CITY IN PAIN

CLARE MILLER

Uncovering the harsh realities—and the human face—of San Francisco's injection drug epidemic. A special report.

EDITED BY GARY KAMIYA AND LINDSEY J. SMITH

Heaven and hell in a $10 bag: a tenth of a gram of Mexican black tar heroin, purchased by a user across the street from the San Francisco Public Library.

DOPE SICK

San Francisco is enduring its greatest public health crisis since the height of AIDS. Will we rise to the challenge, or turn away in revulsion?

Frank ambles across Market Street to the north side, by the BART entrance and the Burger King, across from the main branch of the San Francisco Public Library. A pleasant-looking, nicely dressed Latino man walks up to him. They clasp hands for a fraction of a second. During that brief exchange, Frank hands over a $10 bill and receives a tenth of a gram of Mexican black tar heroin, tightly wrapped in a plastic ball about the size of a pea. "That guy always treats me well," Frank says as we walk up Grove Street. "He treats me with respect, not like I'm some lowlife."

Frank is a 38-year-old former glassblower from Milwaukee, Wisconsin, who's lived on the streets of San Francisco since 2013. He started taking Vicodin pills for carpal tunnel pain when he was about 20 and "didn't know anything about addiction." He soon graduated to OxyContin. When that got too expensive, he started snorting heroin. By 24, he was shooting it. He's been addicted ever since, using three or four times a day—"Breakfast, lunch, and dinner," he says.

"There's an alley here I use a lot," Frank says, still steering us up Grove toward the Civic Center and bustling Hayes Valley. "It's cool. Even if somebody sees you, nothing happens." We turn left on Polk, then right on Dr. Tom Waddell Place. He sits down on the sidewalk, shooing some pigeons away, then reaches into his backpack and pulls out a white plastic box the size of a first aid kit, in which he keeps his works. He carefully unwraps the little plastic ball, revealing a small brownish blob. He places the heroin in the cooker, adds some water, and heats it with a lighter until it dissolves. He draws the mixture into a syringe.

Frank takes a broken piece of mirror from the plastic box. Looking intently at himself and blowing out one of his cheeks, he slowly inserts the needle into the left side of his neck, probing for a vein. Because he's trashed his other veins, he has to shoot in his neck or groin. It's dangerous work. He moves the needle around, looking for the blood in the syringe that will tell him he's hit the vein. But he can't find it. He tries the other side of his neck, again blowing out his cheek and slowly pushing in the needle. As he peers into the mirror, a policeman appears at the end of the alley. Frank pulls the needle out of his neck, quickly puts it into the box, and gets to his feet. We walk to another alley, near Gough. Frank decides to shoot in his groin this time. He spreads his legs, pulls his pants down, and feels for the vein in his groin with his finger. He carefully inserts the needle. Blood appears. "That's it," he says. He pushes the plunger in.

Frank pulls his pants back up and puts the syringe back into his kit. There is no obvious change in his face or behavior. Perhaps he looks a little bit more relaxed, but it's hard to tell. We head back down to the Civic Center. I ask him what he's going to do now before he crashes out in his sleeping spot over near Octavia. "I'll walk back over to Octavia, do some panhandling," he says. Frank won't steal—it's a point of pride with him. This shot will last for four or five hours, and he needs more money so he can do it all over again. The dealers, he says, are "open 24-7."

And if he doesn't score? "I'll wake up at one in the morning, sick, and I won't be able to sleep again," he says. "I'll *cry*—not like horrible tears, I just feel terrible." What about the morning? Does he feel sick then too? "Yeah," he says. "This is what I have to deal with every day. Every day, I'm sick a lot more than I'm high."

There are thousands of people like Frank in San Francisco. No one knows just how many; 22,500 is the official estimate, but many think that figure is too high (see page 95). One expert says 10,000 is a better guess. Dr. Barry Zevin, the medical director of street medicine and shelter health for the San Francisco Department of Public Health, says there are a minimum of 1,000 homeless people who inject heroin and/or methamphetamine. Thousands more users are marginally housed. Close to 3,500 people are in methadone treatment programs, and many others are receiving buprenorphine, the other effective chemical treatment for heroin addiction. Untold numbers are untreated, or have relapsed. And there's an invisible throng of more stable users whose use is secret.

This army of injection drug users used to be invisible. No more. Thanks to widespread development that has removed hiding places, a rise in the number of the chronically homeless, and perhaps more drug users, people can increasingly be spotted shooting up in public. The Civic Center, in particular, has become an open-air shooting gallery. Used syringes litter the streets. "I've lived all over the country, and this city has the biggest public injection scene that I've seen," says Holly Bradford, who heads the San Francisco Drug Users Union, a Tenderloin needle exchange and advocacy group. "I've seen it in Cambodia and I've seen it in India. But I have not seen another place in America like this."

Whatever the numbers, San Francisco's injection drug situation is a full-blown public health crisis, one that every year blights thousands of lives, causes more than 100 overdose deaths, severely taxes our medical, social work, and criminal justice systems, and costs untold millions of dollars. No one can spend time with Frank—a decent, well-intentioned man whose life has been ravaged by addiction—without grasping the human tragedy of drug addiction and the urgent need to fight this problem.

That's why *San Francisco* has undertaken this project—a top-to-bottom examination of the city's injection drug crisis, from the people battling addiction to the providers trying to help them. We chose to engage in this discussion now because our city stands at an important crossroads in that fight.

It's understandable that residents are sick of seeing desperate addicts on our streets, of having to walk past needles and human feces and motionless bodies. But rather than shunning people who use drugs, there's a movement afoot to turn this crisis into an opportunity. San Franciscans are being urged to overcome their revulsion and educate themselves about the true nature of drug addiction—to see those who inject drugs not as criminals but as people, many of whom suffered abuse as children or became addicted after being prescribed opioids for chronic pain (see "The Needle and the Damage Done," page 93). At the same time, policy makers are increasingly open to innovative methods of treatment—including safe injection sites—that they might never have considered in the past.

The good news is that the city is already embracing effective, evidence-based methods. Under the umbrella of harm reduction, a nonjudgmental approach that San Francisco was the first city in the country to adopt in 2000, the city employs a host of best practices—from a variety of treatment programs to medical street outreach to needle exchanges to the dissemination of anti-overdose drugs (see "How to Get a City Off Drugs," page 103). Some of these programs, in particular needle exchanges, were once highly contentious. But these formerly controversial programs proved to be effective and are now widely accepted.

Safe injection facilities, where people can inject themselves in sterile environments with trained staff and anti-overdose medicine present and health and counseling services available, may soon be permitted by both city and state legislators. As Lindsey J. Smith reports in "A Safe Place to Shoot Up" (page 99), almost 100 safe injection facilities have opened in Europe, Australia, and Canada. All have been outstanding successes.

But even though experts and users support safe injection sites, it won't be easy for San Francisco to open them. Doing so will mean braving (groundless) claims that such sites enable drug abuse and enduring attacks from moralists who will howl that America's most notoriously drug-friendly city is back to its overly permissive ways. And it will mean accepting the fact that safe injection sites are not a panacea. The most depressing fact about the disease of addiction is how many sufferers relapse. Dr. Brad Shapiro, medical director of the Opiate Treatment Outpatient Program at Zuckerberg San Francisco General, says that of the homeless or marginally housed patients who successfully exit methadone programs, 40 to 60 percent relapse, according to studies. With patients who have better resources and support, the figure might be half of that. Before or after they relapse, many die—of overdoses, of infections, of myriad physical breakdowns. "This is a really deadly disease," Shapiro says. "It's like getting cancer. You have a markedly decreased survival rate if you get this disorder."

This story doesn't necessarily have a happy ending. But this is the situation we find ourselves in. And so as the full dimensions of our city's injection drug crisis come, literally, into view, San Francisco's character will be tested as it has not been since the AIDS crisis. Thirty years ago, the city overcame its own homophobia, ignorance, and moralism to become the recognized world leader in the war against AIDS. Today it has a chance to do the same thing for an even more stigmatized disease. And to help people like Frank escape the life of sickness and misery that has enslaved them. —*Gary Kamiya*

Lauren Waldrop, above, and her husband left North Carolina three years ago to escape family pressures. They live on the street and use heroin together.

The Needle and the Damage Done

Portraits of five current and former injection drug users.

Interviews by Gary Kamiya

Eric Gonzalez-Wightman, 51

Occasional heroin user; currently in Zuckerberg San Francisco General Hospital's Opiate Treatment Outpatient Program (OTOP, aka Ward 93)

I got bullied at school in Santa Barbara because I was openly gay. And then I would get persecuted and abused and yelled at at home. My mom couldn't deal with it. She didn't want a son of hers to be gay. At 15 or 16, I started running away to Hollywood. I tried coke, but I thought drugs were for fucked-up people.

I applied to the S.F. State creative writing program and got in. I started working as a busboy and bartender at different places on Haight. That's when I got into speed. I was meeting artistic people and people were doing speed, snorting. Then people started shooting it around me. I got injected with meth the first time by an infamous character named Todd. People warned me, don't get involved with him, he loves to find little boys like you and spend all of your money.

I got a job at the I-Beam and met my friend Stephen. He and I realized we both wanted to do some heroin. I'm the kind of person, I want to dive in headfirst. Heroin was wonderful. It was like, "This is what I'm looking for." I became this confident person, like, "La la-la-la, fuck you." It's not just physical, it's mental. If you're an overweight, unattractive girl, it makes you feel like a 120-pound, six-foot model. It made me feel invincible.

We really escalated after we started. After I got fired from my job, I lived for a few months by selling everything I owned. This is 1991. I was reading a book by John Rechy, *City of Night*,

A LIFE WITHOUT REST

Mike Nero has been using heroin and living on the street off and on for the past five years. He says the drug gives him a brief respite from a chaotic life. "I haven't gone five minutes in the last five years where I've just enjoyed a quiet moment," he says. At left, Nero wraps a tourniquet around his arm to shoot up heroin on a SoMa backstreet. Later, he washes up in a Target bathroom on Mission Street (above). At right, syringes at the ready, Nero prepares to cook up a hit of black tar heroin before shooting up near his temporary shelter under a tree next to the 101 freeway behind Zuckerberg S.F. General Hospital.

and I'm thinking, I could do that. I became immersed in the hustling world. I found it fascinating. My corner was Pine and Larkin. The neighbors would call the cops. The cops would say, "Hey, Eric, stop ho-ing! Get your ass inside and quit selling it!" I was getting arrested every day for tricking.

I wasn't practicing safe sex, but I never got HIV. It's amazing I'm alive. I would find a needle with clear liquid in it and think, Oh, it's a hit of speed, and do it. I swear to God I've done that. I've taken water out of the toilet at BART bathrooms to use to shoot up.

Kicking drugs is the most horrifying thing in the world. You're all hunched over, like [*whimpering*], "My legs, my legs"—they have these cramp*y* pains—then you're like, "I'm super hot, I'm super hot," then "I'm super cold, I'm super cold," and you're throwing up, and you have diarrhea. It's excruciating mentally. If you're on the outside, you're not going to kick, because you will literally go into Walgreens and grab a shelf of things and run out. You'll beat Queen Elizabeth over the head to get her jewels. And run. You wouldn't care about the M15.

> "Kicking drugs is the most horrifying thing in the world."

In 2005, I was living at the Golden Eagle Hotel on Broadway, near Kearny, and working for a drug dealer. He was Mexican, kind of like family. The dealers are nice guys, they all have families. They have wives and kids. They liked me because I spoke Spanish. I started driving for them, from 10 a.m. to 10 at night. I would get $100 and a bag filled with heroin balloons to deliver.

So I'm driving one day and I'm like, "I don't want to go back to prison. If I get stopped by a cop, I'm going to prison." This was 2006, 2007. The main thing was my cat, Lucy. What if I lose my house, who's going to take care of Lucy? I'd never had anyone love me the way Lucy loved me. This cat just adored me. I've never had the love of a parent or a brother or sister or lover, boyfriend, girlfriend—nobody loved me the way this cat loved me. That's why I have her name tattooed on my neck. So I was like, "I'm not doing this no more." So one day I just stopped the car on Van Ness, I called my boss, Alejandro, and said, "Hey, your thousand-plus dollars is under the mat. But Alejandro, I still want to be a customer! I'm calling you tonight."

I'm working part-time now. Sometimes I get hired for like cleanup jobs, the most random shit. I worked for a backpack company for a while assembling backpacks. This is the happiest I've ever been in my life. I have a great counselor here at OTOP, the resident psychiatrist, she has helped me beyond belief. I mean, I want to get off of methadone and I want to get off of heroin completely someday. There can be times I haven't used in three months, and then there would be times I've been doing it for 30 days straight.

My dream would be to write a book. I think I write like shit, but people say I can write. If people want to laugh at me and make fun of me, that's fine, I don't care. For somebody who's been using for almost 30 years, I'm still alive and relatively healthy—I can still pick up a guy or two every once in a while. My dream would be to get off of it, meet a guy who loves Dulce, my cat, and have a boyfriend, and the book doesn't have to be a huge hit—but please, I've never done one good thing in my life [*begins to cry*], nothing has ever been successful, nothing except becoming a heroin addict. If I could write one book, they could say, that motherfucker was a total piece of shit, a loser, but at least they could say I wrote a book.

Laura, 30

Former heroin user; currently in the OTOP program

Growing up, I'd never taken a pain pill, I never drank alcohol, until I was past high school. I was a straight-A student, I got scholarships to go to college. But I had a lot of trauma in my childhood. It is stuff I still have to work on today. I started off with pills. At 17, I got hurt really badly in a car crash and broke my leg, my ribs, had internal bleeding, and messed up my back. I rode in the rodeo, I was a barrel racer, and got hurt a lot doing that too. I was prescribed pain medication by doctors, hydrocodone or oxycodone. I started out using them correctly. But as my pain got worse, over the months, I found out that I could take two if the pain got really bad, and three, and soon enough I would get prescribed like 90 pills a month, and those were gone in a week.

Then I moved to morphine and Dilaudid, which is morphine in pill form. I'm taking 15 to 20 pills a day, going to hospitals to get them. When the hospitals finally caught on, that's when the dealers come in. I met a female dealer, and she's got needles out, and she gets prescriptions for these morphine pills and shows me how to break them down and inject them. I'm like 20, 21 now, and I'm starting to inject morphine pills. And the high from that alone is just remarkable. It's better than sex. Think about the best orgasm you've ever had in your entire life and times it by a million. It's physical, it's mental, it's everything.

At 25, I go through my first real withdrawal. That was the first time I'm like, Fuck, I'm in over my head. I'm living in Las Vegas now. To support my habit I'm working the Vegas Strip, I'm working the streets, I'm robbing people. I was pretending to be a hooker and then I'd rip people off. I would find the drunkest person at the bar, I'd help them up to their rooms, lay them down, ask to use the bathroom, spend five minutes in the bathroom, and then come out. They're passed out and their wallets are sitting right there.

I had heard about heroin, but God, it had a stigma. Once you were on heroin, oh my God, you're gonna die from it. But my dealer gets busted again. This time they're really going away. I'm really sick, nobody I know has pills, and I run into a person who does heroin. And they're like, "If you're this sick, just do it." So I smoke heroin for the first time. Oh my God. It was like the best high of my life.

By now I'm prostituting and having to

THE SCOPE OF THE PROBLEM

Are 3 percent of San Francisco's adults injecting drugs?

22,500 **THAT'S THE DEPARTMENT OF PUBLIC HEALTH'S GO-TO NUMBER** for injection drug users in San Francisco, a figure frequently repeated by media outlets. And while it's inarguable that the number of people shooting up in public has skyrocketed in recent years, with the city now collecting more than 10,000 syringes per month—triple the number from a year ago—that 22,500 statistic astounds. It means that approximately 3 percent of the city's adult population as counted in the 2010 census—or 1 out of every 33 adults—currently injects drugs. Is this possible?

Theoretically, yes—given that many people inject drugs without ever developing a substance use disorder. "People start in a fun space, and many people never leave that fun space and recreationally use indefinitely," says Paul Harkin, HIV services manager at Glide.

But it's also possible that that widely cited statistic is simply wrong. "Lots of people ask for these numbers," says Alex Kral, an epidemiologist. "But it is very, very hard to pin down a number for something like this because it is an illegal activity; it is a highly stigmatized activity. So we can't just go and count people."

The figure comes from a study conducted by researchers from UCSF and the San Francisco Department of Public Health and published in the journal *AIDS and Behavior* in December 2015. It uses three different statistical methods and data from multiple sources. But the margin of error for the resulting count is so high that it's impossible to say whether the 22,500 figure is accurate, or even whether the population of people injecting drugs in San Francisco has increased. (The same study found 10,000 injectors in 2005, but the margin of error also makes that figure unreliable.)

While some on-the-ground providers give credence to the 22,500 finding, researchers are skeptical. "It's not a very good number," Dan Ciccarone, a professor at the UCSF School of Medicine, says. "That's one of my big criticisms of how we're handling the current epidemic. Nationwide we know that people are dying—there are all these body counts—but we don't know what the rate of death is because we don't have a good understanding of what we call 'the population at risk.'" Ciccarone has been researching heroin users in San Francisco since the early 2000s; he pegs the injection drug user population at closer to 10,000. That, however, is simply a guesstimate.

So what do we know for sure? We know that in 2016, six syringe-access programs in the city gave out 4.7 million sterile syringes, and that harm reduction teams from Glide and the San Francisco AIDS Foundation met with clients more than 62,000 times over 12 months. These numbers don't yield a final tally of how many people in the city inject drugs. But it's safe to say that it's thousands.

It's also safe to say it's growing. For this we can point to some familiar culprits: the housing crisis, worsening homelessness, and more prevalent drug use by homeless people. When Kral started studying Bay Area injection drug users in the 1990s, one-third of them were homeless. "Now it's moved to three-quarters," he says. And when more and more people who live on the streets are also hooked on drugs, we all can feel it. —*Lindsey E. Smith*

sleep with certain people in order to get money—I've got regular clients. And then after four or five months, smoking isn't enough and I start shooting. A gram is like $90, and I'm spending like $400 to $500 a day. Meanwhile I've met this wonderful man, my best friend, who is trying to give me a life. We're just friends. We tried kissing once and it was like kissing my brother. So we've been family ever since, and he is the one person throughout my whole life that I trust and love. He gets us an apartment. He doesn't know I'm on heroin. We get into this fight because I don't want to admit that I'm an addict. I'm 28 now. I tell him, "I just need a breather, just need to take a walk." So I walk straight to my dealer's house. I get what I need, go out on the Strip. And instead of going back to my home with my family, my dogs, this wonderful man, I stay at the dealer's house.

A couple of nights later I'm on the Strip and I get picked up by a horrible person. He beats the crap out of me, and now I'm no longer able to go home. I either work for this pimp or I die. It happens all the time. They play the part—Oh, I'm a john, I'll pay you this much. So you get in the car with them, or you go to their hotel room, and now they own you. They don't let you out of their sight. They strip-search you to make sure you're not hiding money anywhere, they take all your money, and then they say, "OK, I'll give you all your drugs. You don't need to worry about it. You don't need money."

> "I either work for this pimp or I die. It happens all the time."

All this time, I've got him, my friend, and he's out there looking for me, trying to figure out why I haven't come back yet. He has to leave to be with his son. So he packs up, he moves. And I've lost the one person I've ever cared about.

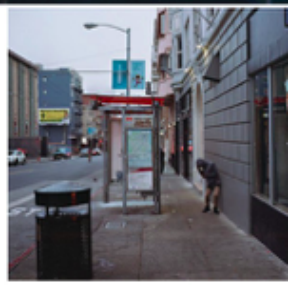
Then one day I make a lot of money. I tell the pimp I'm going to this hotel and I'm up on this floor, and he believes me. Instead I'm like 10 hotels down. I get a weekly motel far away from the neighborhood where I'm at. Because if I run into this pimp, he'll kill me. So I finally check my emails and I see that my friend has written me, saying, "Just call me, I love you, I miss you, I'm worried about you." He's put out missing persons reports. I call him and he says, "Let me come out and get you." He sends me money. I admit I'm on heroin. He doesn't know I'm a sex worker.

I finally realized that I've got to get out of these drugs. I have to or I'm going to die. One way or another. I'm either going to get raped and murdered by a pimp, or I'm gonna OD. My friend buys me a bus ticket. A couple days later I tell him I'm getting on the bus. He doesn't believe it. Once the bus leaves, I send him a picture message on the phone and it's me on the Greyhound bus, and he's like, "Oh my God." Eight or 10 hours later I'm here in California. And he's there waiting for me.

I'm 28, almost 29. My friend takes me to a private methadone clinic in the Tenderloin and pays $200 for it every week. Then I meet my wonderful fiancé, and he tells me about this place, OTOP. So I leave the other clinic and come here. They get me on Medi-Cal within three weeks, so my friend doesn't have to pay anymore. I have a really wonderful counselor here, Michael, really friendly staff, they're here to help.

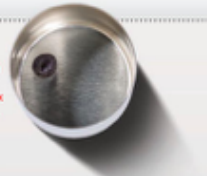
I hate the word *junkie*. Because I'm not a junkie. You're not dirty if you're using drugs. It doesn't make you a dirty person. Yes, I'm an addict, so I have to work at it every single day, but my goal when I started this was to be two years stable on methadone, and then I will try to open Pandora's box little by little to work on all the trauma that brought me to this place.

CONTINUED ON PAGE 109



LIFE UNDER THE NEEDLE

Clockwise from center: Melinda Welsh injects heroin into her neck. Welsh says she shoplifts items and sells them (here on Mission Street) for money to buy drugs; Patrita Tripp (in hat) was abandoned by her father in the Tenderloin when she was a child. She has lived on and off the streets since. She uses speed but avoids heroin; The corner of Eddy and Larkin Streets in the Tenderloin, virtual ground zero for drug use; Civic Center Plaza is filled with users and dealers; Homeless encampments, like this one on Seventh Street, are hotbeds of injection drug use; Eric Gonzalez-Wightman, whose story appears on page 93, looks out the window of his Tenderloin unit; Dallas Staton, 72, injects heroin into his groin near City Hall. He has used heroin for 31 years.



Actual size of one $10 hit of black tar heroin.

BLACK DEATH

From Mexican black tar heroin to "Colombian mimic": how a Latin American peace treaty could mean more overdose fatalities in San Francisco.

The heroin sold in 2017 San Francisco is mostly the same low-grade stuff that has ruled the streets since the mid-1980s: so-called black tar heroin, a crude, sticky, and relatively unrefined dark-brown opiate grown and processed in Mexico. But there are signs that a higher-quality product could be hitting the streets—and if it does, experts say, the city's injection drug problem could get a lot more deadly.

Dan Ciccarone, a UCSF School of Medicine professor who has studied local and national heroin use extensively, says that for three decades, almost all heroin in San Francisco has been of the black tar variety. By contrast, in the Midwest and on the East Coast, powdered heroin—more refined, and more powerful—has dominated the market.

Ciccarone speculates that this division between black tar and powdered heroin resulted from high-level agreements worked out in the 1980s between the Colombian drug cartels, who controlled the illicit trade east of the Mississippi River, and their Mexican counterparts, who controlled the territory west of it. The Colombians sent their higher-grade powdered heroin to the east; the Mexicans, who hadn't yet mastered the refining process, sent black tar to the west. But the status quo changed during the long peace negotiations between Colombia's FARC guerrillas and the government, which concluded this June. One result of the negotiations was that the guerrillas stopped producing heroin for the cartels. Mexico stepped in to fill the void. Thanks to what Ciccarone calls a "technology transfer" in which the Colombians taught the Mexicans how to refine their heroin, Mexican cartels replaced the high-quality East Coast powdered heroin with a similar product. However, that new product hasn't yet been available on the West Coast. "San Francisco seems to be a little stuck in time, which is good," Ciccarone says. "My theory is that we simply don't get heroin from that supply chain."

Why is it good that San Francisco has been "stuck" with black tar heroin? One word: fentanyl. Starting around 2013, traffickers across the country routinely began adding the synthetic opioid to heroin to increase its potency. Because fentanyl is so strong (it's 40 to 50 times more powerful than heroin, which itself is three times stronger than morphine), even a tiny amount can cause a fatal overdose. (Making matters worse, the fentanyl that's added is often bootleg and can contain dangerous impurities.) According to federal drug seizure data, overdoses caused by fentanyl and other synthetic opioids doubled between 2013 and 2016, with approximately 64,000 deaths in the United States. The sudden appearance of fentanyl (both in heroin and in pill-form opioids like knockoff OxyContin), the doubling of the number of heroin users nationally since 2008, and a drop in heroin's price are the three factors primarily responsible for the national opioid overdose crisis.

So far, San Francisco has been largely shielded from that developing crisis for a simple reason: The black tar heroin that still dominates the streets here is much harder to cut with fentanyl than powdered heroin is.

But the city's relative immunity from the overdose crisis that has devastated much of the country may be ending. "There have been reports over the last couple of years of a gray powdered heroin," Ciccarone says. He hasn't heard if it's what the DEA calls a "Colombian mimic"—"because the Colombians taught the Mexicans how to make it"—but Holly Bradford, who as head of the San Francisco Drug Users Union (a needle exchange with more than 1,000 participants) has an unsurpassed connection to the street, thinks it might be. "People say they're seeing more and more powdered heroin on the streets," she says. One user says it's available in Civic Center. If powdered heroin becomes easily available here, and is as widely adulterated with fentanyl as powdered heroin is elsewhere, the toll of overdoses in San Francisco is sure to rise.

—*Gary Kamiya*

LEFT: CLARE MILLER

THE NEEDLE USER'S ARSENAL

Is there a 100 percent safe way to inject a drug? Absolutely not. But the equipment pictured here can make the process safer. Sterile syringes are just one part of the equation: HIV and hepatitis C can be transmitted by sharing a drug cooker, and necrotizing flesh infections can erupt from skin bacteria or impure water. To reduce these and other risks, the city's syringe exchanges and street outreach teams distribute "safer injection kits" with a range of supplies while also educating users about vein care, less damaging injection techniques, and overdose prevention. "When you're injecting three times a day for years on end, little things like that can have a big effect," Glide HIV and hep C outreach coordinator Bill Buehlman says. Between June 2016 and July 2017, Glide distributed 44,713 kits like the one pictured below. —*Lindsey J. Smith*

A Safe Place to Shoot Up

San Francisco is considering opening the United States' first legal space for people to inject drugs. Can the city pass the compassion test again?

"NOBODY WANTS TO BE STUCK in a park dropping their drawers and injecting in their groin. That's not an ambition when people begin to use drugs," says Paul Harkin, HIV services manager for Glide. But as condos encroach on SoMa alleys and SROs are cleared out in favor of hotels, shooting up in public has become a necessary evil for many people who inject drugs.

That might soon change, as San Francisco is poised to become the first U.S. city to open supervised injection facilities. Grounded in harm reduction philosophies, such facilities provide safe, nonjudgmental spaces in which people can inject pre-obtained drugs using sterile equipment under medical supervision. Advocates say such sites are often the first step on a person's road from addiction to recovery.

Safe injection facilities have existed in Europe for more than 30 years, and Bay Area advocates have been clamoring for them for at least a decade. But for most civic leaders, the idea of officially sanctioning injection drug use was anathema. "When this idea was first brought to my attention several years ago, my reaction was, 'Why would we pay for a place for people to shoot up?'" says Board of Supervisors president London Breed. "I was very closed to the idea." But the increasing number of discarded syringes and public injectors, coupled with memories of her sister, who died of an overdose, slowly convinced her of the need to study the model. Around the same time, a coalition of Tenderloin businesses, nonprofits, and residents formed to explore solutions to increased public injection. And Mayor Ed Lee, who like Breed had been adamantly opposed to safe injection sites, also expressed openness to them.

With the time finally ripe, Breed convened a task force in April that included current and former drug users, business owners, medical professionals, policy experts, syringe access workers, and a representative from the San Francisco Police Department to study the risks and benefits of opening one or several sites. "I'm still trying to get my mind around it, but I feel strongly that doing what we're doing now—which is basically nothing, with no potential ideas to change it—is not working," Breed says. "If there's a real possibility that it's working in other places, then let's understand why it's working there and let's understand what the data says and let's make an informed decision."

One of the first things that those who study the issue learn is that injecting drugs in public has serious negative physical and psychological consequences. Rushing an injection can lead to complications, such as bruising and abscesses. Unsanitary conditions are a hotbed for disease transmission and soft-tissue infection, which can lead to loss of limbs or death. And public injection can be a source of deep and abiding shame for the person behind the needle. Many people who inject in public are particularly worried about being seen by children. "On some blocks they have spotters who yell, 'Children on the block! Children on the block!' and people change up on what they're doing," says Terry Morris, director of the San Francisco AIDS Foundation's 6th Street Harm Reduction Center.

The bottom line is that, as Harkin says, "A lot of people are injecting in very kind of shambolic circumstances." A supervised injection site, he says, would remove some of that chaos and stigma, making eventually getting clean a little easier.

THE FIRST LEGAL SAFE INJECTION SITE opened in Berne, Switzerland, in 1986, but there were none in North America until 17 years later, when one opened in Vancouver. Currently, just shy of 100 supervised consumption sites exist in 10 countries worldwide. At their most basic, these facilities consist of a table and chair, sterile injection equipment, a mirror for people who inject in hard-to-see places, and some sort of trained supervision. On the more elaborate end, sites provide a broad range of services, including rooms where people can smoke or vaporize drugs, space for people to relax in after using, residential detox and treatment, medication-assisted therapy, counseling, and linkages to medical care. Some supervised consumption spaces are mobile or pop-up, others are just a booth or two within an existing agency, and others still, like the Vancouver facility, Insite, are stand-alone buildings.

Whether large or small, mobile or brick-and-mortar, these facilities all serve the same goal: to make life safer and healthier for people who consume drugs and better for the communities affected by drug use. Studies of Vancouver's Insite facility have found that it has not increased drug-related crime, that it has reduced public injection and syringe litter in the surrounding area, and that it has reduced the transmission of diseases including HIV and hepatitis C. Insite has hosted upward of 3.6 million injections since it opened in 2003, and clients have suffered some 6,400 overdoses in that time. But there has not been a single fatality.

Like Breed, fellow task force member Lydia Bransten, who manages the dining room at St. Anthony's, came to support the idea after much study. St. Anthony's runs an abstinence-based recovery program, and it used to be part of Bransten's job to kick out people who were using drugs in the bathroom. This often led to conflict and distress, as she recently CONTINUED ON PAGE 111

Sammy Mullally, a nurse at Vancouver's Insite center, assists a client as he injects drugs he bought on the street.

TALES FROM THE FRONT LINES

Police officers, surgeons, firefighters, BART cleanup workers, and others talk about the often-harrowing realities of dealing with an epidemic.

●●

As told to *Gary Kamiya, Ayah Mouhktar, Alex Orlando, Ahalya Srikant, Jordan Winters, and Gwendolyn Wu*

CLINTON BAILEY, 53
BART system service worker, Powell Street station

• • • •

Back in the day 10 years ago, you didn't have this. Like, a needle? We'd all be shocked. "Look at what we found, look at what we found!" But now it's like, "Eh—add it to the pile." It's crazy. We have a worker downstairs in the station at Civic Center, which is one of the worst spots for needles, and she'll fill up a sharps container a day of needles.

You watch 'em shoot up. You watch the dealers sit down and sell them the dope right in the station, and watch them shoot up. All day. We have to call 911. We see 'em overdose, we see 'em throwing up, people passing out all the time. That's why front-line workers don't get the credit, but they're there doing everything.

We have people that sit there and they're high—and I don't know what the hell on—and they jump up all in your face. And here you are, a worker, and you're scared to death. As you notice, most of these stations are three-block stations. So there's times as a worker you're by yourself way out there. Civic Center, the end of the platform, is where they love to shoot up at. We go down there every 20 to 30 minutes to check it, and that's when you get cursed out, threatened.

This one guy I witnessed had the needle in his arm, pants down, he was dead as a doorknob. They almost had to break him to straighten him out to get him in the bag. Needle just hanging out of the arm. You start just to feel sorry for folks. As you work and you start talking to folks and you get to know 'em, you come to find out that hey, some of these people—you could be in their shoes if you were to lose your job or have no family to fall back on.

January, I think it was, I went through with [BART police] because I work this station. There were two guys tapping, shooting up, one guy had already tied him up, tapped him off, and then BART police, we walk up and we were standing right here. The cat just looked up at us and continued to shoot his buddy up. The BART police said, "What are you doing? You see me right here, what are you doing?" He said, "What are you going to do? You're going to put us out anyway, at least let us get high before we go." That's how it simply was for him.

Clinton Bailey


Terry Morris

TERRY MORRIS, 68
Director, 6th Street Harm Reduction Center, San Francisco AIDS Foundation

• • • •

San Francisco has a fairly ginormous number of overdoses and reversals. On my commute home, I found someone OD'ed on the stairs at Civic Center BART. I had given my Narcan to someone I thought needed it more than me, [though] I always carry it in my bag. I started giving rescue breathing and yelled, "I need Narcan! I need Narcan!" Six people who were homeless and used drugs came and helped me, and then a business guy called 911. We laid the guy out, he was on a stairwell and we put him on a flatter part of the stairway in the BART station. I gave him rescue breathing for about five minutes, and the guy that came to assist me administered two doses of Narcan. We saved the guy's life.

●●

DR. CHRISTOPHER COLWELL, 52
Chief of emergency medicine, Zuckerberg San Francisco General Hospital

• • • •

In college, I had a sense of what I thought of as an IV drug user. But now I've seen everybody from the down-and-out that I'd always assumed was an IV drug user to the highest-functioning people in business, medicine, law—whatever you consider high-functioning society. They've all come to the hospital, and they've all succumbed to injection drug use.

It's so hard because we see overdoses literally every day. During my shift on Monday, we had two people die from having an overdose. One was a 28-year-old from overdosing on heroin. We couldn't get there to give him the Narcan in time. At the same time, we had three that we did give the Narcan to on time, and we brought them in for evaluation, and they're sitting there going, "When can I leave?" And we keep saying, "You took an overdose that would have killed you had no one gotten you the Narcan in time. You really need to understand the seriousness of this." And none of the three gave it any real credence.

It's very frustrating. Especially the realization that, somehow, our message is not getting through and that the message of the impact of the drug is more powerful. And I've had them tell me that. I've had patients tell me, "Look, doc. I get what you're saying, I know what you're saying, and I agree with it. But the feeling is too intense. My life focus is on getting back to that feeling again." And the hardest part of all of this is when they'll tell you, "That may have been death, but it was fantastic." The difference between the ultimate euphoria and death is very narrow.

●●

MEAGHAN McMILTON, early 30s
SFPD officer; did Homeless Outreach for six months

• • • •

We start every day—and it's how we spend the rest of our day—with injection drug users. The women always stick out the most. I have a really close family member who's an addict who is a woman. For me it feels personal. Any of these women could be her. Most cops are pretty good about compartmentalizing. Because otherwise I think it would be impossible to not be sad all the time.


Dr. Christopher Colwell

You are essentially watching people slowly drown. We can't just kidnap people and make them get help. You have to remember that addiction is not a choice. Maybe not seeking help is a choice, but who gets addicted and who doesn't is not a choice. I think the way to stay not judgmental is to remember that these are people's kids. They mean something to people, even if they don't feel like they mean anything to themselves anymore. I don't think that I ever feel judgmental about the decisions they made that led them to that point because I'm sure that the vast majority are dealing with all sorts of trauma and ghosts.

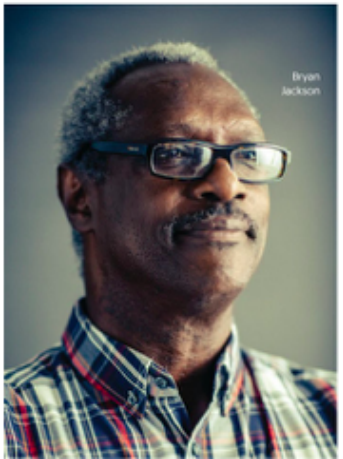
I've had one really good successful story. She's my age. I met her five or six years ago when she was just starting her decline. My regular partner and I would see her all the time. We were on a first-name basis. And I'd say over the course of three years, she looked like she had aged 20. The only way that we felt like we could help her was to arrest her, because she wouldn't do anything willingly—that was back when possession was a felony, so then they're getting booked and they have the opportunity to detox. But then I didn't see her for like two years, and I thought she had died. And then my old work partner ran into her on Market Street. She looked great, she was pregnant, she was clean for a year and a half, and she had a job at a coffee shop. She was really happy to see my partner. It was a lot of oh-my-Gods. My partner sent me a selfie of the two of them. I was working midnights at the time, maybe five or six months ago, and I woke up to that picture and it made me so happy because maybe two days earlier I'd checked her mug shots to see if she had been booked recently. And she had no booking photos for two years, and I was worried. I just assumed the worst, I thought maybe she had died out here. And then I woke up to that happy smiling selfie. It made me very happy.

●●

BRYAN JACKSON, 61

Community program manager, Opiate Treatment Outpatient Program, Zuckerberg San Francisco General Hospital; S.F. General Methadone Van

A lot of people in the Bayview need treatment. If you go over to the plaza there, you'll see people using drugs. We have space for 120 people, and we've only got about 80. I've been putting out flyers, letting people know we're available. But I think a lot of people out there are saying, "Why should I go get on methadone when I have heroin?" Sometimes it's easier to get the heroin than it is the methadone. There's no shortage of heroin out there. And some don't come in because of the stigma of using methadone. They think, "Why should I get on methadone? That's just as addictive as heroin." If a person who's getting high every day has got a place to live, and it's a comfortable place, what reason is he going to have to want to stop? They'll just continue to use. I try to get them to understand that change is a part of their recovery. They might have to change their friends. They might have to change their environment. I try to take them through the stages.


Bryan Jackson

There's a young woman I started working with in 2012. She's been with us on and off for those six years. When she first came in, she had been prostituting herself, she had gotten arrested, and she wound up going to jail. The jail brought her in and we put her on methadone. She did the whole program, got clean, and even went to a residential treatment program for a while. But she still hasn't stopped using drugs and now she's back with us. This time she called us and said she wanted to get back on the program. I keep asking myself, what makes you want to keep going out there? Doing the same thing over and over and over again, when you know what's gonna happen? You're gonna go back to jail, wind up in the hospital, and you've got two children that your mother and father have adopted. We're just trying to see if she's gonna get any better this time. And hopefully she will.


Pauli Gray

PAULI GRAY, 30s

Senior harm reduction specialist, San Francisco AIDS Foundation; San Francisco Hepatitis C Task Force

I do a lot of hep C work. We're trying to get treatment for hep C at needle exchange sites. It used to be you had to be clean and sober for three to six months before you could get treatment. Now we know the people infecting other people are active users, so we have to treat them.

I had hep C for 32 years. It's a devastating disease. It's crippling fatigue and depression. People are like, "I've been exhausted before," but it's different, it's crippling. I didn't have enough energy to go to work or go to school or have a career or follow my bliss and play music again. Drugs will steal your bliss. But I can tell you one thing: If you were out there homeless on the street, you would want to be high too. I'd like to see you try it. It's brutally hard out there, but I've seen astonishing acts of kindness too.

My dog is my best harm reduction worker. I put a hep C shirt on him and people come up to pet him and ask me about hep C. He got me two of my first three clients that I got cured when we started this new program.

●●

DR. CORINNA GAMEZ, 72

Medical director, Office-Based Buprenorphine Induction Clinic, UCSF

My goal is to make patients feel more comfortable from opiate withdrawal. When they're uncomfortable, they want to use, and that's a big trigger for relapse. And I don't want that to happen. We tell them to come in here slightly sick and uncomfortable—I know that's really hard for the patients, but we have to instruct them that way so that when we give them the buprenorphine, all the buprenorphine does is help them with the withdrawal symptoms.

When they're bouncing around, really agitated, irritable, throwing up, and really uncomfortable CONTINUED ON PAGE 117

How to Get a City Off Drugs

The ABCs of fighting San Francisco's injection drug crisis.

●●

WHAT DRUGS ARE INVOLVED?

There are two main types: stimulants and opioids. Stimulants include methamphetamine (speed) and cocaine. Opioids include heroin and morphine, as well as hydrocodone, oxycodone, and the like. Because of the ways they affect users' brains, both types are highly addictive.

HOW DO YOU TREAT PEOPLE WHO ARE ADDICTED TO THESE DRUGS?

For decades, only one chemical treatment was available for opioid addiction: methadone. Methadone is highly effective, but it has certain drawbacks. It is itself a powerful opioid: Between 2010 and 2012, 45.9 percent of the 331 opioid overdose deaths in San Francisco were caused by methadone, although most if not all of these fatalities occurred as the result of improper use. It can only be administered by a federally regulated narcotic treatment program, which requires patients to come into a methadone clinic every day (until they have demonstrated that they can be given take-home doses), pass regular urine tests, and attend counseling sessions. The demanding nature of the regimen and the drug's potent effect make it less suitable for some patients.

Around 2000, an alternative to methadone was approved. The new drug, called buprenorphine, revolutionized the field of addiction medicine. Buprenorphine (also known by the brand name Suboxone) is not as potent an opioid as methadone, does not require daily visits to a clinic (though it is taken daily), and is less intensely regulated. From the user's perspective, the main drawback of "bupe" is that you have to be almost fully withdrawn from heroin before you can start taking it, making the induction process agonizing for some. But it leaves users feeling less drugged, is easier to take, and is as effective as methadone at blocking the craving to use heroin.

No effective medication exists to treat stimulant use disorders.

WHERE DO DRUG USERS GO TO GET TREATMENT?

San Francisco has an extensive network of organizations that offer treatment, ranging from city-run programs to nonprofits to for-profit companies. The city's goal is to provide same-day or next-day treatment with methadone or buprenorphine. The city's respected methadone program, the Opiate Treatment Outpatient Program, administered by UCSF at Zuckerberg S.F. General Hospital, serves 300 patients and also operates a methadone van that serves the Bayview. Another joint city-UCSF program, the Office-Based Buprenorphine Induction Clinic, helps patients get started on buprenorphine. Nonprofits like HealthRight 360 offer substance use disorder programs. There are several private companies that offer methadone or buprenorphine treatment, including BAART, Westside Community Services, and Fort Help; there are also residential treatment programs such as Positive Resource Center (Baker Places) and Delancey Street. Finally, needle exchanges such as the 6th Street Harm Reduction Center, the S.F. Drug Users Union, and Glide provide clean needles and referrals for treatment. For stimulant users, city-run programs like the Stimulant Treatment Outpatient Program at Zuckerberg S.F. General offer counseling and support.

Finally, the city has a program designed to help the highest-risk, most vulnerable injection drug users, almost all of whom are homeless. Dr. Barry Zevin and his team at Tom Waddell Urban Health Clinic Urgent Care, working closely with the city's Homeless Outreach Team, go out on the streets regularly, bringing medical care and treatment to people who otherwise might not get help.

WHO PAYS FOR ALL THIS?

Even indigent patients can receive free medical care and treatment—and the city isn't on the hook for nearly as much money for these programs as it used to be. Medicaid expansion under the Affordable Care Act made substance use treatment an "essential benefit" and guaranteed federal funding for treatment in state-run low-income programs like MediCal. Before the Obamacare expansion, the city had to fund most substance treatment programs out of its General Fund. Last year, of the $70 million spent on substance use by the S.F. Department of Public Health, less than half came from the city.

WHAT ARE THE SNAFUS?

A bureaucratic Catch-22 can disincentivize providers from giving treatment and patients from seeking it. To receive coverage, a MediCal patient must choose a provider to be his or her medical "home." Patients who choose a provider that doesn't offer, say, buprenorphine and subsequently want or need to get on a buprenorphine program will have to go to a different provider. But unless they make that new provider their medical home, their treatment will not be covered by MediCal—meaning the new provider will have to pay. Some providers will not accept patients under these terms, and some patients do not wish to leave their home provider, which means they can't get necessary treatment. Providers are trying to resolve this problem.

—Gary Kamiya and Khalya Siliant

CLARK DELLER

A SHOT OF MERCY

The miracle of naloxone, an injectable drug that has saved thousands.

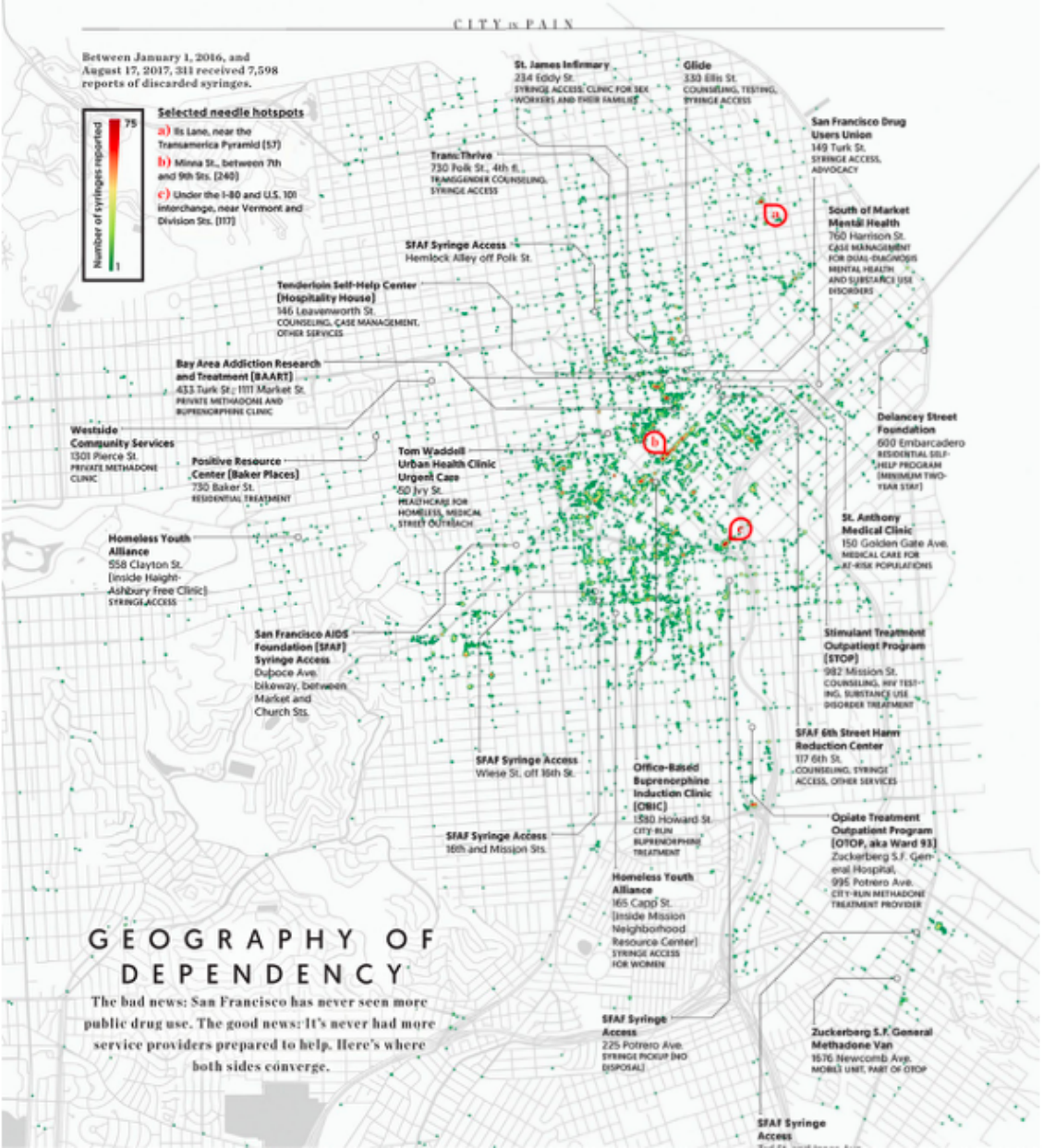
NALOXONE, which reverses opioid overdoses, has pulled thousands of San Franciscans back from the brink of death. Also known by the brand names Narcan and Evzio, the drug has been used by first responders for half a century. But beginning in 2003, San Francisco became the first city in the country to distribute it widely, in partnership with the Drug Overdose Prevention Education project.

In 2010, the drug was used a reported 62 times by civilians trying to reverse overdoses. By 2016, the number of self-reported reversals had soared to 877. "It really is the most incredible drug on the planet," says Hannah Cohen, syringe access coordinator at Glide.

Naloxone reverses overdoses by temporarily knocking opioids like heroin and fentanyl off the brain's opioid receptors, allowing users' respiratory systems to kick back in. The drug has no negative side effects—although it can send people into a rapid and uncomfortable withdrawal and immediately kills a heroin high—and no effect on people without opioids in their systems.

Starting in 2010, the city began allowing trained harm reduction workers to hand over blank-check prescriptions for naloxone to anyone, including people who use drugs, who can now obtain it through syringe exchanges and other programs, often for free.

Naloxone can be injected directly into a person's upper thigh or glute. Although it's the most effective way to prevent an overdose, it's possible to save a life without it. Cohen emphasizes the importance of performing rescue breathing on all overdose victims: laying the person on her back, tipping her head back to open the windpipe, checking her mouth for any objects that she could choke on, and then plugging her nose and breathing into her mouth either directly or through the barrier of a T-shirt or hand, starting with two large breaths, followed by one breath approximately every three seconds. Acting as an outside set of lungs can prevent brain damage due to oxygen deprivation and can keep a person alive until paramedics arrive or until the opioids leave the body. *—Lindsey J. Smith*



GEOGRAPHY OF DEPENDENCY

The bad news: San Francisco has never seen more public drug use. The good news: It's never had more service providers prepared to help. Here's where both sides converge.

ALAIN MCLAUGHLIN

Stalemate in Needle Park

S.F. cops haven't entirely given up on trying to get heroin dealers off the streets, but they know it's a war they can't win.

AS THE OPIATE CRISIS SWALLOWS TOWNS in Appalachia and the rust belt whole, in San Francisco, where the crisis is less apocalyptic, police and pushers find themselves locked in a familiar, uneasy stalemate. It's not quite harm reduction. It's closer to benign neglect.

"It's kind of like a détente," says Dan Ciccarone, a professor of family and community medicine at the UCSF School of Medicine. "The unwritten rules are, 'You get flashy, you get flagrant, you get violent, we're gonna bust you.'" Like many drug policy experts, Ciccarone thinks this somewhat hands-off approach to street dealing is reasonable: "There's no evidence that the heavy arm of the law leads to sustaining benefits," he says.

The SFPD declined interview requests to discuss its approach to street dealing. Asked for arrest statistics, a department spokesperson instead talked about the 17 times this year that police officers saved overdosing opiate users with a naloxone kit. The truth is, street dealing is a no-win subject for the SFPD. Cops won't admit that they tacitly allow a certain amount of blatant pushing, but neither can they deny the reality that citizens see every day.

What data is available supports the notion of a protracted cooling-off. In 2008, there were 7,592 felony drug arrests in San Francisco. That number plummeted to 860 last year. In the courts, felony opioid drug cases that were actually prosecuted dropped from a monthly average of 218 in 2013 to 153 in 2015. The main reason for this drop is Proposition 47, the 2014 ballot initiative that downgraded most drug offenses from felonies to misdemeanors, but other factors play a role as well. District Attorney George Gascón, who as police chief launched an ineffective sweep of dealers in the Tenderloin, has since denounced the war on drugs as a failure.

To get busted these days, says longtime off-and-on heroin user Johnny Lorenz, "you basically have to take a kilo bag and hit a cop in the face with it." A small but telling indication of the department's priorities came when Police Chief Bill Scott recently announced that to fight skyrocketing car break-ins, he was shifting cops from the narcotics division to walk street beats.

However, the SFPD could soon come under more pressure to get drugs off the street. The heroin circulating in San Francisco is cheaper and stronger than ever. Overdoses are skyrocketing, and it's only thanks to naloxone that the body count has remained at around 100 in recent years. Even more ominously, fentanyl, the killer synthetic opioid, is turning up everywhere—including in meth and crack. The number of drug cases in the Hall of Justice has crept up somewhat in the past year. But barring any massive public outcry or a change in the political winds, the drug dealers who have been fixtures at TL corners for years will probably still be there next year, and the year after, and the year after that. —*Chris Roberts*

Street outreach workers from Glide.

WHAT CAN YOU DO?

A lot, actually. Here are four ways regular citizens can fight the injection drug epidemic—and help people struggling to overcome their dependence.

1 VOLUNTEER AT A SYRINGE ACCESS OR NEEDLE EXCHANGE PROGRAM.

Every caregiver who works in this field knows that simply making respectful, nonjudgmental human contact is an essential (and deeply fulfilling) part of their work. By volunteering at a syringe access program, you will help people who inject drugs avoid contracting HIV and hepatitis C as well as prevent other health problems. But just as important, you will have the chance to meet and get to know them, and show them that someone cares about them.

There are a number of respected nonprofit organizations in San Francisco that provide sterile syringes, pick up and receive used needles, and offer education and referrals to injection drug users. (Donations of money and/or goods are welcome too.) Among them are:

San Francisco AIDS Foundation
SFAF's syringe access program handed out 2.7 million needles last year, and it offers a full spectrum of harm reduction services as well. Its nitty-gritty, high-street-cred 6th Street Harm Reduction Center made contact with 47,000 people who inject drugs (this figure includes multiple contacts) last year. **sfaf.org**

Glide
Every Tuesday afternoon, volunteers 18 and older convene at Glide to assemble harm reduction kits. Glide also trains syringe access volunteers for its onsite syringe access program. **glide.org**

Homeless Youth Alliance
Homeless Youth Alliance offers syringe access and other programs for youth and women in the Haight and the Mission. Contact Toivo Ollila (toivo@homelessyouthalliance.org) to learn about volunteer opportunities or to make donations. **homelessyouthalliance.org**

Trans:Thrive
Through a partnership between the SF LGBT Center and the Asian and Pacific Islander Wellness Center, Trans:Thrive's needle exchange program creates a safe space for trans-identifying people to access sterile syringes and other services.
apiwellness.org/site/transthrive

2 LEARN HOW TO ADMINISTER NALOXONE (NARCAN).

Last year 877 overdoses were reversed in San Francisco by naloxone (better known by a trade name, Narcan), an opioid-overdose-reversal drug. You can receive free training in how to administer naloxone Monday through Friday at the CBHS Pharmacy at 1380 Howard Street. No appointment or prescription is required, and it takes only a few minutes to learn. **harmreduction.org**

3 SUPPORT RESIDENTIAL TREATMENT PROGRAMS.

There are several residential programs in the city that specialize in helping people with substance use disorders. They include:

Positive Resource Center (Baker Places)
Since 1964, the nonprofit Baker Places has offered a variety of services including two residential rehabilitation programs that focus on people with HIV/AIDS and gay or bisexual men. To donate, email Gayle Roberts at gaylor@positiveresource.org, or volunteer with Positive Resource Center.
positiveresource.org/supportvolunteer.aspx

Delancey Street Foundation
This nationally regarded model for rehabilitating substance users is run entirely by its residents, who stay in the program for two to four years. During their tenure, they learn marketable skills and receive a GED while living together substance-free. Volunteers are trained to lead workshops for residents.
delanceystreetfoundation.org

4 REACH OUT TO THE SPANISH-SPEAKING COMMUNITY.

Cultural competency can be a valuable asset in helping at-risk people. The Mission Council on Alcohol Abuse for the Spanish Speaking provides outpatient bilingual counseling services for individuals and families struggling with unhealthy drug or alcohol use. If you're a bilingual speaker, call 415-826-6767 for volunteer opportunities. **missioncouncil.org**

—Gary Kamiya, Casey O'Brien, Alex Orlando, and Ahalya Srikant

Damage Done

CONTINUED FROM PAGE 95

Jeff, 38

Current heroin and meth user

It started when I was 10 years old and was hit by a car. That was my introduction to opiates—Demerol and morphine. I had to relearn how to walk. I had eight or nine surgeries and almost lost my leg. By the time I was 14, I was addicted to those drugs.

I still have chronic pain. I've had it my whole life. I had nerve damage throughout my body. At a certain point the doctors stopped prescribing the drugs, so I graduated to other drugs through trial and error. I was searching for something for the pain, and I couldn't find what I was looking for. Heroin was the next-best thing, and it turned out it was a better thing, because it was more potent than morphine.

I went for a couple of years without using a needle. Once I used a needle, everything changed. It all became a lot more serious. It's a job [laughs]. I had to be careful both about OD'ing and getting a disease from a needle. Because my mom—she's a nurse practitioner, pretty much a doctor—my mom is like the rock of my life. There's no way in the world I could ever let her down. So I had to be seriously dedicated to keeping myself healthy while still being strung out on drugs.

I came down here in 2008 after living in Portland and working as a bike messenger for a while. I make my living in mischievous ways. I don't want to talk about it. It's kind of personal and incriminating.

I was homeless for a couple of years. I moved around, didn't stay in one area. Now I live in the Tenderloin. I volunteer at a place and they also give me room and board. I've been here about six months. I can shoot up where I'm living. It's a lot safer and I'm not subjected to the dangers of the streets. For a little while, anyway.

Gary McCoy, 39

City employee; appointed to the California Homeless Coordinating and Financing Council; former methamphetamine user

I started doing heroin in my teenage years, 16 to 19. I was hanging out with older guys and started snorting on weekends, trying to fit in and be cool. It was as recreational as it gets at first, just snorting. I started to inject around the time I dropped out of high school, in my senior year. I got strung out within weeks and started stealing from my family, my grandparents. I did a lot of shameful things.

I was in a relationship with a guy in Virginia who wanted to clean up and had relatives in Visalia. So I came to San Francisco while he went there. I was about 21 and was sober for the first month or two, working for a radio station. Then I met somebody one night, we shot meth immediately and had sex. This was new to me at the time—I didn't mingle sex and drugs when I was younger, and sex isn't prevalent with heroin anyway. But within a month or two I was using every other day—probably less than a quarter gram in one injection, two or three times a day.

In about 2002, I found out I was HIV positive, and after I was diagnosed with HIV I stopped seeing my doctor. I ignored that I had it. For a few years I was asymptomatic and kept the same level of meth use. I was a maintenance user, using about $100 worth a day, sometimes more. It was completely commingled with sex for me. I'd do it in the morning when I woke up to get me going. And then for the rest of the day, it was about finding more sex and finding more meth.

I ran the streets with a bunch of kids my age, 18 to 24. We were all homeless and using and trying to figure out how to support our habit. Living wherever, whether it be with older men, or in elevator shafts, or behind the bushes at 18th and Collingwood. The priorities for me at that age were: where can I get my first hit for the day, who can sustain me for the rest of the day, and whose place can I stay at tonight.

Me and my partner always talked about getting sober, but we always found a way to justify that it wasn't the right time. And one day, it was December 2010, he said, "I'm going into a program tomorrow. I'm done. I love you, but this is what I have to do." I didn't believe him. The next morning his stuff was packed, he had his suitcase ready to go, he did one last hit and hopped in a cab and went. And for the first week after that I thought, Screw it, I'm just gonna do whatever I want. I got high, hung out with a good friend of mine, Rob, who was also a maintenance user. Eventually Rob says, "Have you ever thought about trying a program yourself?" And it's bad when a friend who's a user himself suggests that maybe you should get sober.

So I made a phone call to my caseworker at Ward 86 [an S.F. General HIV clinic]. She said, "OK, we'll try to get you into Ferguson CONTINUED ON PAGE 110

Damage Done

CONTINUED FROM PAGE 102

Place." [Ferguson Place, run by Positive Resource Center, is a residential treatment center that has a triple-diagnosis program for people with HIV/AIDS, mental health issues, and substance abuse disorder.] My goal was to stay sober for 30 days so I could start taking my meds again. I knew I was gonna die if I didn't start taking my meds. When I finally got sober in 2011, I had four T-cells [a healthy person has 200] and weighed 110 pounds.

To be honest, I didn't want to die because I wanted to keep using. The drive was to continue to use, not so much to live. That was the plan. Thirty days in, I took off. I left the Ferguson house to go hang out with two friends I used to hook up with. We were going to have sex and I was going to go back to [Ferguson] house. It didn't work out that way. I ended up getting high with them, they started arguing over something, and I took off and left their house. I went to the baths, nobody was there. Nothing I had planned on happening that night happened. It was miserable. I felt like I'd wasted my relapse. Sex didn't happen, I didn't get to party. And then I got a call from the overnight counselor at Ferguson and he said, "You know, you have a window of opportunity right now to take advantage of, and the longer you're gone, the smaller that window is going to get." And for whatever reason, that clicked. I immediately went to BART, I think I got there at 5 a.m., and sat there and waited for the first train. I went straight back to Ferguson, and I've been sober since.

That night my goal immediately changed. I realized I was done. I see people who have struggled all the time with sobriety, in and out, and then it just takes one thing happening. For me it was that one funny night when everything went to shit. That was February 23, 2011, my sobriety date, the last time I used.

Frank, 38

Homeless heroin and meth user

Since I came here in 2013, I've been homeless. I've never tried to get on a list for housing. I'm such a procrastinator, it would take me years just to get started. I crash over in an area by Church and Market and by Octavia Street. I wouldn't sleep over by the library, it's too violent. I had a friend who was just sitting there and somebody came up and kicked him in the face. A guy slashed a girl's back with a box cutter, cut her two feet down her back, and ran off laughing and saying, "White devil."

My game plan now is to get on Suboxone [an opioid treatment medication]. I don't want to see a doctor or be in a program. In a week to two weeks, I could lower my usage, become a weekend warrior. I've done it before. Then I could save all the money I'm now spending on dope. I could put up $100 a day panhandling. My teeth are all fucked up, and I could get dental implants within a year or two, or I could buy a car and make a move. Maybe fly back home to Milwaukee and see my mom. I could go do something for myself. Right now I just spend my days hustling money, buying dope, hustling money, buying dope. I have no time to do anything else. Right now after I talk to you, I gotta go hustle up more money. This is cutting into my time, but whatever.

On my way here to San Francisco, my buddy and I had a little bit of heroin. We ran out the first day into the trip. We had a couple of Suboxones; we took them when we got here. Then after a couple of months, I was in so much pain. I was about to get on methadone, and I said, "I need something." I started teeter-tottering, walking that fine line, and then I became dependent again. For a while I could do it one day a week and be in control and not have it be a dependency. If I could get to that place again, it'd be great. There are people who do it Friday night, they spend $10 and get fully annihilated and they don't do it again and don't become addicted. You could still have a life.

That lasts for a week. Then you wake up one morning and you just don't feel right. Then you do a dose and you feel absolutely fine. I never knew what addiction was. I never knew what dependency was. All of a sudden you find out what that is real quick. You feel like you're terminally ill with cancer.

One of my best friends was a big marijuana dealer back in Wisconsin. He had a lot of money and he used the money to buy a lot of OxyContin. Finally he blew his brains out. He couldn't deal with the addiction, constantly chasing it, not having anything. He couldn't take that constant doing it over and over again. Getting well, then getting drugs, then the drugs are gone, then do it again. One time we had a suicide pact. We were both going to shoot ourselves in the head. But I couldn't do it. I couldn't leave my brother like that, my mother like that. ■

A Safe Place

CONTINUED FROM PAGE 99

discovered when a client who injects drugs admitted that she'd always been a little scared of Bransten. "'I've only ever been eighty-sixed'—which means removed from services—'once,'" Bransten recalls the woman saying. "'And that was you coming over the stall of the bathroom catching me ready to inject.'" This memory is enough to make Bransten's eyes well up and her voice waver. "Eight years later she remembers that, and for me—I didn't remember her at all.... It's traumatizing for everybody not to be able to say to someone who desperately needs help, 'We can help you.'"

Supervised injection facilities can help users in many ways. Crucially, not only do they reduce disease transmission and overdoses, but they also have been shown to increase the number of people who seek treatment. The first year after Insite opened, there was a 33 percent uptick in the number of people in detox programs. Addiction care professionals credit supervised injection facilities with enabling them to build trust with clients and to offer help without coercion or pressure. "You don't manipulate clients, you don't shame them, you work with them," Harkin says. A 2010 study of more than 600 people who inject drugs in San Francisco found that 85 percent would use a supervised injection site if it were conveniently located.

IN EARLY AUGUST, at its final public meeting, the task force released a draft recommendation supporting the idea of multiple sites across the city located within organizations that already serve people who inject drugs. The final recommendation will be released in September and will go to the Board of Supervisors and Mayor Lee for consideration.

The task force's draft recommendation proposes facilities in neighborhoods with high rates of public drug use, including the Tenderloin, Civic Center, SoMa, the Mission, the Bayview, and Haight-Ashbury. It also calls for a model that links clients to other services, employs trained peers who use drugs, and considers expanding to serve people who use drugs without injecting them. Factoring in reduced disease transmission, soft-tissue infection, and overdoses, as well as an increased number of people in treatment, one 13-booth supervised injection site could save San Francisco as much as $3.5 million annually. So far, public commentators at task force meetings have been overwhelmingly supportive, with only a handful of critics questioning whether safe injection sites would attract drug dealing and other criminal activity, become a lure for outside drug users, or waste taxpayer dollars on additional security measures.

Still, formidable hurdles to opening even one safe injection facility remain. The city's ever-present NIMBY factions could block it, as happened in Seattle, which approved a supervised injection facility this year but hasn't yet built it because of community backlash. And there are legal barriers, including the so-called crack house statute, a section of the federal Controlled Substances Act that criminalizes landlords who knowingly allow drug use on their property. A recently introduced bill, AB 186, would have exempted property owners, staff, volunteers, and clients of injection facilities from such charges. But it fell short by two votes in mid-September. Even if it's revived and passes at the state level, city-sanctioned facilities could face federal opposition from Attorney General Jeff Sessions, given the Department of Justice's revived war on drugs.

Despite these obstacles, injection site supporters are optimistic. "It's going to happen because I believe that this city is a loving city, a caring city, that has always stepped forward," says Bransten. "Whether it was the AIDS crisis or needle exchange, throughout the years we have shown ourselves to be leaders in the field of compassion."

For Paula Lum, a member of the task force and a doctor at Zuckerberg San Francisco General Hospital, the significance of a supervised injection site goes far beyond cost savings. Lum was around in 1993 when the city got its first syringe exchange, in 2000 when it adopted harm reduction as official policy, and in 2003 when it became the first American city to make naloxone, which reverses opioid overdoses, widely available to the public. The unconditional acceptance at the root of safe injection sites is "the original spirit of San Francisco," Lum says, "which I think we've seen less of over the years." In the idea of a supervised injection facility—a place where drug users could come with their trauma and their illness and be welcomed, respected, and helped—she sees the potential for the city to return to its radical, compassionate roots, and heal. —*Lindsey J. Smith*

Front Lines

CONTINUED FROM PAGE 102

from their withdrawal symptoms, when you give them the medication you can see a visible difference in their behavior and how they're doing. When they feel like the medication is working out, they're more inclined to follow up and stick with the program and do the rest of the treatment, like counseling, other interventions, and things like that.

A few years ago, we had a patient we were concerned about because he was an injection drug user. He was injecting in his right groin because he couldn't find any more veins in his arms or his legs. When I did the physical examination, you could actually hear that the blood vessel was weakened—it was making a hissing sound. It sounded like it was an emergency that anytime could pop. You know when you have a hose that bubbles up? That can explode.

So we called to transport him to the emergency room. We had our people at the general hospital ready to receive him, they walked him to the ER, and the ER people saw him and called surgery. With this chain of providers wanting to help him, they repaired the blood vessel and he was doing well.

A few months later, he came back to my clinic and I said, "How are you doing? I'm so glad to see that you're doing well and you're alive! But why are you back here?" And he said, "Oh, I'm using...but now it's on the left side." This, truly, is addiction. After everything—where we all tried to pull together to help him—he stayed clean for a little bit. But after that, he was injecting on the other side. That was the sad reality. So we helped him again.

●●

DANNY GRACIA, 48
San Francisco firefighter

In the '90s, when we would respond to heroin overdoses in the Tenderloin, it would be mostly people inside their SRO units, hallways, basements. You didn't see nearly as much of it in the wide open, all day every day, out on the streets and sidewalks. I would say 70 percent was behind closed doors, and now you see the opposite of that; I think it's probably 70 percent out in the open and 30 percent is indoors, because there are a lot more people living on the streets now.

We do what we need to do, whether it's outside or inside. We start working on them—oxygen, CPR, et cetera, and then the medics come and inject Narcan. In a few minutes, a person will sit up and start talking to you. Sometimes they complain that you ruined their high and you should have left them be. Sometimes they throw up on you and complain. You try to help them, and you do what you can for them, but you might come back the next day and the same person did the same thing.

●●

DR. JOSEPH PACE, 45
Director of primary care homeless services, San Francisco Department of Public Health

A lot of the people that we care for have lived pretty tumultuous and traumatic lives. You talk to some people about their substance of choice, and they often will talk about it as if they have a relationship to it. It's their friend, it's their companion, it's the person that gets them through rough periods of time.

If you think about how long it took for these coping mechanisms to develop, to reverse that, or help people find new coping strategies, can take quite a bit of time and persistence. We as medical providers want people to be as healthy as they can be; ultimately, that is up to what the person is ready for. If that means they want to stop using drugs, great, we'll get them on that path; if that means they're not ready to stop using drugs, well, how can we reduce the harm? And then we try to move people along a spectrum of change toward something. We try to hold out hope that things can be different for people.

We try to employ a strengths-based approach. Someone has survived all this adversity and they have picked and chosen things that they have needed to get them through the day, and through the years. But they've done something that's allowed them to survive, so they must have some strengths they've brought to the table. So how can we identify those strengths and use those to help someone find a way forward? Some of it is a little bit of a discovery for the client. They might not see themselves as having strengths. For us it's about identifying that for them and saying, "Hey, you're really good at this. You get your needs met, or you know how to focus when you really want to, so let's find ways to build on those strengths." ■