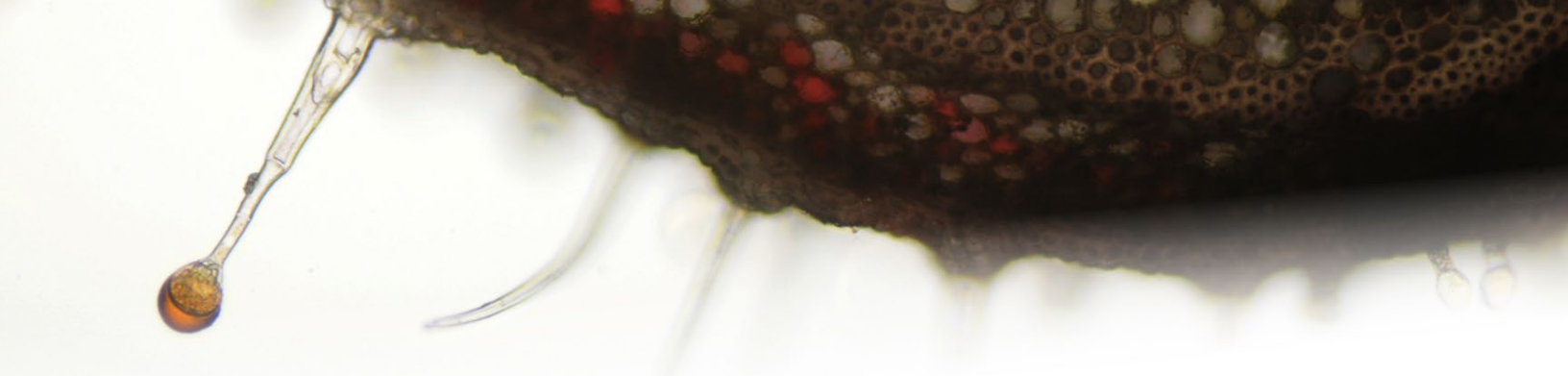

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HISTORY OF MEDICINE: PEER-REVIEWED ARTICLE

Drawing on Black and Queer Communities' Harm Reduction Histories to Improve Overdose Prevention Strategies and Policies

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Abstract

Harm reduction emerged as a set of strategies developed by and for people who use opioids and other substances and strive to do so in ways that are as safe as possible. This article reviews histories of Black and queer community-based harm reduction practices and suggests how these histories can inform harm reduction policy and guide development and implementation of anti-overdose interventions.

Overview of Harm Reduction

Harm reduction can be considered as a set of both practical strategies and tools to prevent the harms of substance use, sex work, or other potentially problematic behaviors, but—perhaps most importantly—it is also a philosophy and practice born of people's lived experience of structural violence arising from the HIV/AIDS epidemic in the late 1980s.[1] Harm reduction is not simply access to sterile syringes, naloxone, or condoms but a lifesaving movement of mutual aid by and for people who had been relegated to harm or death by society more broadly.[2] Harm reduction must be seen as an evolving and emergent set of strategies that can be utilized and adapted by people who use drugs or engage in sex work; to prevent harms associated with these practices, public health officers and medical professionals must work in tandem with local communities to implement harm reduction interventions and promote harm reduction policies. We consider harm reduction to be a crucial part of the spectrum of interventions for responding to the current overdose death crisis facing the United States, with its unrelenting upward mortality trend—more than 110 000 overdose deaths in the previous 12-month period ending August 2023—largely due to the rise of illicitly manufactured fentanyl in the unregulated drug supply.[3]

Pioneers in Harm Reduction

Harm reduction began as a movement by regular people who performed extraordinary lifesaving acts that were often illegal at the time and now can be fully understood as essential to public health and safety. In the United States, this multiracial movement was led by Black, Latinx, Muslim, and queer communities that started HIV/AIDS groups for structurally vulnerable people at risk for HIV and harms of substance use. Imani Woods, Dan Bigg, John Paul Hammond, Keith Cylar, Charles King, Kiyoshi Kuromiya, Michael Hinson, Dr Rashidah Abdul-Khabeer, Waheedah Shabazz-El, Jose Demarco,

Paul Yabor, Charlene Arcila, Jaci Adams, John Bell, and Tyrone Smith are an incomplete list of minoritized harm reduction pioneers in the United States. Dr Abdul-Khabheer, for example, is a Black registered nurse who founded a group called Bebashi (Blacks Educating Blacks About Sexual Health Issues) in 1985 and played an essential role in the Philadelphia HIV prevention scene for Black women.[4] Jose de Marco, a Black and Puerto Rican queer man, was foundational to the AIDS Coalition to Unleash Power Philadelphia, which was organized by the queer community and protested for decades for access to HIV medications and harm reduction efforts across the country.[5] Imani Woods, another leading voice of the harm reduction movement, offers a critical role model in harm reduction advocacy as a Black woman who operated within a history of structural marginalization in all her work. She writes about how she converted from being a staunch opponent of harm reduction—even calling harm reduction a genocidal operation—to grasping the power of providing practical tools to ensure health and protect the Black community against the harms of HIV and substance use.[6] Her transformation occurred in 1989, when she witnessed a man displaying sterile syringes on a table out in the open and how individuals came up to him and exchanged their used syringes and took educational materials.[6]

Harm reduction was also a global movement. Harm reductionists around the world have advocated for decriminalization of drug use, paraphernalia, and sex work; access to sterile supplies, naloxone, and drug consumption sites; and low-barrier access to methadone and buprenorphine. The earliest harm reduction efforts originated in the Netherlands in the 1980s, when the Junky Union distributed sterile syringes in solidarity with community health care workers to prevent HIV and hepatitis B transmission.[7] In the United States, early needle exchanges emerged in Tacoma, Washington, and in New Haven, Connecticut.[8,9]

Nurses and doctors were essential in providing solidarity and material support for people who used drugs during the 1990s to early 2000s. For example, in 2002, nurses at the Dr Peter Centre in Vancouver started supervising injections with the support of the Registered Nursing Association of British Columbia, which stated that it was part of their ethical obligations and duties as nurses to supervise drug consumption and ensure the safety of patients under their care.[10] In an act of civil disobedience, a nurse was arrested as one of the so-called “Needle Eight” who was tried in New York City in 1991 for handing out clean needles to protest the illegality of syringe service provision under Mayor Dinkins.[11] Doctors like Sarz Maxwell and Shawn DeLater participated in harm reduction services that distributed naloxone in Chicago in the late 1990s before the establishment of legal frameworks (E. Wheeler, personal communication, February 1, 2024). Unlike other professionals, health care clinicians risked their licenses and livelihoods to provide solidarity and care for people who used drugs.

Formal Harm Reduction Frameworks

The Biden administration has declared that harm reduction is 1 of 4 pillars (prevention, harm reduction, evidence-based treatment, and recovery support services) in the US Health and Human Services federal overdose prevention strategy.[12] To guide these harm reduction efforts, the Substance Abuse and Mental Health Services Administration (SAMHSA) recently convened community harm reduction leaders to draft a harm reduction framework.[13] The framework builds on the expansion of syringe access programs, naloxone access legislation, and harm reduction technical assistance, as well as decades of advocacy by communities and advocates doing this work.[14] The framework outlines several core values, such as respecting autonomy and practicing

acceptance of people who use drugs. Critically, it acknowledges that people with lived and living experience of substance use have and should inform all initiatives. However, it does not capture the nuanced gendered and racialized experiences of diverse marginalized communities with particular local histories.

To learn from diverse community leaders, those seeking to apply the framework can turn to harm reduction organizations that specialize in prioritizing assistance to people experiencing homelessness (eg, VOCAL-NY's homeless union), street-based sex workers (eg, Project SAFE), women and non-binary people (eg, Metzineres), Black or other racialized peoples (eg, HIPS), or trans people (eg, Ark of Safety). These organizations have arisen out of the lived experiences of people who have been discriminated against and oppressed in mainstream spaces and are maximally effective, as they have the trust of—and experience working within—disenfranchised and stigmatized groups of people at risk of violence or harm from law enforcement. For example, groups like HIPS work with communities where minoritized groups are subject to everyday police harassment and violence and where even carrying naloxone as a Black person or a person doing sex work could put that person at risk of arrest or harassment.[15]

The harm reduction principles adopted by the SAMHSA framework have not arisen in an ahistorical vacuum, and they risk losing their original radical meaning and nature upon becoming mainstream and being adopted by public health more broadly. If interpreted within a narrow clinical scope, these principles can lose their community-oriented origins and focus myopically on individual behavioral interventions without recognizing political and economic structures of violence and harm. Thus, funding for minoritized groups and their community development and resilience must be specifically earmarked in harm reduction proposals.

Contested Histories

As historian David Musto has argued, US drug policy swings between periods of relative liberalization and relative conservatism, as well as between a medical or public health approach and criminalization.[16] Currently, carceral approaches are favored, given the proliferation of fentanyl in the street drug supply, with politicians calling for increased criminalization of people who sell and use drugs,[17] medicalization of and involuntary conservatorships for people who use drugs or experience homelessness or mental health exacerbations,[18] and a more expansive border surveillance apparatus to stop drugs from entering the country.[19]

Current criminal-legal approaches to drug use lean heavily on "carrots and sticks," with drug court or diversion programs, for example, offering incentives (treatment) backed by threats of punishment (judicial accountability).[20] Unfortunately, these programs continue the legacy of putting punishment before treatment and care. In some recent instances, state judicial systems such as Pennsylvania's have been sued by the federal government for judges prohibiting those who are participating in drug court programs from using medication for opioid use disorder and violating the Americans with Disabilities Act.[21] These carceral responses are not rooted in harm reduction history.

Rather than relying on carrots and sticks, approaches to drug use should be informed by experiences of people who use drugs, with some recent texts advocating community-based solutions.[2,6,22] Imani Woods' legacy of community building among minoritized groups by funding and empowering them provides some steps forward. Woods focused primarily on the Black community, analyzing the struggle for harm reduction in the

context of Black employment, health, and general opportunities. Woods understood that harm reduction and public health programs led by White people would be viewed with suspicion by the Black community due to its members' history of slavery and experience of violence.[6] Faced with increased overdose rates among minoritized populations,[23,24] clinicians and communities alike must take these histories into account for interventions to be relevant or effective.[25] Woods framed the overdose crisis as requiring an understanding of self-determination of individuals and their communities. She argued for the need to reckon with racialized drug policy harms and leverage the resilience of Black people.[6] Supporting this kind of community leadership, informed by harm reduction history, is essential to present efforts.

Look Back to Envision Forward

As harm reduction hits milestones in gaining political and funding footholds in the United States, it is imperative to trace its history in grassroots organizations built out of hardship and necessity within local communities of people helping others with grave needs. There was a power forged by giving or receiving a new syringe or condom to another person who looked like you. These structures and the leadership of people who use drugs must be cultivated and nourished with material support, space, and solidarity. Community-based harm reduction organizations with class-conscious and gender- and race-based approaches are often sidelined and forced underground. Although many organizations in the United States continue to distribute naloxone, sterile syringes, pipes, and testing supplies, in some states, such as Texas, syringe exchanges are still illegal.[26]

Harm reduction must be accompanied by decriminalization efforts, such as Oregon's[27] (partially reversed in 2024[28]). Globally, there have been efforts to reverse so-called War-on-Drugs responses, such as Uruguay's and Colombia's decriminalization of drug possession.[29,30] Yet, unfortunately, there is no panacea for the unacceptably high rates of overdose deaths in the United States, including harm reduction or other strategies such as decriminalization. However, harm reduction is and always will be an evolving care strategy developed by and for people who use drugs to keep each other alive and safe.

There are clear policy goals to advance harm reduction in communities facing racialized disparities in overdose deaths. Clinicians must work with local harm reduction groups at the clinic and statehouse level to provide them with expansive support, including in states like Texas. Clinicians must not be gatekeepers or moralizers but rather must partner with communities to create accessible, affordable, and low-barrier access to all services people need to obtain health and well-being. As community activists and clinicians, we must work in concert to ensure as much safety and compassion as possible for our patients and their communities, recognizing the complex history of harm reduction. Involving people with trusted histories in their communities, such as Imani Woods, to participate in all levels of decision-making and fairly compensating them is vital. Funding must be specifically allocated to community groups led by people of color, as well as to organizational development and fostering of young leaders. Finally, policy and research efforts should be intersectional by design and co-created by people with lived and living experience of substance use.

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