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Why we need needle exchanges and more drug treatment programs

San Jose

AS A YOUNG police officer, I had no patience or sympathy for alcohol and other drug abusers. After all, didn't they make a free choice to use, to abuse and to become hooked on various substances, legal and illegal? Besides, weren't these people just bored, or thrill seekers?

Now, as a trial judge handling criminal, juvenile and family law cases, I deal with the lives of real people.

Experience and education have shown me a side to the problem that many in Washington or Sacramento choose to ignore or are politically afraid to acknowledge.

Approximately two years ago the Santa Clara County Board of Supervisors was forced to discontinue a modest needle-exchange program developed in an attempt to help prevent the spread of HIV/AIDS.

The supervisors had been informed that state Attorney General Dan Lungren wanted such programs halted. He felt that they were illegal and would contribute to increased drug usage. He was prepared to file suit.

A 1995 study showed drug injection, presumably with unclean needles, causes more than 60 percent of HIV cases in certain areas.

More than 70 percent of HIV infections among women of childbearing age are related either directly or indirectly to injection drug use.

And more than 75 percent of babies diagnosed with HIV/AIDS were infected as a direct or indirect result of injection drug use by a parent. The numbers alone suggest that aggressive action is needed.

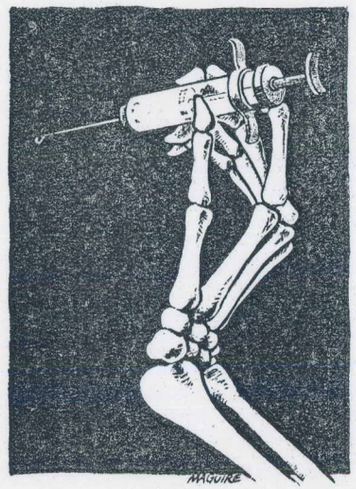
Recently the federal government has taken contradictory policy positions regarding the appropriateness of needle-exchange programs.

Gen. Barry McCaffrey, director of the Office of National Drug Control Policy and advocate on behalf of the White House, has taken the position that needle-exchange programs re-victimize the disadvantaged.

The programs are almost all in predominantly minority, low-income neighborhoods. The theory is that such programs are magnets for crime, violence and drug dealing — and drug usage is said to increase owing to the availability of free needles. Therefore, according to that viewpoint, needle-exchange programs should not exist and, in any case, should not be supported by federal dollars.

His position is a difficult one to accept when consideration is given to the fact that demands for drug treatment programs greatly exceed the supply in all sections of our communities, and especially in the minority communities.

Health and Human Services Secretary Donna Shalala has supported needle-exchange programs because they provide a means of producing a marked decrease in



HIV infections without escalating drug use.

The National Institutes of Health has funded much of the research into the effectiveness of needle-exchange programs and their impact on drug use.

Their recent findings conclude that such programs have achieved their goals: Reducing the rate of AIDS/HIV infection without increasing drug use.

What is not in the debate between the various Cabinet members are the appalling facts — the correlation between drug usage and HIV/AIDS infections. Since the AIDS epidemic began in 1981, injection drug use is increasingly responsible for the spread of AIDS.

I know that an indicator of the possibility of sexual, physical or emotional abuse is when youngsters begin to abuse alcohol or drugs; that substance abuse is a method of self-medication, to help numb the mind, to help forget the horrible experiences that one has suffered through, usually in early life.

Substance abuse may also indicate a dual diagnosis — the combination of a major mental health disorder along with addiction.

I have seen women in abusive relationships who have at least temporarily escaped their predicament through a drug-induced haze.

Pregnant intravenous drug users present a special set of challenges, especially to judges. Common sense tell us that the fetus benefits from the cession of drug use at any time during the pregnancy and, naturally, the sooner the better. However, "cold turkey" withdrawal detoxification from depressants like alcohol, heroin or Valium, virtually guarantees a spontaneous abortion.

Unless the jail has appropriate prenatal procedures to deal with detoxifying pregnant inmates, the humane course might well be to allow the woman to obtain outpatient prenatal care coupled with alcohol and other drug treatment.

Pregnancy provides a unique time for treatment intervention because the mothers are motivated by fear of harming their babies. If treatment is not made available, however, we cannot expect them to stop using drugs on their own, no matter how badly they want to stop.

Needle-exchange programs provide opportunities for much more than clean needles. They provide a direct linkage to drug treatment and counseling as well as needed medical services. They also provide the opportunity for education regarding safe sex, drug usage, prenatal education and treatment.

Why is it then that so many are opposed to needle-exchange programs on the local, state, and federal levels?

First is the political perspective that "law and order" issues sell to the public and that the "lock 'em up" model is the preferred one. It's a perspective based upon the view that abuse is a sign of moral decay. It doesn't recognize addiction as a medical treatment issue.

Second is the sentiment that addicts are damaged goods — disposables — and that their children are "throw-away babies" who will be a burden to the public and become addicts themselves.

As a judge, I have worked with abusers of alcohol and drugs for almost eight years. More than half of the people in our jails and prisons are nonviolent substance abusers. With adequate treatment, most could hold productive jobs and care for their families.

Studies by the Rand Corporation, the United States General Accounting Office and the state Department of Alcohol and Drugs, as well as numerous other government agencies and other institutions, have demonstrated that prevention and treatment are seven times more effective than straight police intervention.

Treatment need not be extensive or expensive. I have seen miracles performed for some persons by involvement in Alcoholics Anonymous or other 12-step programs — although these are not considered "treatment" in the strict sense of the word.

It is cruel how many prisoners are denied such basic treatment opportunities, and yet we continue to expect that they will leave custodial facilities clean and sober for all eternity.

Legalization or decriminalization are not answers for these social issues. Coerced, structured treatment is our only hope for long-term sobriety for the addict and for our communities.

In conjunction with good prevention programs, treatment may help start our own community's recovery. Santa Clara County has tried to provide appropriate treatment opportunities in numerous settings but has been has been limited by a lack of funds.

Most addicts are like most of us, ordinary people who do not possess special gifts or strengths.

There is however, inside most of us, an inner strength.

We must help addicts overcome their chemical problems with belief in that inner strength: Grab it, hold on to it, and use it. They must never surrender it nor lose faith in it — or in their abilities or ours to provide the necessary treatment facilities.

We must convince our elected officials that effective treatment on demand is a right that should be extended to all who request it, for no child or parent is expendable.

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