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## The case of a needle exchange policy debate in Fresno, California

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### Abstract

Needle exchange is one of the most effective public health interventions to prevent the transmission of infectious disease by injecting drug users. Despite the preponderance of scientific evidence, US federal funding for needle exchange programmes has been banned since 1988. This prohibition has resulted in the lack of a centralised policy on needle exchange and has given birth to a patchwork of diverse practices and regulations throughout the nation. This article focuses on how various local players interpreted the meaning of needle exchange through the debate on an unauthorised site in Fresno, California. In exploring a specific context, this study delineates the narratives used to outline competing views about needle exchange and to offer a snapshot of how the issue of widespread injecting drug use was handled in an impoverished and socially conservative region of the United States.

### Keywords

harm reduction; injecting drug use; needle exchange; policy narratives

### Introduction

Injecting drug use poses many health and social risks, including the spread of diseases, such as HIV and Hepatitis C, as well as violence, self-harm, and incarceration. It also causes distress to families and communities that deal with the many consequences of addiction. Needle exchange is one of the most effective public health interventions to prevent the transmission of infectious disease by injecting drug users (IDUs) (Delgado, 2004; World Health Organization, 2004). Though needle exchange has often been constructed as solely a health intervention, evidence indicates it enhances resilience and social well-being by linking clients with services and reducing stigma (Sirikantraporn et al., 2012). Despite the preponderance of scientific evidence of the efficacy of the intervention, US federal funding for needle exchange programmes (NEPs) is banned. The 2009 Consolidated Appropriation Act passed by Congress temporarily modified the ban on funding needle exchange and three NEPs in the United States (or 1.6% of all NEPs) received federal funding (Green et al., 2012: e11). However, the ban was reinstated by Congress in 2011. The prohibition has

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resulted in the lack of a centralised policy on needle exchange and has given birth to a patchwork of diverse practices, regulations, and funding models throughout the nation (Bowen, 2012).

This article focuses on how various local players interpreted the meaning of needle exchange through the debate on an unauthorised site in Fresno, California. In exploring a specific context, this study uses a narrative policy framework (Jones and McBeth, 2010) to outline competing views about needle exchange and to offer a snapshot of how the issue of widespread injecting drug use was handled in an impoverished and socially conservative region of the United States. This case study indicates the need for social workers to take a more active role in local policy advocacy for harm reduction as a policy intervention that decreases social exclusion, stigma, and social injustice.

Drug addiction is a highly emotive issue as it is embedded in narratives of shame, devastation, and criminality. In 2011, it was estimated that nearly 9% of non-institutionalised Americans over the age of 12 (22.5 million people) had used illicit drugs (Substance Abuse and Mental Health Services Administration, 2012). Illicit drug use and the abuse of prescription medication have been on the rise over the past ten years. Drug overdose deaths rose for the eleventh consecutive year in 2011 and appear to continue their upward trajectory (National Institute on Drug Abuse, 2014). Injecting drug users have a higher prevalence than non-users of homelessness, unemployment, and mental health issues (Lazzarini, 2001).

Drug policy in the US tends to be framed either as zero tolerance/abstinence, which puts the responsibility for control on law enforcement, or as harm reduction, which places responsibility on public health (Des Jarlais et al., 2006). Social work is often absent in this discourse, focusing its attention instead on pragmatic interventions to treat addiction which commonly use a disease model (Lushin and Anastas, 2011). Scientific evidence suggests that harm reduction has greater efficacy in reducing infectious disease transmission than abstinence interventions (Abdul-Quader et al., 2013; Logan and Marlatt, 2010). Needle exchange programmes (NEPs) are also often used as a gateway to services, where users can connect with social workers (Hagan et al., 2000). Yet, it is generally considered more politically expedient to promote criminalising zero tolerance policies towards drug use rather than harm reduction which can be interpreted as enabling addiction (Bowen, 2012).

This article proceeds by first outlining the emergence of harm reduction policies and interventions in the US. It examines ways that illicit drug addiction has been viewed historically and linked to how contemporary policy frameworks narrate drug policy. The method of narrative policy framework and data collection is discussed. The article then focuses on the case study of the legalisation debate on needle exchange in Fresno, California between 2006 and 2011. The significance of the debate on needle exchange is summarised with its implications for social work and health care policy.

## **The emergence of harm reduction policy and interventions**

Harm reduction was defined by the World Health Organization in 1974 as policies and measures 'to prevent or reduce the severity of problems associated with the non-medical use

of dependence-producing drugs' (World Health Organization, 1974). The General Assembly of the United Nations has endorsed harm reduction and set targets in 2001 for all countries to make such interventions available to drug users (United Nations, 2001). Although syringe exchange has been endorsed by the American Medical Association, public policies on addiction often exemplify the contradictory attitudes of stigma and the impulse to treat a disease (McLean, 2011). Despite the fact that syringe exchange has been officially endorsed by many medical associations (Maher and Iversen, 2009; Satcher, 2000) and recognised as an important harm reduction intervention by scientific research (Cox et al., 2009; Des Jarlais et al., 2009; Ksobiech, 2006; Riley and O'Hare, 2000; Tsai et al., 2010; World Health Organization, 2004), public policies often remain in thrall to perceptions that it enables drug abuse (Des Jarlais et al., 2009).

When the AIDS epidemic first hit, advocates sought to find ways to reduce its transmission which was highly prevalent in IDUs. However, they were only able to recommend abstinence or the use of bleach to clean needles owing to laws banning the sale of syringes. Edith Springer, who worked with drug users in New York City, first brought European notions of harm reduction to the United States in the early 1980s after observing syringe exchange in Amsterdam and Liverpool. As she later reflected:

It was so eye-opening to go over there and see the different attitudes they had in general towards people, and towards drug users. It made you realize how terrible the attitudes were that we were holding here [...] In all my work I saw that the services were the least of it, the most of it was the way you treat people and the relationship that you make with the person as a helper. And you say whether in words or deeds: 'we are equal. I'm just like you and these are your choices. I'm here to give you tools and to help you, but I'm not here to control you'. (Harm Reduction Coalition, 2011)

Needle exchange thus sprung from a community-based harm reduction, client-centred framework.

The first American NEPs were started in the late 1980s in Tacoma, Washington, Portland, Oregon, San Francisco and New York City (Centers for Disease Control, 2005). The aim of NEPs is to ensure that IDUs use a clean needle every time they inject, and dispose of the used syringe safely. As drug users often inject many times per day, an average IDU can easily use over 1000 needles yearly. Needle exchange is a harm reduction activity because it reduces the spread of infectious disease in the community. NEPs do not require that addicts stop using to receive services. Harm reduction is an alternative to moral, criminal, and disease models of addiction (Marlatt, 1998). Although scientific evidence shows the efficacy of harm reduction, these types of efforts are often viewed as enabling addicts because they focus on mitigating the negative impact of addictive behaviours on the individual and community rather than eradicating addiction. From the perspective of harm reduction supporters, however, syringe exchange is a social justice issue that ensures equal access to health and enhances personal empowerment to utilise safer practices.

## The context

Fresno County, with its population of nearly one million, is one of the fastest growing regions in California. Located in the Central Valley of California, Fresno has some of the highest rates of intravenous drug use per capita in the US (Tempalski et al., 2007). Heroin, oxycontin, and methamphetamine are the most common drugs of choice. Widespread injecting drug use brings a relatively high prevalence of Hepatitis C and HIV in local vulnerable populations (Fresno County Department of Health, 2011). Recently, Fresno ranked number 23 in the list of American cities with high HIV infection rates (US Census, 2012). Fresno County has higher rates compared to the rest of the state of admission to treatment for alcohol and drug dependency, arrests due to dangerous drug offences, as well as hospitalisations and deaths due to drug and alcohol use (Center for Applied Research Solutions, 2010: 3). Addiction and its associated health consequences are therefore intertwined with pervasive poverty in a region that is ranked as among the lowest on the Human Development Index in the United States (Lewis et al., 2010; Springer et al., 2010).

Access to clean syringes is very difficult in the Fresno region due to socially conservative policies that made the distribution of clean syringes illegal (Blumenthal et al., 2008; Des Jarlais et al., 2009; McLean, 2011; Maher and Iversen, 2009; Shaw, 2006). For nearly 20 years, every Saturday, a small group of community activists has distributed free clean syringes in a one- to two-hour period at a site in an empty cul-de-sac. All funding comes from private foundations, none from the state or county. Until a state law came into force in 2012 which precluded local ordinances, the Fresno NEP was unauthorised and operated without the explicit consent of the county. Between 2006 and 2011, two distinct narratives defined opposing viewpoints in the debate over the authorisation of a community-based needle exchange in Fresno County, California. Although the dominant local narrative of harm reduction as an enabling activity won the vote at the time, the process of competing narratives opened up the possibility for other ways of understanding and working with drug addiction. In 2012, a state law ensured the legality of needle exchange in California, thus decriminalising the existing needle exchange.

## Evolving narratives of drug use and addiction

Contemporary social and health policies towards opiate misuse intersect with social care and law enforcement to discipline the individual user. Some research suggests that the source of opiates and methods of use have a strong influence on which groups are most at risk (Unick et al., 2013). Other studies indicate that social vulnerability has a strong influence on reasons for use (Agar and Reisinger, 2001). Yet, perceptions of users (and the need to care for or criminalise them) form the basis of policy narratives of drug control and addiction treatment rather than the structural causes that often shape addiction.

Early stereotypes of opium addicts were often constructed through the 'poet syndrome', viewing certain individuals as needing opiates to contain their hypersensitivity to the world (Rauch, 2000). Although opiate addiction was prevalent among Chinese immigrants and working class white people, the most common opiate addict at the turn of the 20th century in the US was a middle-aged, middle class, 'respectable' white woman (Keire, 1998). Most of

these women had become addicted to opiates through physicians' prescriptions. However, there was a striking change in patterns of addiction that coincided with the Harrison Narcotic Act (1914), which greatly restricted legal access to opiates and was interpreted to outlaw maintenance therapy thus altering prescription practices (Courtwright, 2012: 487).

After the First World War, iatrogenic addiction became less common and opiate abuse became prevalent among working class urban males. By the end of the 19th century, however, fears of race and class had intersected with fears of drug use resulting in an increased desire to regulate, criminalise, and prohibit opium use (Cohen, 2006). Drug control policy thus emerged in the 20th century as a way to contain urban working class and minority ethnic young men. A growing epidemic of heroin use and petty crime arose in American cities in the 1960s culminating in the popular War on Drugs initiated by President Nixon in 1971. This policy sought to stem the rise in opiate addiction through the active interdiction of the international drug trade (Heath, 1992). At the same time, however, Nixon also quietly enhanced methadone treatment, a harm reduction intervention, which compensated for the lack of street heroin by enrolling users in maintenance treatment and was thought by many to be responsible for the reduction in crime rather than the War on Drugs (Agar and Reisinger, 2002). The crack cocaine epidemic of the 1980s gave rise to mandatory sentencing for certain substances, often reflecting racial disparities by drug of choice, and led to the United States becoming the country that imprisons the largest percentage of racial and ethnic minorities in the world (Alexander, 2012: 5; Ciccarone, 2009; Gilmore, 2007). In 2013, it was estimated that 51% of the federal prison population was imprisoned for drug offences (Carson, 2014).

As the criminalisation of drug use emerged as the dominant policy towards substance use in the US by the end of the 20th century, abstinence was seen by social and health care as the primary way to approach addiction (Fitzgerald, 2010; Vrecko, 2010). Most treatment centres and group meetings (such as Alcoholics Anonymous) require that participants are completely sober before being admitted and pathologise behaviour seen as 'enabling' drug use. Hence participating in an intervention in which drug users take personal responsibility for their addictions is often seen as the only way to overcome the assumed powerlessness these individuals have over drug dependence. In these models, successful interventions are measured by the amount of time in sobriety (Simmonds and Coomber, 2009).

Harm reduction privileges the safety of the individual and community over criminalisation. In this narrative, people who use drugs are seen as autonomous and capable of making their own decisions. Though methadone maintenance was started in the US in 1964 in response to a post-war epidemic of heroin addiction, harm reduction has largely remained an anomaly in American public policy (Agar and Reisinger, 2002). In Europe, however, there are organisations of people who use drugs that advise governments on drug policy through networks such as the European Harm Reduction Network. The fact that abstinence is not the goal of harm reduction has made it a controversial intervention to many socially conservative groups in the United States. Funding for harm reduction research by institutions such as the National Institutes of Health has therefore come under increased scrutiny owing to political pressure (Bourgois and Schonberg, 2009).

Ways of narrating addiction have transformed considerably in recent decades. Addiction is no longer seen as an essential quality, but rather as ways that people have learned to behave or manage their emotions as well as chemical dependency (White, 2007). Addiction is also explained in terms of genetics and biology, but often diagnosed in terms of social factors, such as impaired social functioning (e.g. damaged relationships) or feelings of shame, guilt, and loss of control (Leshner, 1997; Vrecko, 2010). Many intervention efforts focus on interpersonal relationships, personal growth, and small-scale individual change (Payne, 1997). As Ulrich Beck argues, contemporary neoliberal society places the burden of hazards and risks increasingly on the individual rather than the collective (Beck, 1992). Addiction is therefore seen as a problem to be managed through bio-psycho-social interventions rather than as a community social justice issue.

An absent element in narratives of addiction is often the role of environment and social structure. As the physician Paul Farmer has pointed out, social and health professionals are generally acutely aware of how the larger structural forces of oppression have an impact on the health and well-being of their patients and clients (Farmer, 2003). Public health has long discussed the social determinants of health and how the structural violence of oppression reproduces health inequalities (Hofrichter, 2003). However, there are few studies on how structural violence is linked to biosocial understandings of medical phenomena, such as addiction (Farmer et al., 2006). Owing to the focus on the individual and her recovery process, many addiction theories do not contextualise the trajectory of the illness in a socio-economic and political context (Maté, 2010). Philippe Bourgois and his team have conducted numerous studies of how addiction must be seen in the wider context of oppression and inequality (Bourgois, 1999; Bourgois and Schonberg, 2009). Anthropologists Agar and Reisinger argued that policy has little effect on the onset of a drug epidemic. In order to understand the rise in use of a particular drug, the socio-cultural and political-economic context must be understood (Agar and Reisinger, 2001). The rise of crack cocaine in poor African American communities, for example, can only be understood as a response to social suffering by marginal population groups experiencing extreme forms of structural violence (Bourgois, 2003: 32). Drug use, in short, can be one response when there is an unexpected change in a group's circumstances and a gap emerges between expectations and reality, such as industrial closures that produce mass unemployment or community displacement due to gentrification, which causes collective trauma and can preclude individuals from leading fulfilling, socially connected lives (Agar and Reisinger, 2001). In this perspective, policies that focus solely on controlling the drug user as an individual rather than working with the social suffering of the community cannot address the real reasons for substance misuse.

### **Narrating policy: Method and data**

The aim of this study is to examine how a local debate in a city in California on needle exchange as a harm reduction activity was structured through two distinct narratives of policies on drug use. Narratives are understood here as temporal accounts of the origins, aims, and impacts of policies. They use plots, emotions, victims, and villains to explain why a situation is as it is and how it should be changed (McBeth et al., 2014). The power of narrative lies in its ability to touch people's hearts and make meaning of a situation.



Therefore, researchers are often focused on ‘what narrative does’ instead of ‘how narrative does it’ (Andrews et al., 2008: 8). The narrative policy framework (NPF) methodology has brought the role of emotion and storytelling in the policy-making process to the centre of analysis (McBeth et al., 2014). NPF explores the emergence of policy as ways that different interests make sense of a series of events through narrating solutions (Shanahan et al., 2013).

The data for this study consists of five interviews of local needle exchange activists (completed with human subjects’ approval and not under conditions of confidentiality), news articles written about the Fresno needle exchange in both local and national media, Board of Supervisor audio recordings and minutes, and the Fresno Grand Jury report on local harm reduction efforts. The author was also directly involved with the exchange as a volunteer and ethnographic researcher from 2007 until 2014. All texts were analysed using a NPF approach to coding textual data and constructing the distinct narratives on needle exchange policy.

## The story of the Fresno needle exchange

The Fresno needle exchange was founded by two siblings from Northern California in 1995. They had volunteered earlier with an unauthorised Santa Cruz needle exchange, which began as a community-based response to the AIDS pandemic (Rodriguez, 2006). American harm reduction efforts in the 1980s were a highly politicised activity in which activists risked arrest to distribute syringes to prevent the transmission of disease. Often intertwined with notions of civil disobedience and anarchism, emerging unauthorised needle exchanges in the US challenged the moral panic surrounding AIDS by viewing drug use as a choice and seeking to reduce the harm produced by addiction (Smith, 2012: 210). Thus, a harm reduction narrative was constructed in the US that (unlike European counterparts who had governmental support) combined elements of anti-authoritarianism and distrust of authorities based on the principles of autonomy and mutual aid (Smith, 2012: 213). As the cofounder of the Fresno needle exchange stated: ‘When the powers that be don’t even listen to reason, then I have no problem [breaking the law]’ (Rodriguez, 2006). Needle exchange therefore became an avenue to challenge the moralising narratives used by government officials to justify stigmatising policies towards drug users, gay people, and sex workers that led to higher rates of infection, criminalisation, and often early mortality (Bowen, 2012).

Congress banned federal funding for needle exchange in 1988 (Hulkower and Wolf, 2013). As a result, state and local authorities became key players in formulating policies to reduce HIV and Hepatitis C infections (Collins and Summers, 2002). Needle exchange was first taken up by the California legislature in 1999 with the introduction of Assembly Bill 136. Originally, the Bill sought to define the conditions to legalise needle exchange programmes. However, through compromise, the resulting law in 2000 amended Section 11364.7 of the California Health and Safety Code to allow NEPs by local declaration of a critical health emergency. It was widely held, though not explicitly stated in the law, that these emergencies must be reconsidered every 14–21 days for renewal following the California Emergency Services Act (Blumenthal et al., 2008). A study of the impact of the 2000 law found that though there was a 46% increase in approved NEPs, just one programme opened in a county that previously did not have one (Blumenthal et al., 2008). This suggests that only in

counties that had political will to sustain needle exchange were programmes able to expand their services.

Founders Tony Mello and Jean Rodriguez initially approached the Fresno Health Department in the mid-1990s asking to collaborate in starting a needle exchange. Officials were sympathetic, but said that it would never work in socially conservative Fresno County. Mello then began going to the community centre where HIV results were being given and distributed cards with his phone number for people wanting to exchange used syringes for new. As demand gradually increased, the siblings initially started home delivery before moving to a stationary location. According to Rodriguez, Mello discussed his plan to hold a needle exchange at a fixed location with the chief of police who said that the police would only respond if there were complaints (Rodriguez, 2006). As Rodriguez noted: 'Of all the people in town, they [the police] get it'. Unable to come out publicly for the needle exchange, both the local police and health department provided behind the scenes support for the activists. Police, according to Rodriguez, would often pull up to the exchange in response to a complaint from a vantage point in which they could not see the needles and therefore could avoid arresting the pair on drug paraphernalia laws.

In 1998, however, police did see the boxes of syringes and were compelled to arrest three activists for possession of drug paraphernalia when passing out sterile needles at the Fresno exchange. Threatened with one year in jail and a fine, the activists went to trial with public health expert Dr Peter Lurie testifying on their behalf that they were acting in the community's interest by reducing the spread of infection. Exonerated of all charges after a two-year process, the activists asked the Fresno Community Health Department (CHD) to declare a public health emergency that would allow local needle exchange (*Los Angeles Times*, 1999). Despite the fact that CHD Director Edward Moreno declared a health emergency due to the high rate of infectious disease among IDUs, it was the Board of Supervisors that was required to act to decide on which measures should be taken in the event of a health emergency.

A medical resident and former social worker, Marc Lasher, volunteered at the needle exchange in 1996 as his culminating community project for his residency (Lasher, 2011). Motivated by the human suffering he saw and the needles found in the alley behind his house, he eventually founded the Fresno Free Medical Clinic (FFMC) which has operated inside of an old school bus independently but alongside the NEP since 1998. The clinic has become an integral part of the exchange providing ongoing medical care at the site and attracting social and medical care students and professionals to volunteer at the site. According to Dr Lasher: 'Addicts have a very unique set of problems, and need a lot of medical care. We act as a portal to the health care system for a population that has fallen off the edge of the world' (Conley, 2011). The FFMC provides essential health services to the marginalised populations that utilise the site. Most importantly, it offers a 'medical home' for people who may need documentation to prove that they are indeed opiate abusers to get benefits to enter methadone treatment.

The Fresno County Alcohol and Drug Advisory Board recommended that the Board of Supervisors support the NEP in 2004. The following year, the Fresno County Grand Jury



issued a report supporting needle exchange as a public health measure (Fresno Grand Jury, 2005). The local newspaper wrote an editorial calling for authorisation of the exchange (Kaiser Health News, 2005). The editorial made the argument that the exchange mitigated the cost of caring for people with HIV. Several articles appeared in state and local newspapers exploring the high social and economic cost of IDU infections (e.g. Branco, 2011). Consequently, a proposal was made to legalise the needle exchange in Fresno but it was voted down by the Board of Supervisors who claimed that they had concerns about potential liability, even though AB 136 exempted localities from criminal liability in operating a NEP. More importantly, supervisors cited the perception that NEPs promoted enabling behaviour towards addiction. Democratic supervisor Henry R. Perea said that he would consider voting for the needle exchange if 'it was connected to a mandatory treatment program' (Anderson, 2005), though he did not say where the many treatment beds would come from. Supervisor Phil Larson commented: 'I feel it's an enabling process for someone to stay on drugs longer and not to get them off' (Branco, 2011). This view was mirrored by Sheriff Margaret Mims who stated in a Board of Supervisors meeting that needle exchange attracts drug users from other places and would cause increased crime in Fresno. A clear division thus emerged between politicians, who viewed the exchange as promoting drug use, and community advocates, who considered it a public health intervention. Only one supervisor, Susan B. Anderson, voted in favour of the exchange stating: 'It's a health issue'.

In 2008, the Fresno County Department of Community Health proposed authorising the syringe exchange within the framework of the Community Health and Safety Collaborative Pilot Project. It was narrowly approved, though the details of the collaborative project had not yet been formed and no funding was appropriated for its development or operation. The project was therefore required to find agency partners, to make a concrete plan, and to bring the contracts back to the Board at a later date for final approval. The idea of the collaborative project was to take the exchange off the streets, establish wraparound services, and house it in a shopfront available at certain times. The pilot project was to be developed with the local behavioural health substance abuse programme, substance abuse treatment services, HIV support services, employment and temporary assistance services, and health department, while integrating the Fresno Free Medical Clinic as an independent contractor. These agencies had been largely supportive of the unauthorised exchange within the restrictions of the law. Several planning meetings were held to discuss the details of the project. There were nonetheless competing visions of what the collaborative project should do. There was some discussion of whether IDUs would feel safe in a space with government workers, often seen as representatives of an oppressive system rather than helpers.

The contracts for the project were not brought before the Board until nearly three years later for various reasons, by which time the composition of the Board had changed. The Board rejected the contracts, with registered nurse and County Supervisor Judy Case stating: 'It's a philosophical question whether you give someone the tools to continue an illegal behavior, I just think providing needles to addicts is enabling' (Alexander, 2011). The view of drug use as a personal failing rather than a local health issue ultimately won the day at the Board of Supervisors. Indeed, the project seemed doomed to fail when the Board hesitantly authorised it but refused to allot any funding for it. In 2012, a bill was signed by the Governor of California that gave legal permission for syringe exchange to operate in regions of high risk,

with some limitations. In effect, this authorised the Fresno needle exchange without its requiring the consent of the local Board of Supervisors. However, the lack of funding ensured that even though it was authorised, the needle exchange would continue to operate within the restrictions of its very limited resources. This meant that there would be no restroom facilities, hours would be very limited, clients would have to continue to wait outside in the elements to exchange needles, and the availability of the amount of needles and other supplies (cottons, condoms, alcohol wipes, etc.) would be subject to the current state of funding. Most importantly, there would be no wraparound services on site and the clinic would only be able to treat a limited repertoire of ailments.

## Discussion

The story of the Fresno needle exchange debate illuminates the power of narratives that surround drug misuse. Despite scientific evidence that needle exchange is the most effective way to prevent the spread of infectious disease among injecting drug users and protect the community, social anxiety remains focused on the addict. Seeing it as a law enforcement issue to be contained, the county first attempted to shut down the needle exchange by claiming that it was distributing paraphernalia rather than operating as a health intervention. Later, when the first discussions about authorising the exchange started due to the declaration of a local health emergency, a supervisor insisted that addicts needed to accept treatment to exchange for a clean needle. These reactions were framed within politically popular narratives that constructed users as hazardous individuals to be controlled through incarceration or care. The public debate in the Board of Supervisors nonetheless gave an opportunity to proponents to demystify the intervention and explain the notion of needle exchange as harm reduction for the community as a whole.

Needle exchange is now legal throughout California, though it remains illegal in 23 states (Carpenter, 2015). Until 2012, NEP authorisations in California were decided on a county-to-county basis, while regions in which needle exchange was previously unauthorised remain underserved. Policy debates on needle exchange were often framed in Manichean terms of favouring enabling drug use or putting public health and safety as a priority (Blumenthal et al., 2008). Underlying such discussions were stereotypes about people who inject drugs and whether they were 'deserving' of services if they did not terminate drug use. These types of debates reveal the power of cultural narratives of individual responsibility versus collective solidarity as redefined in the neoliberal age of the risk society. The philosopher Ulrich Beck has argued that we live in circumstances in which the individual rather than the community organises life narratives and thus assumes the agency and risks for choices and turns of events (Beck, 1992). The politically powerful anti-NEP narrative in Fresno County viewed IDUs as responsible for their choices and therefore not entitled to a publicly sanctioned space in which to exchange needles, an activity considered as enabling behaviour. Many of the proponents of this perspective were politicians or from county law enforcement. The emotionally powerful pro-NEP narrative constructed IDUs as human beings entitled to access to tools to ensure their safety regardless of their drug using behaviour. This view was largely promoted by physicians and public health experts, with some former users of the exchange (usually those in recovery to mitigate fears of being arrested) speaking out publicly. There were few voices, however, from the social work

community backing the needle exchange, as interventions that utilise social workers generally require abstinence from clients. While the sympathetic treatment of the Fresno NEP in the national press often placed IDUs and their behaviour in a broader social context, there were scant local visions of how the larger structural forces of oppression that reproduced social and health inequalities could be tackled.

The 2011 compromise with the Board of Supervisors to create a collaborative health pilot project fizzled out due to the lack of common ground, funding and a clear timetable. Many of the social service agencies participating in the process viewed themselves as contracted-out providers rather than coming to engage with the exchange as a potential site for social transformation of the drug using community. The failure to come together reflected the ambivalence of both sides regarding whether drug use was a choice or should be controlled through mandating sobriety to receive services. It also showed the complexity of bringing a community-based intervention sceptical of the authorities into partnership with government agencies. Discussions regarding the vision of the collaborative project were torn between social and health care professionals who saw benefit in working with the authorities and activists who sometimes felt cooperation meant complicity with an unfair and oppressive system.

How, then, do we interpret the silence of social workers in Fresno? The answer perhaps lies less in a monolithic conspiracy of silence than in the implicit consequences of the neoliberal shift in the social work field towards market ideology-driven services that see clients solely as individuals in need of treatment. Social workers, who are educated in the multiple systems of oppressions that affect individuals, families, and communities, perhaps should have been best positioned of all professionals to advocate for the complex needs of injecting drug users. Despite social work's roots as a community-focused set of interventions committed to the collective struggle for equity and social justice, neoliberal market forces have increasingly positioned social workers as clinically-based professionals engaged in expert-led direct practice with individuals, groups, and families (Hill et al., 2010). As many clinically-based professionals work for contracted-out direct services managed by non-profit or for-profit companies, or even in private practice, social workers face the dilemma of how to advocate for interventions that may be seen as contrary to their own or their employer's interests in obtaining and maintaining clients or contracts. Fresno County has contracts for services with at least 12 in- and outpatient facilities that treat addiction. County costs for these contracts are high. Moreover, the ideology of the risk society has filtered down into clinical practice often in the form of 'empowerment', where clients are increasingly guided towards making consumer-driven individual choices for services rather than finding ways to heal and uplift the whole community. As the profession of social work has become fragmented across the spectrum of public and private agencies, practices, and interests, it has become ever more difficult to define a professional perspective on socially just community interventions. Hence, there were few voices from the local social work community advocating for the importance of harm reduction in the form of needle exchange in Fresno.

At present, the Fresno NEP operates much as it has since its start with the same small budget and minimal services. This case study reveals the shortcomings of an absent national harm reduction policy. Lacking funding ensured by the state and clear guidelines for

implementation, each needle exchange must advocate for itself amidst the prevailing state and local political winds and narratives that view drug users as flawed individuals. In areas such as Fresno, where there is a socially conservative political structure in a region of extreme poverty with a high prevalence of intravenous drug use, there are very limited possibilities to develop harm reduction services to mitigate infectious disease when pathologising and criminalising narratives dominate decision-making bodies.

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