Copping, Running, and Paraphernalia Laws: Contextual Variables and Needle Risk Behavior among Injection Drug Users in Denver

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This paper addresses syringe sharing, the primary method of HIV transmission among drug injectors. It argues that this high risk drug injection behavior cannot be adequately understood by relying on psychological and cultural explanations alone. Rather, this ethnographic study contends that, among drug injectors in Denver, syringes are shared because they are scarce, and they are scarce because they are illegal to possess without medical justification. A legal mandate combines with other aspects of law enforcement to discourage street-based drug users from carrying syringes, particularly when they are in the process of obtaining drugs. The result is that drug injectors are least likely to have syringes when they need them the most. This study concludes by suggesting that the paraphernalia laws currently in place in approximately 44 states and numerous municipalities may no longer be serving the public interest.

Key words: drug injectors, HIV, hustling strategies, needle sharing, paraphernalia laws

This article describes injection drug use in Denver and identifies how contextual factors that influence hypodermic needle availability contribute to high risk needle use practices. This study specifically explains how a legal mandate restricting needle possession, combined with strategies commonly used by injection drug users (IDUs) to obtain drugs, increases the likelihood of needle sharing, which occurs even though needles can be purchased without a prescription in Colorado. The research presented has direct social policy implications, and it demonstrates the important contribution of the ethnographic perspective and methods to our understanding of disease and its prevention.

Since the advent of the AIDS epidemic in the United States, a major emphasis of applied, government-funded research has been on developing public health interventions designed to change the behaviors that place drug injectors and their sexual partners at risk for HIV infection. Research efforts quickly identified syringe "sharing" as the dominant mode of HIV transmission among injectors, and offered explanations for this practice. Needle sharing was portrayed as a way drug injectors could reduce the mistrust that permeates their illegal and insecure lifestyle, as a means for individuals to "bond" with each other, as a substitute for sexual intimacy, and as a ritual (Des Jarlais, Friedman and Strug 1986, Howard and Borges 1972). With the increase in ethnographic research among IDUs, these explanations for the rationale underlying needle sharing are being re-examined (Calsyn, et al. 1991, Kane and Mason 1992, Koester 1992). By studying the context in which syringes are "shared" and by eliciting injectors' own explanations for this behavior, ethnographers have demonstrated that sharing needles and syringes is not an essential trait of a deviant subculture, and that the meanings researchers initially attached to this high-risk drug using activity are not necessarily the meanings injectors assign it. Instead, increasing evidence suggests that much of what we call "needle sharing" is a pragmatic response to needle scarcity.

A primary reason syringes are scarce is because most states and many cities have legal sanctions restricting their availability (CDC 1993, Pascal 1988). In some states and municipalities availability is restricted by laws requiring a prescription to purchase and possess syringes (Clatts, et al. in press, CDC 1993, Murphy 1987, O'Keefe 1991, Singer, Irizarry, and Schensul 1991, Singer, et al. 1992, Watters 1989). In other locations, the availability of syringes is curtailed because syringes are defined as drug paraphernalia, and their possession is illegal (Booth et al. 1993, Celentano et al. 1991, Kane and Mason 1992, Koester 1988). By requiring a prescription to purchase syringes and/or making their possession illegal, drug paraphernalia laws create an ar-
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representative of the larger quantitative sample. Selection criteria all indicated that these communities included a comparable population of drug injectors who frequented relatively open drug coping (buying) scenes and injectors who support their own drug use by "running" or purchasing drugs for other users.

Background

The research presented here was conducted as part of HIV prevention studies funded since 1988 by the National Institute on Drug Abuse. Both qualitative and quantitative methods were used to examine high risk drug using and sexual behavior among drug users living in two inner city areas of Denver, and to develop and test intervention models aimed at reducing the risk of HIV transmission among these individuals. The analysis presented is based on ethnographic investigations among active drug users residing in and/or frequenting Denver's northeast and northwest neighborhoods. These neighborhoods were selected for intervention and research because data on drug treatment admissions, drug-related arrests, emergency room admissions in which illicit drugs were mentioned, and key informant interviews all indicated that these communities included a comparatively high number of drug injectors as residents.

Methods

Ethnographic research was carried out intermittently over a five-year period, from January 1988 through December 1992, in the neighborhoods targeted for intervention. Throughout the course of this research, the author has served as both ethnographer and project manager. During the project's first three years, 1988 through 1990, ethnographic research was aimed at describing Denver's drug scenes, and adapting and refining the Indigenous Leader Outreach model developed by Wieland (1988) to fit the local context. To accomplish this aim, key informant relationships were developed with both outreach workers and active drug injectors. Direct observation was carried out in the neighborhoods targeted for intervention, and open-ended interviews were conducted with a sub-sample of injectors who were also recruited as subjects for the survey instrument designed to assess HIV risk behavior. In selecting individuals for qualitative interviews, an attempt was made to find IDUs who were representative of the larger quantitative sample. Selection criteria included types of drugs used, gender, ethnicity, sexual orientation, neighborhood affiliation, and self-reported risk behavior.

Beginning in 1991, ethnographic investigations have centered on topics identified during the first three years of study. These studies focus on specific aspects of drug use, their relationship to HIV transmission, and the contextual variables that influence their occurrence. This article reports on ethnographic data collected as part of one of these focused studies: an examination of the effect of law enforcement on drug using behavior. This research topic emerged from discussions with IDUs and from direct observation in neighborhood drug-buying locations. To pursue this area of inquiry, a research guide was designed, and focused, open-ended interviews were conducted with 20 active drug injectors recruited from the larger survey sample. Nine African American, eight Hispanic, and three white injectors, 13 men and seven women, were interviewed. Eleven subjects considered heroin as their primary drug, while nine preferred cocaine. Seventeen of those interviewed, however, reported the use of both drugs. Individuals ranged in age from mid-twenties to early fifties; injectors whose primary drug was heroin were generally older than their cocaine-injecting counterparts. All 20 informants reported that they sometimes obtained drugs by assuming the role of liaison between a drug buyer and a local dealer.

Both formal interviews and more casual conversations focused on the everyday activities in which street-based injectors engage, and included detailed discussions about syringe sharing, drug coping, personal economic strategies, and the impact of law enforcement. Specific attention was focused on understanding situations in which syringes are transferred among users, and the circumstances that led to these incidents. Interviews were conducted in both the project office and in the communities where injectors purchase and use drugs. Formal, open-ended interviews were audiotaped and transcribed. Individuals were assured of confidentiality and were compensated $10 for their time.

The 20 focused interviews were augmented with less formal interviews and discussions with other IDUs, interviews with representatives of the legal system, and with direct observation in coping areas and drug-injecting locations. Interviews and discussions were conducted with a Denver city attorney, the District Attorney, three Denver police officers, and a member of the Colorado State Pharmacy Board, who were asked to discuss their perspective on law enforcement strategies aimed at drug users; they also helped verify information provided by drug injectors. In addition, a brief survey was administered by outreach workers to 24 active injectors in one predominantly African American drug-buying site on the city's northeast side. Subjects were selected using a convenience sampling plan. In this survey, IDUs were asked if they carried syringes and if not, why not. They were also asked if they had ever been issued a citation for possession of a syringe.

Locations for observation included neighborhood streets, public parks, shooting galleries, bars, automobiles, private homes, and apartments. These observations were essential to this study as they enabled the author to witness how small quantities of drugs are bought and sold, and to see the various strategies injectors employ to minimize the danger involved in conducting these transactions. On several occasions, while the author was conducting field work in neighborhood drug-buying locations, police interactions with suspected drug users were observed.

Why Do They "Share?"

From an epidemiological perspective, the term "sharing" summarizes the act that places drug injectors at risk for HIV infec-
tion. "Sharing," however, does not accurately reflect the motive for this behavior or how it is perceived by the actors. From the perspective of the drug users, "sharing" is a misnomer. It implies that the exchange of a syringe between users is conscious and deliberate, and that it occurs as an act of reciprocity. As researchers in Dayton/Columbus contend, "Implicit in the term sharing is an attitude of altruism that is inconsistent with the self-centered nature of intravenous drug use" (Carlson, Siegal, and Falck in press). Ethnographers have reported that, in many cases, drug injectors do not consider the passing of a used syringe as sharing (Carlson 1991; Carlson, Siegal, and Falck in press; Clatts et al. in press; Fernando 1991; Kane and Mason 1992; Koester 1992; Murphy 1987; Page et al. 1990). When asked if they share syringes, injectors will frequently say no, but, when asked if they ever let someone else use a syringe they just used, they will say yes. For these injectors, the person who "shares" is the recipient of the syringe, not its donor. In addition, individuals who jointly purchase syringes and injectors who are sexual partners may not regard their common use of a single syringe as "sharing" (Koester 1992, NRC 1989).

The terms "needle transfer" and "needle circulation" have been suggested as more accurately reflecting the way injectors perceive the passing of syringes from one user to another (Carlson, Siegal, and Falck in press). In many instances, syringes are transferred anonymously when injectors take syringes from a common stock in a shooting gallery or find a syringe that another injector has "stashed" for later use.2 These forms of anonymous syringe "sharing" have been more accurately described as needle pooling (Page et al. 1990). Although potentially misleading, I have chosen to use the term syringe sharing in this paper due to its widespread acceptance as the term of choice for describing the transfer of needles between drug injectors.

Drug injectors have several reasons for not sharing syringes. Long-term injectors have contracted, or know of other injectors who have contracted, Hepatitis B from using a previously-used syringe. In addition, a new needle is much easier to inject with, an important concern for users who are "hard to hit" or who want to protect their remaining "good veins." Veins develop scarring tissue from repeated injections and eventually "collapse," forcing the injector to find alternative veins for injecting. It is not uncommon for long-term users to inject in their legs, hands, feet, and neck. In addition, used needles clog and break, and plungers wear out. As one African American woman who had been injecting heroin and cocaine for over 15 years explained, "...they're [syringes] only designed to be used once, so about after three times, that's when you start getting burrs on them, they get dull, they'll start clogging up.

These mechanical failures can be serious if the injector is without a substitute. In addition, "shooting behind" someone [using a syringe after others] requires a waiting period that can often be quite long. The first injector may be unable to locate a vein, or s/he may like to repeatedly pump or "boot" the blood and drug mixture into his or her vein. Some injectors, particularly users of cocaine, contend that "shooting" increases or prolongs the "rush," the initial feeling of getting high. Finally, shooting behind someone is often regarded as an expression of subordination (Carlson, Siegal, and Falck in press). Nonetheless, even with these pragmatic reasons for not sharing, the practice is common (Booth et al. 1991, Booth and Wiebel 1992), a consequence, in part, of laws that create an artificial scarcity of syringes.

The Law and Its Consequences

In 1979, the US Drug Enforcement Agency developed the Model Drug Paraphernalia Act, which provided a comprehensive definition of drug paraphernalia that enabled states and municipalities to standardize their laws controlling the sale and use of these items. Included as drug paraphernalia are "hypodermic syringes, needles and other objects used, intended for use, or designed for use in parenterally injecting controlled substances into the body" (Model Drug Paraphernalia Act 1979; quoted in Pascal 1988:122). Currently, 44 states and the District of Columbia have laws regulating the possession of drug paraphernalia based on this model. In addition, ten states, including California, New York, Massachusetts, Rhode Island, and New Jersey, require a prescription to purchase a syringe (CDC 1993, Fernando 1991, O'Keefe 1991).3 Many cities have created equivalent municipal ordinances.

In Denver, syringe access is controlled by enforcing laws that restrict their possession. Both a state statute and a municipal ordinance define a syringe as drug paraphernalia if "...used, intended for use, or designed for use in...injection...into the human body..." (CRS 18-18-426). Possession of drug paraphernalia (CRS 18-18-428) is a Class Two misdemeanor, punishable by a maximum $100 fine. Denver police normally enforce a complementary city ordinance (38-173) outlawing the possession of "injection devices," rather than the state statute because it requires less paperwork. The penalty for violating the city ordinance is determined by the judge and can vary from a small fine to time in jail. A city attorney suggested that judges commonly consider the offender's record in determining the penalty.

Prescriptions are not required to purchase syringes in Colorado. It is, however, technically illegal to knowingly sell a syringe if its intended use is to inject illicit substances (CRS 18-18-427). Staff members of the Colorado Pharmacy Board were unaware of any cases in which pharmacists had been prosecuted for this offense. Injectors interviewed for this study stated that although they knew of some pharmacies that refused to sell syringes to persons suspected of illicit drug use, they were aware of other pharmacies that commonly sell to IDUs. Pharmacies were, in fact, a frequent source of syringes among the individuals interviewed for this study.

Some researchers have suggested that laws requiring a prescription to buy syringes may be more significant in influencing high risk drug injecting than laws that only regulate possession. Studies in Dayton and Columbus (Carlson, Siegal, and Falck in press) and in Seattle (Calsyn et al. 1991) contend that because syringes can be purchased without a prescription in these cities, drug injectors have a relatively easy time obtaining them. There is thus less needle sharing and, partially in consequence, low HIV seroprevalence rates in those cities. In Dayton, Columbus, and Seattle syringes are regulated only by laws restricting possession. The situation in Denver, with its analogous paraphernalia laws and comparably low HIV seroprevalence rates in those cities, drug injectors have a relatively easy time obtaining them. There is thus less needle sharing and, partially in consequence, low HIV seroprevalence rates in those cities. In Dayton, Columbus, and Seattle syringes are regulated only by laws restricting possession. The situation in Denver, with its analogous paraphernalia and comparable low 1% seroprevalence rate among injectors, appears to support these observations. Nevertheless, research in Denver found that among 129 injectors interviewed, 83% reported "sharing" syringes during the prior six months. Members of this cohort shared with an average of 5.49 partners.4 To understand why requires "sharing" to be examined within the context in which it occurs.

In Dayton, Columbus, and Seattle, enforcement of laws regulating needle possession is minimal. In Seattle, "possession
of equipment leaves one subject to mild harassment but not arrest” (Calary et al. 1991:188). In Dayton and Columbus, enforcement is situational, and in most cases police simply destroy the confiscated syringe (Carlson, Siegel, and Falck in press). It appears that sanctions against needle possession are more rigidly enforced in Denver, and that consequently, injectors are more cautious about carrying them, particularly when they are in the process of obtaining drugs.

At first, drug injectors’ concern and compliance with paraphernalia laws seem ludicrous when, in the course of a single day, these same injectors may commit far more serious offenses, including buying, selling, and using illicit drugs, and engaging in illegal acts to obtain drugs. From a drug user’s perspective, however, being caught with a syringe is a serious matter. Committing this offense identifies the offender as a drug injector to the police. It results in a court appearance and fine, and occasionally leads to incarceration. In addition, a paraphernalia violation goes on the user’s record, making it more difficult to plead not guilty to future drug-related charges. Injectors reported that being cited for a paraphernalia offense could be especially detrimental if, in the future, they were arrested on another drug-related charge like drug possession. As they explained it, having violations for paraphernalia on their record would make it difficult to convince a judge of their innocence regarding more serious drug-related offenses in the future.

Breaking laws to buy and use illicit drugs, and committing crimes to obtain money to buy drugs are unavoidable consequences of drug addiction, but carrying a syringe is not. Drug users spend a great deal of time thinking about and actively engaging in strategies to avoid detection. An injector summarized this common preoccupation by stating, “I never put my shit on the streets.” In explaining this statement he said that he goes to great lengths to minimize his visibility and to reduce the number of reasons for which he could be arrested; not carrying drug paraphernalia is simply one of these ways.

When injectors are caught with syringes, they are normally issued citations requiring a court appearance. If the injectors plead guilty or no contest, they usually receive fines of between $50 and $100. It is not uncommon, however, for users to receive short jail sentences. Individuals charged with violating this ordinance can also plead not guilty and have a trial. None of the users interviewed knew of anyone who pleaded not guilty. The threat of this fine is reason enough to discourage users from getting caught with a syringe, but the likelihood that it will begin a process leading to jail is an even more compelling reason not to carry one. This scenario occurs because drug injectors often fail to appear for misdemeanor criminal charges. As a result, they frequently have outstanding bench warrants. When IDUs are stopped by police, an identification check reveals these warrants and they go to jail. According to Feldman and Biernacki:

> The illegality of hypodermic syringes prevents many publicly labelled addicts from keeping needles in their possession, since another arrest for “old timers” may result in jail sentences. For those persons with previous incarcerations, the periods in jail have been bitter experiences which they dread and strive to avoid repeating (1988:35).

Injectors in Denver reported incidents when, after being found with a syringe, police took them to jail even though they did not have an outstanding warrant. One woman described how, after shooting cocaine at 3 A.M., she was “tweaking,” experiencing a cocaine-induced nervousness or paranoia that is difficult to hide. She took a walk, forgot she was carrying a syringe, was picked up by the police, searched, and subsequently taken to jail. This encounter occurred very early on a Saturday morning, and so she remained in jail until her court appearance the following Monday. She was found guilty of possessing an injection device, sentenced to three days in jail, and credited with the time served.

Another informant described how he was caught with a syringe as he came out of a shooting gallery. The police ran an identification check, and although he had no outstanding warrant, he was taken to the police station and placed in a holding cell until a member of his family posted his $100 bond. Thirty days later when he appeared in court, he was fined $100 and placed on unsupervised probation for a year. He explained that this experience deterred him from carrying syringes:

> I just waited until I got home [to inject] or I'd try to get one [a syringe] right away from whoever I could. If you're on foot, you're going to use the first [syringe] you can get hold of.

These two illustrations suggest that police can use paraphernalia violations to arrest individuals they suspect of more serious offenses. In cases where they feel there is “probable cause” to suspect illegal activity, officers will question an individual and conduct a “pat down search.” In the two cases described here, police officers may have suspected these IDUs of possessing drugs or of having drug residue in their syringes. A city attorney explained that even when found with a syringe, injectors are not normally arrested unless “something else is going on.” A police officer substantiated this claim, saying that enforcement of paraphernalia laws is discretionary and often used as a “tool” for dealing with what seems to be a more serious problem: “If we find someone with a syringe we know they’re either going to use, have just used or are on their way to score.” As if for emphasis, he concluded by saying that it was more likely to find an IDU with a gun than a syringe. In addition, as Lindesmith (1965:36) observed in his extensive examination of drug laws, arresting users on charges like paraphernalia violations provide police with opportunities to elicit information about the drug scene and its players.

**Copping, Running and Carrying Syringes**

Street-based drug injectors are particularly susceptible to the enforcement of drug paraphernalia laws because they are so noticeable. Their visibility is a consequence of both their impoverished lifestyle and the strategies they must employ to obtain drugs when they have little money to purchase them. Their drug use and poverty often result in temporary living arrangements. In many instances they simply have no place of their own to consume drugs. Their limited access to transportation and telephones means that they often have to arrange drug deals in person and on foot.

Sources of income common among drug injectors, including jobs, disability payments, public assistance, and petty crimes, are often inadequate, temporary, and unreliable. To subsist and to maintain their drug use, injectors frequently rely on flexible economic strategies with multiple components. In addition to the sources of income mentioned, most injectors’ strategies in-
exclude ways to obtain drugs with little or no money. Two common methods are the formation of situational drug buying partnerships and assuming the role of liaison between drug buyers and dealers. In carrying out these “hustles,” injectors are often forced to operate openly in drug copping (buying) locations.

Drug injectors often form temporary partnerships in order to pool their limited assets to purchase drugs. Doing so becomes necessary because even low-level dealers or “connects” have minimum amounts they will sell. In Denver, the smallest unit of cocaine available is normally a quarter gram at $20 to $25. A “pill” of heroin, the quantity required for one or two “hits,” usually sells for $20 to $30. Injectors without a steady source of income, or who have had little success hustling on a given day, are often required to go in together on the purchase of even the smallest quantities of cocaine or heroin. In other instances, IDUs may combine their resources in order to purchase larger quantities of a drug at a more favorable price. To establish these temporary drug copping arrangements, IDUs must go to known coping sites to meet other IDUs with the same objective.

“Running” for a “Taste”

Another hustle that increases a drug injector’s visibility is that of being a “runner.” Injectors frequently support their habits by “running” or connecting buyers with local dealers. This particular strategy requires the “runner” to seek out buyers (touting), take their money to the “connect” or dealer and then return with the drug. Runners provide an important drug scene service, especially for IDUs who come from other areas to purchase drugs. Injectors from outside a known coping site may go there to purchase drugs for a variety of reasons. They may wish to avoid detection as a drug user in their own neighborhood; they may be trying to obtain a better quality of drugs; or drugs may be unavailable from their usual source. Under these circumstances the buyer has little choice but to go through a runner. Dealers benefit by working with runners as well; runners generate business by touting the dealer’s product. In addition, employing a runner cuts down traffic to the dealer’s place of business, thus reducing the operation’s visibility.

In exchange for assuming the high degree of risk that accompanies this liaison role, the runner is given a “taste” (a small amount) of the drug by the buyer. Sometimes dealers also give runners tastes for their efforts, and runners frequently augment the buyer’s payment for this service by “pinching” a small amount of the drug before delivering it. In some cases, they may simply take the buyer’s money and not return, or they may give purchasers less than they had bargained for. Runners must, however, be careful about whom they “burn.” If they get a “jacket,” a bad reputation on the street, no one will buy through them. There are several variations of running. Some runners only work with people they know, while others may be willing to buy drugs for almost anyone. Female drug users often combine running with prostitution.

A woman who supports her cocaine and heroin use by running for other users in a poor and working class, largely African American, neighborhood described how she conducts business:

Somebody comes to you and asks you cause you know where it is. You know where it’s good. Everybody can’t go to people, and you run and you get it. Because you got that inside connect with the person with the good stuff.

I don’t ever go for nobody I don’t know. Now if somebody like you [the white anthropologist] came and you was with my friend, I don’t take no money from you but I could take it from her. She might know you but. . . . and they [you] don’t know where I’m going. You have to put your trust in me. A lot of people they will beat you [take the money and not return]; you’ll never see them again you know . . .

Avoiding Detection

In conducting these hustles to obtain money to buy drugs, and when buying and carrying drugs, drug injectors are vulnerable to detection. The need to engage in illegal activities with people who may be unfamiliar and to do so in a relatively open manner makes it likely that individuals depending on these hustles will eventually be arrested. This risk is exacerbated because, as previously mentioned, runners often meet potential buyers in known coping areas and perform this task on foot. If stopped and searched by the police they can be charged with a felony for drug possession.

Injectors take certain precautions when coping or running. They carefully hide the drugs on their bodies, and they limit the time they are in possession of drugs by consuming them as quickly as possible after purchase. Heroin and cocaine are relatively easy to conceal because they are purchased in small quantities. A “pill” of heroin, for example, looks and feels like a piece of tar, and is only about half the size of a pencil eraser. Wrapped in foil, it can be carried in one’s mouth. If stopped by the police, it may not be detected, and if necessary, it can be swallowed.

Syringes are not as easy to hide or discard. Often, there is a significant time lag between purchasing a syringe and obtaining the drug. During this period, the individual is vulnerable to arrest for possession of drug paraphernalia. Unlike the crimes they commit because they are addicted and attempting to support a habit, this offense can be avoided. As an injector explained, “Addicts don’t normally worry about getting a fit [syringe] until after they cop their dope. Nobody wants to put a fit in their pocket until after they get their dope.”

Another injector emphasized this same point, saying, “One thing you will not catch is someone on the (northeast side) just walking around carrying a needle. You’ll catch them with dope before you’ll catch them with a needle.”

These injectors’ apprehension about carrying syringes was confirmed through a brief survey conducted with a convenience sample of 24 IDUs in this same neighborhood. Of those surveyed, 23 stated that they did not carry syringes because they were afraid of arrest. What makes this response to law enforcement, and in particular to the paraphernalia law, so potentially dangerous is that it leaves drug injectors without syringes when they need them most.

The Social Construction of High Risk Injecting Situations

Researchers in Miami have described how the composition of a drug injecting group is determined during the steps users take to get drugs. These scholars suggest that if an individual joins with other(s) to obtain money to buy drugs, it is likely that they will continue their relationship until they achieve their
common objective of “getting off” (Page et al. 1990:66). Preble and Casey made this same point in their classic description of heroin use in New York City. They described arrangements for acquiring heroin that concluded with the users involved injecting together (1972).

In Denver, similar patterns have been observed. Individuals who form partnerships to buy drugs almost always use the drugs together. Runners are given a share of the drug in exchange for their service, and so they often end up using drugs with the individuals for whom they buy because participants are anxious to get high, they want to limit the time they are in possession of drugs, and because drugs are most often divided when they are being mixed for injection. It is more efficient to divide quarter grams of cocaine and single “pills” of heroin by dissolving the entire amount in water and then dividing the liquid drug solution according to the calibrations on the syringe. Doing so assures the runner of an adequate “taste” and eliminates the possibility of getting more of the ingredient used for “cutting” the drug than the drug itself.

The female runner cited above illustrates this pattern. Her standard payment for coping for others is a portion of the drug. She frequently receives her payment during the process of preparing the drug for injection. As she describes it,

> OK well, when I cop it's a fee; I get something out of it. It depends on if I'm in a good mood, sometimes I beat and sometimes I don't. I might take a little off the top and stash it, and be happy when they leave so I can do mine. And some people I cop for, they know me pretty good and they fix me up [prepare and inject the drug with her].

She explained that she “cops” both heroin and cocaine, and that the smallest amount she will purchase is a quarter gram of cocaine or a $20 pill of heroin. She is willing to buy small amounts of a drug for people because in those cases, “...we're going to get high together. We'll put so much cc's in a syringe and we all just split it. We all get high.”

In the week prior to this interview she had “copped” for nine people, all of whom paid for her service by giving her a share of the purchased drug. With six of these buyers she obtained the drug prior to actual preparation for injection. In these instances she did not use the drugs with the buyers. With the other three buyers, she received her share in the process of drug preparation and injection. In all three of these cases, she shared a single syringe with each buyer.

Strategies to obtain drugs such as forming temporary partnerships to cover the cost of drugs and coping for other injectors often lead to unsafe injecting episodes. This occurs because none of the participants are likely to be carrying a syringe while engaged in these activities. As described here, this is often a conscious decision IDUs make to avoid the immediate risk of arrest. To obtain a syringe in these instances, they will do whatever is most expedient. If one of them has a syringe it may be “shared.” If none of them has one, all of them will go to the nearest place they can get one, most often an apartment whose tenant allows injectors to “get high” in exchange for money or drugs, or a shooting gallery located near the coping site. Providing syringes is a primary service of these establishments.

Since runners may buy for several people in a day, they may end up sharing multiple syringes. This may be true for runners of both heroin and cocaine. The “taste” a heroin runner receives in payment for arranging a single drug purchase will probably be insufficient to overcome withdrawal symptoms or to get high, and runners who are cocaine injectors may buy for several purchasers in a day because the cocaine “high” is short-lived and the desire for more is strong. Some runners mentioned that they “didn't like getting down with someone they didn't know,” but all runners interviewed said that they inject with individuals with whom they are familiar.

**Conclusion**

This study is consistent with other studies linking impediments to syringe possession with high risk drug using behavior. Researchers in Scotland suggest that a 900% difference in seroprevalence among drug injectors in Glasgow and Edinburgh may be explained by these cities’ contrasting policies regarding the enforcement of needle possession laws. In Glasgow, where the infection rate among drug injectors is 5%, syringe possession laws are not enforced, while in Edinburgh, where syringe possession is subject to strict enforcement, the seroprevalence rate among the city’s injecting drug users is 5% (Conviser and Rutledge 1989). Studies by researchers in Connecticut have concluded that restricting syringe possession has encouraged high risk behavior while doing nothing to inhibit drug abuse (O'Keefe 1991, Singer, Irizarry, and Schensul 1991).

Other researchers contend that in cases where syringe access is legal or relatively uninhibited, high risk injecting behavior is reduced. Researchers in Baltimore found a lower seroprevalence among diabetic injectors than their non-diabetic counterparts, a finding they attributed to the fact that diabetic injectors “had greater access to sterile needles and syringes and, therefore, a lower frequency of using contaminated injection equipment” (Nelson et al. 1991). The diabetic subjects in this study reported lower frequencies of sharing syringes, less frequent use of shooting galleries and a lower frequency of going second, or shooting behind another injector, when they did share needles. Diabetic IDUs explained these differences as a result of their “having greater access to, and less threat of arrest for possession of drug injection paraphernalia” (Nelson et al. 1991: 2261). Grund and his colleagues, concluded their study of drug use in the Netherlands contending that “when drug and syringe availability is stable and possession of injection equipment is legal, needle sharing decreases markedly” (1991:1605). Finally, Des Jarlais and Friedman (1992) reviewed worldwide efforts aimed at providing drug injectors with legal access to syringes. They found that syringe exchange programs, over-the-counter sales, and decriminalizing syringe possession reduced AIDS risk behavior and did not lead to increased illicit drug use.

“Sharing” syringes and injecting in high risk environs like shooting galleries are not maladaptive rituals of a vast drug subculture, and they do not necessarily occur because of poor planning on the part of street-based injectors. On the contrary, these high risk activities often continue as deliberate responses to what drug injectors perceive as a more immediate threat than HIV infection. Laws criminalizing syringe possession have made drug injectors hesitant about carrying them, especially during the times they are trying to obtain drugs. As a result, users are frequently without syringes when they are ready and eager to inject. Nevertheless, this artificially created scarcity of syringes does not seem to prevent drug users from injecting. Instead, injectors respond
by transferring used needles among themselves and by going to places where they can "borrow" previously used syringes. These socially constructed responses to legally-imposed syringe scarcity increase the likelihood that injectors will use an HIV contaminated syringe. As several studies have shown, injecting drugs in shooting galleries has been directly linked with unsafe needle hygiene (Carlson, Siegal, and Falck in press; Celentano et al. 1991; Chitwood, McCoy, and Inciardi 1990; Clatts et al. in press; Des Jarlais, Friedman, and Strug 1986; Des Jarlais and Friedman 1990; Dolan et al. 1987, Kaplan 1989, Page et al. 1990, Singer, Irizarry, and Schensul 1991). The research described here suggests that minimizing HIV transmission among drug injectors demands more than educating them about risk reduction techniques; it also requires a corresponding change in the social policies and legal mandates which have been instrumental in fostering practices that increase HIV risk among drug injectors. Paraphernalia laws restricting the possession and/or sale of syringes should be reassessed. Slowing the spread of HIV may require that these laws be repealed or amended, or that a moratorium be placed on their enforcement.

Notes

1 For the first three years (1988–1990), the University of Colorado Health Sciences Center's AIDS intervention project was a subcontract of the University of Illinois School of Public Health's NIDA-funded demonstration project led by Wayne Wiebel. Ours was one of three sites (Denver, El Paso and Baltimore) implementing the "Indigenous Leader Outreach model," more frequently referred to as the "Chicago model" (Wiebel 1988). This intervention approach relies on indigenous outreach workers, individuals intimately familiar with the local drug scene, to take the public health message to individuals in the community exhibiting high risk behaviors. The model was adapted from a community-based effort in the late 1960s and early 1970s to stop a localized heroin epidemic on Chicago's southside (Hughes 1977). Since 1991, the Denver project has been funded by NIDA as a cooperative agreement. Currently, two distinct intervention models are being examined: a standardized program developed by NIDA and a second generation, local adaptation of the "Chicago model."

2 Shooting galleries exist as a response to the illegality of drug use, and they can be found virtually anywhere there is a street-based drug scene. This generic term, however, covers a variety of forms from largescale commercial establishments to places where a small group of users may go on a temporary and situational basis. Regardless of their form, galleries or "get offs" allow users a degree of privacy and security for preparing and using drugs, and they provide a common site for users to exchange pertinent information regarding current law enforcement activities, and the cost and quality of drugs. A primary function of galleries is to provide access to the items necessary for a drug user to "get off." In some galleries, these items, including syringes, are rented or sold by the management, in others, users transfer them among themselves. Drugs can be purchased in some galleries as well.

In Denver, most shooting galleries are small in scale and temporary in nature. They are not as well organized or established as some commercial galleries described in New York (Des Jarlais, Friedman and Strug 1986), Chicago (Ouellet et al. 1991), or Miami (Page et al. 1991). Rather, they are similar to those described in San Francisco (Watters 1989) and in Dayton and Columbus, Ohio (Carlson, Siegal, and Falck in press). Perhaps the most common form is a user's apartment or motel room. The tenant provides a space for others to obtain syringes, and to inject with a degree of privacy and security. In exchange, he or she is given a "taste" of the client's drug or is paid a small fee. In Denver, this form of gallery is usually limited to the tenant's social network, a group of people who buy and use drugs together on a fairly frequent basis, and who may "hustle" together to obtain money to buy drugs. Another form of shooting gallery found in Denver is simply an abandoned building within walking distance of a drug coping site. Users without any other nearby alternative come to an abandoned building for privacy and to obtain a syringe they had previously "stashed" there or to borrow someone else's syringe.

3 In response to the growing number of AIDS cases associated with injecting drug use, the state of Connecticut enacted laws allowing drug users to purchase as many as ten needles at a time without a prescription, and to possess as many as ten clean needles. These laws became effective July 1, 1992 (CDC 1993). These statistics are from a cohort of Denver injectors who were interviewed using the AIDS Initial Assessment (AIA) versions 6 and 8. This instrument was employed in AIDS demonstration projects funded by the National Institute on Drug Abuse throughout the United States from 1987 through 1990.

4 Street-based drug users routinely combine a variety of activities to maintain their needs, including their drug habit. There may be periods and combinations of legitimate employment and public assistance as well as criminal acts. Heroin addicts frequently include periods of employment in their economic strategies (Stephens 1991). Long-term employment, however, is problematic; the work is usually low-paying, temporary, and scarce, a situation that has been exacerbated by the restructuring of America's economy (Wilson 1987). Supporting the kind of lifestyle necessary to meet the demands of a steady job routine is difficult for addicted individuals. Their drug use may directly interfere with their performance, and their need to purchase drugs may leave little income for maintaining a living situation compatible with employment. This seems to be particularly true among individuals addicted to cocaine. In addition, many street-based drug users have little interest in the difficult, dead-end, low-wage jobs available in America's inner cities. As a result, street drug users rely on a "catch-as-catch-can" mélange of activities designed first to assure an adequate supply of money and drugs, and secondly to provide for all other living expenses (Stephens 1991:94–95).

5 Among social scientists studying American urban life, the terms "hustle" and "hustling" are used to describe the quasi-legal or illegal activities and behavior in which impoverished individuals engage to survive. "Hustling" encompasses "a wide variety of unconventional, sometimes extralegal or illegal activities, often frowned upon by the wider community but widely accepted and practiced in the slums and ghettos of large cities" (Valentine 1978:23). Among these scholars, hustling is not limited to drug-related activities (Spradley 1970). Bootlegging, operating an illegal gambling operation, fencing stolen goods, selling food stamps, stripping abandoned cars and houses of salable parts are all kinds of hustles. What they have in common is that they are forms of "irregular" work that generate income, but if discovered would put the individual performing them in jeopardy of criminal prosecution (Shaffir 1987:35).

Among scholars of illicit drug use, hustles and hustling frequently refer to criminal activities like burglaries and robberies (Preble and Casey 1972), or the skilled manipulation of situations to defraud or take advantage of someone else. Lex (1990) describes several hustles that fit this last category, including confidence games, faking slips and fall cases, and theft by deception. Users often have a primary hustle at which they are particularly adept (Agar 1973, Biernacki 1979; Lex 1990) including petty crimes such as shoplifting, sophisticated confidence games, or prostitution, as well as any number of "jobs" in the drug business like selling or "running" drugs. Not all users have such well developed hustles, however, and even among those who do, it is sometimes necessary to employ other methods to obtain drugs. Heroin injectors, for example, "will draw on a wider hustling repertoire as the opportunity arises" (Agar 1973:45).

7 Dividing the drug, preparing it for injection and injecting are carried out in a series of rapid steps. When users buy small quantities...
of a drug together, they often mix it in a single “spoon” and then draw it up into a syringe to measure each other's share using the calibrations on the barrel. Shares are then divided by squeezing all but one individual's share back into the spoon, or by backloading, taking out the plunger of the other injectors' syringes and injecting their share of the drug directly into the barrel of their syringe. This common method of distributing shared drugs may facilitate HIV transfer even when injectors have their own syringes. If the syringe used for measuring and distributing the shared drug is contaminated, then it is possible that HIV could be passed to receiving syringes. I have labeled these common drug preparation procedures as forms of “indirect sharing” (Koester 1992).

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