layer of needle exchange to a harm reduction program allows for expanded reach of clientele and prevents the spread of serious illnesses like HIV, AIDs, or syphilis. João Said:

> "A lot of people just think we're just exchanging needles and that's true but we're also building rapport. Because at some point a lot of those people are going to want to get treatment and maybe we can help them. Maybe they need help with other things too. With the needle exchange, some people think we're just giving them clean needles and we're encouraging them to use… but with the clean needles they don't get as many abscesses and they don't end up in the hospital."

Rapport is a critical aspect to a needle exchange program because trust in institutions has eroded for many substance users. Often, users are leery of approaching an institution out of fear of criminalization, stigmatization, or a combination of the two. A needle exchange program that either regularly visits known locations or has a permanent location builds a relationship of trust among its clientele and oftentimes may serve as a platform for them to access other useful services they might otherwise avoid. João provides a personal account as an example for the ways in which trust has been eroded:

> "I was hired to work for this organization and my job was to be the social worker. The outreach people were going to pick up people and move them to the office. Well, if you've got a 40oz-er in your hand,

4 Hart, Carl. *Drug Use For Grown-ups: Chasing Liberty in the Land of Fear.* Penguin Books. 2021. Pg. 13.

5 Pisani, Elizabeth. *The Wisdom of Whores: Bureaucrats, Brothels and the Business of AIDS.* W. W. Norton & Co., New York. 2008. Pg. 46.

> you're not going to get in a van and leave that 40oz-er sitting on the sidewalk. The other problem was that our local mental health agencies were telling people they were going to take them to get help and they were taking them across the street directly to jail. So they were definitely not going to get in our van… To my knowledge that's no longer happening, but back in '96, '97- '98, they were going to take you to go get help and then you ended up in jail."

João highlights a practice from 1996; however, the distrust created is not easily forgotten by the community of users. These instances of betrayal, stigmatization, or criminalization are traumatic and are carried on in the collective memory of the community. It is within the community's collective trauma that a syringe exchange service coupled with outreach begins the process of restoring trust, and this restorative process empowers a user to seek out the available resources.

Legal Landscape

The legal landscape in Texas is confusing and complicated. From the collective memory of the seasoned professionals in harm reduction surfaced an incident of legal prosecution from 2007. Prior to 2015, Susan Reed was district attorney of Bexar County and she was not in favor of needle exchange programs. She made this known in 2008 when she opened a case prosecuting three members of the Bexar Area Harm Reduction Coalition for charges of possessing drug paraphernalia. This was after the implementation of SB 10, § 531.0972, in September of 2007 which loosely permitted the establishment of a pilot needle exchange program under the guidance of state approved medical professionals; however, there was a conflict within the legal framework due to the language of the Controlled Substances Act. This discrepancy was made possible because § 531.0972 did not offer any clear language to protect an authorized individual and their work with syringes from being considered distribution of illegal paraphernalia. These charges were ultimately dropped due to the amount of national media attention the case received nationally. However, this incident serves as a cautionary tale among harm reduction workers.

In 2021, HB 3233 brought by Rep. Joe Moody attempted to amend § 531.0972 by suggesting changes to the language describing what entities may operate a needle exchange program with the addition of subchapter J,

chapter 81. Subchapter J directly responds to the legal ambiguity around needle exchange: "... an organization that contracts with a county or hospital district to operate a program under this chapter may establish a disease control pilot program… (1) provide for the anonymous exchange of used hypodermic needles and syringes for an equal number of new hypodermic needles and syringes," which was approved in 2021. However, the initial pilot program as defined in 2007 by § 531.0972 was only current through 2021. As of 2022, the pilot needle exchange program has expired and has not been reinstated with UT Health San Antonio; however, in December of 2022 an organization called Be Well Texas received a large grant to support a substance use disorder response team for rural counties in Texas.[6]

Major Findings

There were a number of topics addressed throughout the interviews. Among these, participants had a lot to say about transportation, gentrification, racial disparities, and mental healthcare services in San Antonio. However, the consistent themes among interviews dealt with socioeconomic position, communication and support among the community, nationwide political narratives, and the morality of the drug user. Here I will address these key themes and how they relate to the overarching function of a harm reduction program by providing a comprehensive view of what participants had to say, and how it relates to the source materials they recommended to me. Additionally, I look beyond the participant recommended resources to build a more comprehensive and holistic frame to contextualize these themes.

Socioeconomic Position

Many of the clientele serviced by the outreach portion of a harm reduction program are either without a permanent residence or with limited access to resources. This does not mean that all clientele struggle with housing or job stability. Balinda speaks clearly in saying, "It's been my experience that-- I know just as many housed people doing drugs as houseless people doing drugs. And, so, you know, there is some serious drug use with some housed people, you know, I can't say it's a thing that's limited to the houseless people. Not at all. It's a community-wide problem in every- in every socioeconomic status." This complicates the traditional narrative around the demographic clientele of a harm reduction program and encourages a little digging

6 Josh Peck, "UT Health San Antonio Receives $2 Million Grant for Opioid Addiction Response Program in Rural Texas," *TPR*.

about the socioeconomic demographics of the city as a whole. As it turns out, there is significant evidence to indicate that income disparity in San Antonio is leading the nation.[7] Balinda, who regularly serves the houseless community, would need no convincing as she noted, "I have a lot of clients on the street who have full-time jobs, but they're minimum wage."[8] This might strike some as counterintuitive–what might be the reason they remain houseless? Cecil provides additional insight by saying, "The lower economic classes, what we call the slums, away from the city center… they're out of sight, where the people use that material, and it can be a very short distance from very prosperous, shiny, commercial activities. It's the alleys, backstreets, transportation-- it's the unseen element in transportation." While Cecil notes this relationship to transportation routes, I believe it may relate more generally to the history of how those routes were developed in San Antonio.

Some of those routes are explained if we apply a historic lens to the development of San Antonio from the early 20th century. Tovar writes, "The work of B.G. Irish and H.E. Dickinson from 1903-1925, as well as the work of Home Owners Loan Corporation (HOLC) in the 1930's contributed to the rise and expansion of redlining and segregation in San Antonio... Resulting in division by race with the Mexicans mostly residing in the west and south areas and a little in the east where it was mostly where African Americans resided, and where the north is predominantly white."[9] When compiled, the history of redlining in San Antonio provides significant evidence to demonstrate that the current clustering of racial and socioeconomic groups across the city are impacted greatly by development patterns established in the early 20th century.[10]

Jack addressed gentrification and displacement of the houseless with redevelopment plans, saying, "You can view this change and go like what happened? But still, see, you still have this great population that are displaced, that are homeless, that are being shuffled from one sector of town to the other sector of town based on what corporation or who's moving into what area. So then they'll just move to another section." Jack later goes on to poignantly state, "Until it started going into other communities of affluence… as long as there was a restriction to lower-income people, African-Americans, Hispanics, the communities of a lower economic position, it really wasn't that big of a deal. It

7 Tovar cites "the rise of residential segregation by income" by Richard Fry and Paul Taylor on the first page.

8 For further reading about income disparity in San Antonio, see Sakian, and Kofler.

9 Tovar, 1.

10 Tovar writes in more detail about this point throughout his paper, here I have just summarized the point.

was only until it started going into affluent neighborhoods-- then the state started really trying to put treatment centers into place and everything." This is not a unique factor to San Antonio. Sociologist Shannon Monnat published her findings on the relationship between economic discrepancies and drug mortality rates, writing, "Economic disadvantages like unemployment, poverty, low education, and housing challenges are associated with increased risk of family conflict, social isolation, stress, and substance misuse."[11] Balinda pointed to this by bringing up the "Rat Park" study from 1978.[12] The original Rat Park study was conducted by Bruce Alexander, et al. in 1978 and revised in 1980.[13] Rat Park attempted to understand a correlative relationship between the psychological state of rats as influenced by environment and their preference in opioid consumption. The Rat Park study challenged the traditional narrative of substance misuse of chemical dependency driven through physical addiction alone. Simply put, "If most users of a particular drug do not become addicted, then we cannot blame the drug for causing drug addiction."[14] This suggests substance misuse may develop into habit for some reason beyond chemical dependency itself and implores exploration into the sociopolitical and cultural crossroads. Historical trauma theory lends itself in understanding the sociopolitical, historical, and individual intersections of minorities in the U.S. and their health.[15]

Historical trauma theory, also known as cultural trauma, sheds light upon the various ways in which minority groups experience living in a racialized country, including the various stresses they experience in daily life. Expanding beyond historical trauma theory, acculturation becomes crucial to questions pertaining to the vulnerability of certain communities towards substance misuse behaviors. Researchers De La Rosa, Vega, and Radisch define acculturation as "the process of adjustment that a person from another culture usually goes through as they learn about the host society's cultural values and lifestyle."[16] Building from a position that accepts the marginalization of the racialized, acculturation can be used as a sort of measuring stick to understand how a

11 Monnat, Shannon M. "Factors Associated With County-Level Differences in U.S. Drug-Related Mortality Rates." *American journal of preventive medicine* 54, 5 (2018): 613.

12 Alexander, B. K. et al. "The effect of housing and gender on morphine self-administration in rats." *Psychopharmacology* 58, 2 (1978): 175-9.

13 Alexander, B. K. et al. "Effect of Early and Later Colony Housing on Oral Ingestion of Morphine in Rats" *Pharmacology Biochemistry & Behavior*, 15 (1980): 571-576.

14 Hart, Carl. 14.

15 Antonio L. Estrada, "Mexican Americans and Historical Trauma Theory: A Theoretical Perspective," *Journal of Ethnicity in Substance Abuse* 8, no. 3 (2009): 330-340.

16 Mario De La Rosa, Rodolfo Vega, and Matthew A. Radisch, "The Role of Acculturation in the Substance Abuse Behavior of African-American and Latino Adolescents: Advances, Issues, and Recommendations," *Journal of Psychoactive Drugs* 32, no. 1 (2000): 41.

multi-ethnic individual relates to their ethnic identities and roles within a dominant American culture. Acculturation models can be applied to assessing adults; however, they are more commonly applied when assessing adolescents and parent relationships. For example, "The Family Effectiveness Training (FET) model by Szapocznik and colleagues (1989) is the most widely known drug treatment model which accounts for the role of acculturation-related stress or conflict on the drug-using behavior of Latino adolescents."[17] Although FET deals with adolescents, acculturation is a multidirectional process of identity building that occurs at any age in a person's life. A Latinx adult who is a second generation American might struggle with the process of acculturation just as much as an adult who recently migrated to the U.S. because each must contend with their perceived position within society psychologically, economically, and politically.

Communication & Community Support

There are several harm reduction programs operating within San Antonio, each one operating at a different degree of legality. Some of them do not operate with explicit consent of the state, nor do they receive state funds. Others operate with explicit consent of the state and do apply for state funds for various aspects of their harm reduction program. The degree of city, state, or federal funding received often has to do with how well the organization can navigate the process of interpreting state law and applying for available funds. This process can become financially tedious because no federal or state funds can be associated with the purchase of sharps. Cecil explained this to me: "The problem there is [that] agencies that collect federal money are forbidden to purchase needles for distribution. That's why, you know, my agency has never taken any money from [government] sources at all. So we're not under that restriction. The resources that we're getting now come from Bexar County, and we've gotten resources from them before, but it's Bexar County money not federal money. The agency that is managing our resources now keeps that separate from their other budget that does contain federal money. There are really really severe penalties for violating the federal requirements… Which makes it very difficult for us to raise funds across the board. I do not know of any other agency in town right now that is actually doing needle exchange." Cecil explains the financial aspects of operating a harm reduction as he answers the question, "How many other organizations operate a needle exchange program in San Antonio?"

17 Ibid. 36.

None. This was the most common answer each participant gave me when I asked that very same question. Two participants were able to list other harm reduction programs operating either within Bexar County, Travis County, or San Antonio; however, none of them was certain if those organizations offered needle exchange.

In fact, there are about three underground operations in San Antonio that either offer needle exchange or simply distribute clean needles. None of these organizations appears to be in communication with each other. This may be in the interest of preserving anonymity; however, the varying level of legality can cause harm reduction programs to operate in a disjointed way. The gist I got from my participants was that needle exchange had been going on in San Antonio long before the pilot program was approved, approximately 25 years prior. Jack explains: "It's been mostly underground because of the paraphernalia laws. We tried back 22 years ago. Susan Reed was the DA at that time. We were going to be able to do the syringe exchange and [our organization] tried to do that publicly, out in the open, and they… it didn't turn out too good. Some people were arrested for some paraphernalia laws and stuff. So we started just doing it completely undercover, underground. And we've really been underground up until last year." A downside to operating an underground needle exchange is that communication across the city becomes a challenge, thereby fragmenting programming, coordination and collaboration among agencies. Dr. Carl Hart wrote, "[t]he current legal restrictions impede communication between users and health-care professionals, as well as communication between more knowledgeable heroin consumers and the general public."[18]

Nationwide Political Narratives

I was not anticipating the prominence of nationwide political narrative within my interviews; however, understanding politics as a form of historical narrative, this should come as no surprise. Each law shapes the experiences of a social body and in turn creates a cultural memory, which is actively built upon. In this way, "historical memory provides a connective tissue between past wrongs and present injustices."[19] This section explores the passage of major drug laws within the U.S and examines their potential social outcomes within the scope of the research topic in chronological order.

Beginning with the passage of the Controlled Substances Act in 1970, the United

18 Hart, Carl. 56.

19 David M. Temin and Adam Dahl, "Narrating Historical Injustice: Political Responsibility and the Politics of Memory," *Political Research Quarterly* 70, no. 4 (2017).

States government created a punitive narrative around substance use and misuse through the justice system. This marked a new chapter in how these criminals are defined by the U.S. legal justice system by creating severe penalties for those caught with drugs. The Controlled Substances Act paved the way for an urban battle against drugs, which subsequently influenced the collective American conscience about who these criminals were and informed a great many stigmas around substance use, along with stereotypes about the user. These laws were racially biased.[20] Arguably, these laws remain racialized. Carceral rates due to substance possession are substantially higher for persons of color than that of Caucasians.[21] Continuing to 1984, the Comprehensive Crime Control Act formally brought about larger movements against drugs, and in 1986 the Drug Free America Act was approved. The Drug Free America Act targeted Crack cocaine with severe prescriptive punitive measures.[22]

Outside of the legal system, organizations like DARE became popular anti-drug movement supporters and prominent actors in shaping the stigmas and stereotypes of drug users. These laws and campaigns seem to be the birthplace of drug use stigmas, user stereotypes, and more generally, the modern visions of drug use captured in popular media today. The Anti-drug movement became popular enough that there were DARE advertisements on TV throughout the 80s and 90s. These advertisements weaved a narrative about drug misuse in popular media that aimed at inciting fear, creating what Adi called, "the us and them. The good people and the bad people." Adi remembers these sorts of strange anti-drug campaigns appearing on TV:

> "There were commercials where it's a kid who was smoking some pot and then his dad busts him and gets mad at him. Then he's like, 'you dad! I learned it from watching you!' The only message I got from that was that he had a shitty dad. He had a kid getting angry at his dad for giving him a bad example. Then the other one was an egg frying on a pan and it just said this is your brain and this is your brain on drugs. There's no, 'why's your dad smoking pot to begin with?' Or like… I don't know. It was just very one, drawing the line in the sand and if you can't do that then you're on the other side. There's no option other than just say no."

20 Crack cocaine laws as described by the Drug Free America Act of 1986 is a prime example of the racial prejudices that can be embedded into laws. See "A Cracked Remedy: The Anti-Drug Abuse Act of 1986 and Retroactive Application of the fair sentencing Act of 2010."

21 According to the UNODC, as of 2015, "77 percent of people incarcerated in federal prisons for drug offenses are Black or Latino."

22 Fabens-Lassen, Ben. "A Cracked Remedy: The Anti-Drug Abuse Act of 1986 and Retroactive Application of the Fair Sentencing Act of 2010." *Temple Law Review* 87, no. 3 (Spring 2015): 645–92.

Adi also recalls officers making school visits where they brought up the slogan Just Say No. Certainly, I am not equipped to assess the ramifications of anti-drug laws across the nation, nor is that the intention of this work; however, the history of this political narrative is vital in understanding some of the current ideas circulating around substances and political responsibility. The past molds political responsibility of the present, but additionally, "responsibility implies response, and thus a relationship not just to others but to historically rooted regimes of power and injustice."[23] Carl Hart captured this when he wrote, "politicians have long recognized that political and economic currency can be reliably garnered by arousing public fear. The perennial "drug problem" is outstanding in this regard. Today, the problem is opioids; tomorrow, it'll be something else."[24] In 2010, Congress passed the Fair Sentencing Act, which amended "the drug quantities required to trigger mandatory minimum sentences… The commission incorporated the new drug-quantity ratio into the Guidelines."[25] However, the Fair Sentencing Act was not retroactively applicable for those who were already sentenced for possession of illicit substances.

Morality of the Drug User

We all know at least one stereotype about drug users. You might know any number of alternative terms for a drug user: junkie, addict, burnout, or druggie. Each one of those alternative terms conjures up palpable notions of the kind of person they refer to. You might imagine someone who lacks motivation, or someone who is stupid or has poor moral character, or that they are a danger to society, or simply a drain upon the community as some type of creative nuisance. I assure you, these stereotypes are well known and thriving. Each participant named a handful of stereotypes about drug users: degenerate, low morals, loser, sick, disgusting, thief, or dirty, just to name a few. These stereotypes impact how a drug user, or a perceived drug user, moves through the world; however, they are poor descriptions of the variety of drug users that actually exist within any given community. Cecil noted, "The description that I hear in AA meetings all the time is: they live under the bridge, they drink out of a paper sack, they're not dressed appropriately or properly. But yet there are all sorts, teachers, half a dozen PhDs."

Alcoholics Anonymous provides an interesting means to evaluate the stigmas and stereotypes of the addict that fits well into

23 Vasques-Arroyo, Antonio. *Political responsibility: Responding to Predicaments of Power.* 2016. Qtd in Temin and Dah. 914.
24 Ibid. 103.
25 Fabens-Lassen, Ben. 650.

American culture because at its core, AA is shaped by Protestant, middle class values.[26] AA demands that each member prioritize cleanliness, punctuality and self-control. All of those values reify the basics of the good citizen: a fictive, exemplary community member who is productive, diligent, and clean; it's an impossible standard to achieve. The good citizen can relate to Christian principles "through the rights and duties with which the good Christian was expected to comply: moral rectitude, temperance, and subsidiarity."[27] The expectation of temperance clearly brings up the negative assessment an individual may receive regarding moral character if they drink or use drugs. Many of the stigmas and stereotypes of drug use and alcoholism overlap in harm reduction models like AA to reveal a process ultimately dependent upon a form of forgetting[28] to pave a way for identity creation.[29] What is crucial about these processes is they all rest upon the belief that the existing identity is rooted in shame. In this way, AA becomes a useful structure to assist in understanding the ways the addict is systematically made to feel shame.

Conversely, a good citizen is made to feel pride in their life and work. The good citizen is expected to complete a culturally appropriate amount of work. Someone who is drunk is unable to work and is therefore regarded as a problem in the good citizen model. The ability to work is critical in a conversation regarding an addict's morality because of the Christian expectation of subsidiarity. When the drunk is unable to work, an obvious issue arises: without an income how will they provide for themself? The burden of the drunk falls to the community, and here the political narrative becomes critical, particularly at the state level. Employability becomes a factor in understanding the good citizen model as "state capacity proves of crucial importance also for creating the structural preconditions to effectively shape the 'good citizen' as a productive member of society."[30] However, there is a mismatch here as many substance users are in fact able to and do work.

Khoshekh explained to me, "Not all drug use is good. A lot of it causes trauma. A lot of people don't wanna talk about it because it opens up a lot of trauma." There should be no mystery regarding the trauma someone can experience when they have to navigate a stigmatized identity. Furthermore, trauma can

26 Brandes, Stanley. *Staying Sober in Mexico City*. University of Texas Press, 2002. 26. *This is a finding from William Madsen cited by Brandes.
27 Mioni, M. "The "Good Citizen" as a "Respectable Worker:" State, Unemployment, and Social Policy in the United Kingdom and Italy, 1930 to 1950". *Politics Policy*, 49: 2021. 925.
28 Garcia, Angela. *The Pastoral Clinic: Addiction and Dispossession along the Rio Grande*. Oakland: University of California Press, 2010. See chapter "Elegiac Addict," 69-110.
29 Brandes, Pg. 80. "Carol Cain interprets personal stories as mechanisms of identity acquisition".
30 Mioni, M. 919.

originate from incarceration, which duly adds additional stigma. Let us imagine the experience of navigating through addiction and couple it with incarceration, which carries its own set of stigmas. Such a combination of social position and identity may seem insurmountable in the eyes of society. For the sake of clarity, let us adopt a definition of stigma using "Goffman's (1963) work, theorizing stigma as a mark of deviance that leads to unjust social rejection."[31] Returning to our imaginary experience, incarceration coupled with the reason for arrest can generate a new set of additional stigmas. In the case of substance related arrests, the labels of felon and addict are weighty and certainly impact the opportunities an individual may encounter or services they may be willing to seek out. Khoshekh explains this:"You don't see people who had been addicted and they don't find treatment until they have no veins left. They don't try to find a hospital because they'll get treated poorly for being an addict." Psychologist Zoe Feingold notes that "individuals with a history of incarceration are more likely to experience unemployment, poverty, and homelessness as well as psychological impairment, substance use problems, disruptions in health care access and mortality in the weeks and years following release."[32] The stigmatization of the drug user is poised to assess the moral character of the individual and their ability to be a good citizen. In this way, the stigmatization seeps into personal aspects of life and influences the decision an individual may make about seeking healthcare.

A majority of participants recounted to me an instance of medical bias against a patient. Balinda addressed the issues of medical racism and a need for culturally appropriate health care extensively. Something she discussed was the need for inclusivity in healthcare. She describes inclusive healthcare as "culturally appropriate health care [that] takes into account systemic and historical medical racism." Culturally inclusive care seeks to promote doctor-patient relationships and encourages meeting a patient where their needs are. In the case of dealing with individuals who live with stigmatized identities, culturally inclusive healthcare can serve as a means of restoring trust in the medical community.

Concluding Thoughts

San Antonio's particular circumstances around needle exchange programs provides a valuable opportunity to understand the sociopolitical dynamics of marginalized, underserved, and poor community members. Furthermore, San Antonio demonstrates how a

31 Feingold, Zoe R. "The Stigma of Incarceration Experience: A Systematic Review." *Psychology, Public Policy, and Law* 27, no. 4 (November 2021). 551.
32 Ibid, 550.

supportive community responds to meet the needs of the marginalized, despite the precariousness of the Texas legal landscape. I believe an ethnography of this type is necessary, especially when examining the sociopolitical impacts of the legality of harm reduction programs in Texas and elsewhere. By examining the legal framework of harm reduction programs through a community's lens, local social constructs that influence and shape cultural opinions of norms become exposed.

In viewing the law through a lens of historical context and within terms of political responsibility, we can also build an understanding of the individual in society. In this way, we may think of "the idea of the body as a natural symbol."[33] Mary Douglas wrote much about the body, borrowing from Mauss and Durkheimian principles. She elaborates on the body, writing, "We cannot possibly interpret rituals concerning excreta, breast milk, saliva, and the rest unless we are prepared to see in the body a symbol of society, and to see the powers and dangers credited to social structure reproduced in small on the human body."[34] I implore the adoption of this natural symbol. Through this process we can see a map of a social nebulus take shape on the flesh of an arm possessing sores left untreated, and we can understand some of the ways in which to treat them. If indeed political history creates a narrative, the war on drugs has generated a novel set of stigmas surrounding substance use that negatively impact the individual. The political responsibility to respond may find solutions in culturally inclusive harm reduction programs and needle exchange because these measures seek to restore trust among the most vulnerable parts of a community. These processes are not isolated; rather they seem to extend into any form of substance misuse, addiction, or houselessness. A needle exchange program is a means of radically empowering the addict rather than socially shaming them through stigmatization.

33 Strathern, Andrew. "Body Thoughts". Ann Arbor: University of Michigan Press. 1996. 13.
34 Douglas [1966] 1984, 115. Qtd in Strathern, 14.

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