Understanding Racial Inequities in the Implementation of Harm Reduction Initiatives

Andrea M. Lopez, PhD, Matthew Thomann, PhD, Zena Dhatt, BS, Julieta Ferrera, MAA, Marwa Al-Nassir, MPH, Margaret Ambrose, BA, and Shane Sullivan, BA

Objectives. To elucidate a structurally oriented theoretical framework that considers legacies of racism, trauma, and social exclusion and to interrogate the "unmet obligations" of the institutionalization of the harm reduction infrastructure to provide equitable protections to Black and Latinx people who use drugs (PWUD) in Maryland.

Methods. In 2019, we conducted a rapid ethnographic assessment of and qualitative interviews with PWUD (n = 72) and stakeholders (n = 85) in 5 Maryland counties. We assessed PWUD's experiences, service gaps in as well as barriers and facilitators to accessing services, and the potential to expand harm reduction programs.

Results. The unmet obligations we found included enforcement and punitive governance of syringes, naloxone, and other drug use equipment; racism and racialization, social exclusion, and legacies of trauma; and differential implications of harm reduction for populations experiencing racialized criminalization.

Conclusions. The implementation of harm reduction policies are a first step, but assessment of structural dynamics are needed for diverse communities with unique histories. This research illuminates a key paradox: progressive policy is implemented, yet the overdose crisis escalates in communities where various forms of racialized exclusions are firmly entrenched. (*Am J Public Health*. 2022;112(S2):S173–S181. https://doi.org/10.2105/AJPH.2022.306767)

AJPH Supplement 2, 2022, Vol 112, No. S2

The inequitable effects of the US overdose crisis on Black communities, indigenous communities, and other communities of color have been well established, particularly within the past 5 years.[1–5] Between 1999 and 2018, growth rates of overdose death among Black Americans outpaced those among White Americans,[6,7] and in urban areas, synthetic opioid-related fatalities increased 361% for Black adults and 350% for Latinx adults.[1,8] Latinx and Black people who use drugs (PWUD) are less likely than White PWUD to have received or used naloxone, to have received overdose prevention training,[9] and to obtain a naloxone refill.[10] Recent data showed an association between COVID-19 and increases in overdose among Black people, while demonstrating a decrease among White people.[11] Hypotheses suggest that increases in overdose death rates among Black people are linked to differential engagement with prevention because of structural racism and being less likely to report access to and utilization of services overall.[9]

Since 2017, White Marylanders experienced a 14% decrease in overdose deaths, whereas Black Marylanders experienced an increase of more than 40%.[12] In Prince George's County, Maryland, a majority Black county, there was a 135.1% increase in opioid-related fatalities in the first half of 2020.[13] In 2021, the Maryland Department of Health established the Racial Disparities Task Force[12] to address disparities in overdose fatalities in Maryland among Black communities, where rates of overdose have escalated despite an institutionalization of harm reduction infrastructure.

In 2019, we conducted the Statewide Ethnographic Assessment of Drug Use and Services in collaboration with the Maryland Department of Health to conduct research outside Baltimore City,

Maryland, where little to no research on harm reduction had been conducted. Our objectives were to (1) characterize the experiences of PWUD at county levels, (2) examine service gaps and barriers and facilitators to accessing services from the perspective of PWUD and providers, and (3) assess the potential for expansion of harm reduction programs outside Baltimore City. A University of Maryland research team partnered with the Maryland Department of Health and conducted study activities in Prince George's, Montgomery, St. Mary's, Calvert, and Charles counties. Findings from the larger statewide study were made available in a series of reports,[14] and a series of community-based dissemination activities were conducted throughout the state.[15]

We highlight findings that elucidate the experiences of Black and Latinx PWUD and providers. Through rapid ethnographic assessment (REA), we report on embodied experiences at the intersection of legacies of social exclusion and structural racism, including fear of policing and other forms of punitive governance, historical trauma, and implicit and explicit exclusions from initiatives that shape racialized experiences with drug use, overdose prevention, and harm reduction. We elucidate the role of embedded structural racism and social exclusion in institutionalized harm reduction initiatives. Specifically, we asked: What are the structural conditions that make it possible for racial disparities in overdose fatalities to continue amid a historic moment of expanded harm reduction infrastructure to address the overdose crisis?

We developed a structurally oriented theoretical framework that considered legacies of racism, trauma, and social exclusion to interrogate the "unmet obligations" of harm reduction initiatives in providing equitable protections to Black and Latinx PWUD. The framework of unmet obligations is a way to theorize the gaps between the structural initiatives that have occurred as harm reduction has become institutionalized (e.g., naloxone access, Good Samarian legislation, access to syringes) and how much these initiatives protect people who live at the intersection of drug use, racism, and racialized forms of exclusion. A key component of our framework was to consider that when harm reduction initiatives are institutionalized in state policies and programs, extra attention must be given to ensure that these initiatives can be decoupled from the punitive arm of the state (e.g., punitive enforcement) and that they directly confront legacies of racialized social exclusion to optimize their effectiveness and inclusivity. We qualitatively generated this framework from data regarding the experiences of Black and Latinx PWUD as they negotiated emergent harm reduction infrastructures in Maryland.

METHODS

We conducted the Statewide Ethnographic Assessment of Drug Use and Services between December 2018 and September 2019. We split study activities between research teams at the University of Maryland and Johns Hopkins University Bloomberg School of Public Health. We conducted data collection in each Maryland county, excluding Baltimore City. The statewide study included all counties in Maryland with stakeholders (n = 288) and PWUD (n = 314). We report only on the 5 counties where our research team conducted study activities: Prince George's, Montgomery, St. Mary's, Calvert, and Charles County. Our findings are based on REA activities and semistructured interviews with a sample of stakeholders (n = 85) and PWUD (n = 72). For this study, we defined PWUD consistent with ethnographic orientations to research: through self-report of experience and identity by participants who underwent a screening during recruitment. Participant demographics are outlined in Table 1.

The study team began with REA[16] to map county contexts and inform strategies for sampling and recruitment. We collected ethnographic data on local histories of harm reduction through document review, existing services for PWUD, and observation-based ethnographic site visits. We sought to identify transportation infrastructure, built environment composition, service accessibility, drug use sites in diverse environments, and the infrastructure for police and first responders. We used this initial phase as the basis for organizing our sampling frame for each county and to inform which stakeholders to target for recruitment and where to recruit PWUD in community contexts. This approach was consistent with REA,[16] which adapts ethnographic methods to more punctuated periods when the need for findings is time sensitive and will be used by collaborators, such as health departments. This ethnographic data collection also informed the domains for probes during interviews, so that interviewers could probe about local services, risk environments, and community factors.

The second phase of research was recruitment and semistructured interviews with stakeholders. Based on phase 1, we created our purposeful sampling list of frontline service providers, program administrators, family members of PWUD, and first responders. During stakeholder interviews, we

TABLE 1— Demographic Characteristics of People Who Use Drugs Sample in Maryland: January–December 2019

Demographic Characteristic	No. (%)
Age, y	
< 30	17 (24)
30–50	40 (55)
> 50	15 (21)
Gender	
Men	45 (63)
Women	26 (36)
Other[a]	1 (1)
Race/ethnicity	
White[b]	29 (40)
Black/African American	41 (57)
Native American	1 (1)
Latino[b]	2 (2)
Drug type[c]	
Opioids	31 (43)
Stimulants	25 (35)
Marijuana	24 (33)
Inject	
Yes	23 (32)
No	41 (57)

Note. The population size was n = 72.

[a]One participant identified as a transgender woman.
[b]One participant identified as White and Latino.
[c]Participants also disclosed the use of K2 (synthetic cannabinoid; n = 4), PCP (phencyclidine; n = 4), and alcohol (n = 3).

probed for recruitment sites for PWUD. Phases 1 and 2 were fundamental to REA, allowing us to establish rapport in each county context, despite the time constraints of the study.

In the third phase of the study, we recruited PWUD through both stakeholder referral and direct outreach in settings identified through REA. Interview domains for stakeholders are included in Figure A (available as a supplement to the online version of this article at http://www.ajph.org). Eligibility criteria for this sample included (1) being older than 18 years, (2) self-reporting use of drugs other than alcohol (e.g., heroin, nonprescription opioids, crack cocaine, methamphetamine) in the past year, and (3) residing in a county where research was being conducted. All participants underwent written informed consent and completed a 1-time, 90-minute semistructured interview. Participants were paid $25 cash for participation.

The University of Maryland research team also conducted an exploratory substudy targeting stakeholders who engage with Latinx PWUD in Montgomery and Prince George's counties. Little has been written about Latinx PWUD in Maryland, and, because of issues related to immigration enforcement, this population may not access harm reduction services. One author (J. F.) conducted interviews with stakeholders serving the Latinx community in both English and Spanish.

We analyzed the data using thematic analysis.[17,18] We generated an initial codebook for all data, using deductive codes derived from research questions and iterative codes to allow salient themes to emerge. We organized initial codes, drawing from the theoretical and methodological frameworks of REA, including structural, community, and individual-level domains.[16] A PhD-level qualitative analyst coded the data using MAXQDA (VERBI Software, Berlin, Germany). We analyzed interviews from both PWUD and stakeholders using the same code book and process. After we coded the entire data set for first-level themes, A. M. L. and M. T. conducted a second phase of coding, specifically querying for the experiences of Black and Latinx participants. We compared all data in the second phase of the 2 investigators' coding to ensure consistency in their code application.

RESULTS

Our analysis was grounded in a methodology that centers how personhood and experience are shaped by sociostructural contexts. Development of the theoretical framework of "unmet obligations" is generated by 3 key analytic domains that emerged in our data: (1) intense enforcement and punitive governance regarding syringes, naloxone, and other drug use equipment that PWUD possess; (2) historic racialization, social exclusion, and legacies of trauma among Black PWUD and other PWUD of color; and (3) the differential implications of harm reduction policies for populations who experience racialized criminalization.

Our data highlight the role of 3 governance structures in the lives of PWUD: policing, legacies of racism, and the implementation of initiatives those forces inevitably shape.

Enforcement and Punitive Governance

In our analysis, we acknowledged the baseline adversities that all marginalized PWUD face as they interface with services, health care, and the police. This baseline reflects the deeply embedded systems of punishment directed at poor, marginalized, and racialized communities.[19] Our data demonstrate that PWUD, regardless of racial self-identification, are subject to various forms of punitive governance related to the possession of drug use equipment or naloxone. These issues are well documented in the literature, so we present a brief summary of these findings in Box 1.

Syringe service programs were legalized in Maryland in 2016 (SB97), and state law authorizes "the retail sale of syringes without a prescription with no direct prohibition on sales to people who inject drugs" (Md. Code Regs. 10.13. 08.01). However, we found that retail worker discretion and other forms of community stigma inhibit access to syringes for PWUD. This was especially true in rural and semirural areas, where PWUD were familiar to community retailers. Even when participants were able to access syringes, they described anxiety, anticipated stigma, and known criminalization if they encountered the police while in possession of syringes (Box 1). The findings in domain 1 of our theoretical framework are consistent with issues affecting all PWUD; however, they are the baseline experiences of adversity on which other adversities are compounded for Black and Latinx PWUD.

Racialized Histories of Trauma

Study participants, regardless of racial self-identification, described histories of trauma and loss connected to compounded adversity over their life course, including comorbid physical and mental health conditions, adverse childhood experiences, intergenerational drug use, multiple forms of violence, posttraumatic stress disorder, and trauma associated with witnessing overdoses or not being able to save someone during an overdose. However, our data yielded critical information regarding broader sociopolitical contexts affecting Black and Latinx PWUD.

Participants in Prince George's County discussed the intense and rapid impact of fentanyl in recent years and their experiences of concentrated fentanyl-related deaths affecting local Black communities, particularly in the District of Columbia–Maryland border area. They described the existential weight of witnessing overdoses, while managing grief from the overdose deaths of loved ones and their own continued fear of fentanyl. The lived experience for Black community members during the rapid onset of fentanyl is described in Box 2.

Larger historic dynamics also affected the impact of fentanyl locally. Participants expressed a generalized perception that public health prioritization of overdose prevention had long been needed. However, it was only when White communities began to experience the impacts of overdose that resources were rapidly

BOX 1— Domain 1: Enforcement and Punitive Governance of Drug Use Equipment: Maryland, January–December 2019

Community stigma and discretionary gaps affecting syringe access: "If we wanted to go to [pharmacy retail store] and buy a box of 100 [syringes] at a time at $13 a box. If they would sell them to you, depending on who was there and if they gave a shit, also depending on who they [the drug users] were. So, a lot of people aren't even allowed to go [to retail store] around here because they got caught stealing from there. . . . [That retail store is] your only option . . . if you do not have a diabetic card and have a prescription for them [the retail store] is not going to give them to you." 32-y-old White man, Calvert County
Inconsistent practices at retailers: "There's always been problems with [pharmacy retail store]. One day you'll be able to buy a box and the next day they'll be like, 'Oh, we stopped selling needles' or 'We stopped selling 10-packs. You've got to buy a whole box' or 'We stopped selling needles altogether.' And it was always a lie, because there's supposed to be a harm reduction model where pharmacies are supposed to . . . sell you needles regardless. But they don't care there." 27-y-old White man, St. Mary's County
Fear of arrest and anticipated stigma when engaging with police and first responders: "If you get pulled over and you don't have nothing on you, but you've got Narcan, they're going to think like, 'Oh, yeah. Now the police know.' Or they think, 'Somewhere I'm associated with it. So, now they're going to dig in my car more.' Or they think, 'They're going to harass me.' You know what I'm saying? Because I have seen people that's clear in active use that have denied Narcan. This on the street." Community organizer, St. Mary's County
Lack of trust when engaging with police: "They'll charge you right off the jump . . . they'll charge you straight possession . . . If it's a new needle, they'll get you for distribution of paraphernalia. If it's a used needle, they'll get you for possession of drugs. Then you got to fight it in court to get the lab results to prove that it just has residue." 32-y-old White man, Calvert County

BOX 2— Domain 2: Racialized Histories of Trauma in the Era of the Overdose Crisis: Maryland, January–December 2019

The impact of fentanyl on Black communities in the DC metro area: "When fentanyl came through and hit the population real hard, there were a lot of people you thought weren't on drugs [who] was OD'ing and dying. It's been hitting really hard in the Black community. When I was working at the needle exchange over in DC, we lost 14 to 15 people from fentanyl. Some of them don't look like they do nothing. Everyday clean cut. Dress nice. Go to work. But they'll end up getting bad dope, OD, and they're gone. People just like us. Everyday people from all walks of life." Frontline provider, Prince George's County
The impact of fentanyl on Black communities in the DC metro area: "So, that's why I say it's getting worse . . . since I got out of treatment, 6 people have overdosed and died that I knew. Six. . . . From heroin, [people] that I went to treatment with. It had to be [fentanyl laced]. It had to be, because nobody uses straight heroin anymore. There is no such thing anymore. There is no such thing as straight heroin anymore. From the heroin addicts that I do know, or the ones that were addicts and that are clean, there is no straight heroin anymore." 31-y-old Black woman, Prince George's County
Compounded loss: "We can go back and I tell you how many people I lost. So I had a friend in my addiction. I woke up and next to me dead. I woke up, he was dead next to me. Dead. He died right next to me. . . . My friend B died over fentanyl overdose. I lost, like, 3, 4 people. Last year when my father—year before last when my father died—I lost 7 people in that same year." 40-y-old Black man, Prince George's County
Anxieties related to anti-immigrant climate: "What I do see is that Hispanic people do sometimes, or several times, express their concern about the current anti-immigrant climate . . . and there is anguish, worry, and anxiety." Provider serving Latinx community
Political climate affecting engagement with services: "I think we've seen it since the [2016] elections. . . . I've heard from jurisdictions in the area that traffic through their health and human services department has dropped dramatically. . . . People have chosen to not renew their children's Medicaid or abandoned applications halfway through. Disenroll from other programs like SNAP [Supplemental Nutrition Assistance Program] or free and reduced lunch. Anywhere that they feel that their information can then be shared with other agencies or just out of fear of having their information in any kind of database or registry has been prevalent." Provider serving Latinx community
Compounded trauma with threat of immigration enforcement: "The ongoing attacks, it just exacerbates everything else. If you're already dealing with the trauma of coming here, and then dealing with the trauma of then living here under all this anti-immigrant rhetoric, I think it just exacerbates everything else. And it distracts from everything else, too. Like we were talking about people being fearful to leave their house and being out and about in the community. Then it makes everything else that much more secondary. So, yes, I may want to connect to these services, or go into treatment. And I was already thinking twice about it, and now these raid threats are here. It just pushes everything back even more, and potentially exacerbates all the needs in our community." Provider serving Latinx community

mobilized. Some stakeholder participants noted that Black community members were hesitant to engage with broader discussions or programs regarding overdose in the county. This was because they had historically been overlooked as victims of overdose death and their communities had not previously been prioritized for prevention measures. This new focus on the "overdose epidemic" as framed in national discourse thus garnered "eye rolls" from some community members, who felt that their experiences had been ignored or invalidated for decades. The dynamic that participants described in this county mirrors experiences of PWUD in Washington, DC, when fentanyl arrived in the local drug supply and overdose deaths escalated.[20] Both speak to the marginalized histories of overdose death in Black communities.

Similarly, stakeholders serving Latinx communities discussed the impact of the political climate on how people engage with services. We collected the data for this study during a particularly volatile moment of anti-immigrant discourse and racism in the United States and operations by US Immigration and Customs Enforcement nationally and in Maryland.[21] In our substudy with these providers, participants pointed to histories of trauma related to migration experiences, which were exacerbated by intensified fears of deportation that generated intense fear about engaging in any services. They described how their clients lived under chronic duress, anxiety, and fear because of current immigration policy and discourse. Threats of detention and deportation were realistic, as reports of local Immigration and Customs Enforcement raids circulated. These clients were subject to multiple intersecting stigmas owing to both their immigration status and their drug use. The stressors of the anti-immigrant political climate had tangible impacts on how Latinx people access all social services. Box 2 also outlines participant descriptions of the political climate's impact.

Racialized Criminalization

In 2015, Maryland passed its Good Samaritan legislation, which provides protection from arrest, charge, or prosecution of 6 misdemeanors when evidence of these misdemeanors was obtained during the time someone is seeking medical assistance. We found that people did know about the legislation but that it did not relieve concerns about engaging with police during an overdose. A 32-year-old White man from Calvert County reported, "That's why people get found dead all the time in peoples' houses, because they're like, 'Oh, shit, I'm not calling the cops. I'm not going to jail for this.'" Furthermore, some participants reflected on

differential applications of the law for people of color. This was rooted in lack of trust based on histories of disproportionate policing and criminalization of communities of color and direct experience with the carceral state. This fear and mistrust extend not just to those who witness the overdose but to the person experiencing overdose themselves. Data demonstrating domain 3 of our model are outlined in Box 3.

DISCUSSION

Our data facilitated the development of a structurally oriented framework for the unmet obligations of the institutionalized harm reduction infrastructure in ensuring sufficient protection for Black and Latinx PWUD. We found intense experiences of enforcement and anticipatory punitive governance regarding drug use equipment (domain 1), consistent with research that finds policing to be a structural determinant of health[22,23] associated with a range of negative health outcomes among PWUD.[24,25] Our data are also consistent with research examining the punitive impacts of policy for PWUD in the United States and globally.[26] Participants described an overall lack of trust in harm reduction policies meant to grant them legal protections and specifically feared police interaction and arrest. These findings are consistent with a large body of research that demonstrates that PWUD are hesitant to call 911 or engage with police based on personal and community experience and believe that they will be subject to punitive measures at the time of an overdose event.[27–33]

Participants described racialized histories of trauma and social exclusion for Black and Latinx PWUD that hindered engagement with harm reduction services (domain 2). These included the rapid impact of fentanyl on overdose deaths in Black communities in the Washington, DC, metro area and a perception that resources to address the overdose crisis came because of increasing overdose deaths and prioritization in White communities. These legacies are important structural contexts for Black communities' experiences of exclusion or disengagement from harm reduction efforts. We also found that the structural context of immigration enforcement and threat of detention and deportation is an important backdrop for understanding how Latinx communities prioritized service engagement. For both Latinx and Black PWUD, historical experiences and current fear of enforcement (whether by police or immigration officers) intersected with feeling less protected by the harm reduction infrastructure (domain 3).

In our development of the framework of unmet obligations, we drew from scholarship that views the examination of drug use and addiction-related experience as inextricably tied to the construction and maintenance of racial hierarchies in the United States[34] and the implications of the legacies of racialization and criminalization of drug use[35] in Black and Latinx communities.[36] Given the literature on the effects of policing on health and wellness in communities of color,[36] the pressing contemporary question is not of whether disparities are rooted in legacies of racialized enforcement and policing of communities of color—this has been well established.[36,37] Rather,

BOX 3— Domain 3: Racialized Criminalization in a Life-Saving Policy: Maryland, January–December 2019

Hesitancy to engage with police: "People are still going to be hesitant. It's still scary to call the cops. It's a scary thing, especially if you're on drugs. Your experience . . . and sadly, the experience with the cops around . . . is they're just out to get you. They're not there to help you. They're out to get you. So, just calling the cops is just one thing you just never want to do here, no matter what." Calvert, 33-y-old man, declined to report racial identification
Gaps between the law in its ideal form and the realities of practice based on broader perceptions and experiences of racism and policing: "But you really think that they won't try to do nothing to you if you're using too? And you help them [person overdosing]? . . . Man, these people will be trying to lock you up too. That's the whole thing. You probably want to do right by somebody that's out, but then there's so many other things that are going to come with that . . . . Questions: 'Was you with him?' You know? . . . I'm not saying I wouldn't trust it. I don't know to be honest. . . . I mean I hate to see anybody fall short, you know? Nowadays, you've got to really watch yourself. To get involved in stuff like, that especially a person like me and where I come from. A young lady like yourself, they probably wouldn't even question, but I don't know. They probably think I gave it [the drugs] to them. I don't trust the police at all. . . . You've got to watch yourself . . . when they stop you, you've got to be mindful of everything with these people today because they shoot you and everything." 63-y-old Black man, Montgomery County
Perceptions of ramifications faced when calling 911 to save a life: "Yes, I got out of there and dialed 911 because that means they going to shake [search] the whole house. There was a lot of crack pipes and all kinds of stuff going on in that house. . . . I got out of there." [Recounting conversation he had with 911 dispatcher]: "'There's a dead man in that house, okay? You go there.' 'Who are you?' 'Nobody. Don't call me back. Okay? Go get him.'" 40-y-old Black man, Prince George's County
Witnessing others flee their own overdose event for fear of criminalization: "Two days ago, a dude was standing up talking, and he put his hands on the fence, and all of a sudden he collapsed. And I knew then what it was. Called an ambulance, but he had come to by then [regained consciousness], and he hauled it [fled quickly]. I mean he left!" 66-y-old Black man, Prince George's County

the task is to elucidate the machinations of structural racism that manifest in everyday experiences for PWUD and to show how the linkages between punitive arms of the state and harm reduction initiatives become implicated in their everyday maintenance. These dynamics include the constant threat of differential and harsher enforcement and a historic consciousness of the racialized trauma of deprioritization and abandonment in overdose death.

Research has explicated the dynamics of structural racism in overdose crises, demonstrating the interplay of the medicalization of addiction for White PWUD versus the criminalization of addiction for Black PWUD[38–40] and the ways that race becomes "invisible," in policy and practice, yet always operates as a "ghost variable."[39] Building on this scholarship, we argue that when harm reduction initiatives are institutionalized, these institutionalized forms must be critically analyzed as both implicitly and explicitly racialized, given that its enactment is done in the context of decades of mass incarceration of PWUD and the racialization and hypercriminalization of Black people and other people of color. Despite its rootedness in community-based movements among PWUD, harm reduction has been institutionalized in broader public health and legal systems and, thus, is subject to the well-documented systemic racism rooted in those governance systems and the role that enforcement plays in those systems.

In line with numerous calls to make public health practice explicitly antiracist,[4] we add to the literature on structural causes of the overdose crisis and urge the development of an accountability-oriented framework that directly names and confronts the unmet obligations of our institutionalized harm reduction infrastructure. Accountability-oriented public health practice should be understood as a direct engagement with how structural racism and punitive practices, as always-present mediators of institutionalized harm reduction, might disallow the possibility for equitable protective initiative effects. We posit that if we take racist and racialized unmet obligations as a starting point established in the evidence base, we can begin to interrogate and dismantle the taken-for-granted constructs of Whiteness embedded in harm reduction policy that harm communities of color. This framework allows us to change from solely focusing on behavioral interventions (e.g., getting people to engage with overdose prevention education) to instead include reimagining structural interventions to strengthen protections for Black people and other people of color who have been historically excluded from institutionalized health services. This framework provides guideposts to investigate how to hold harm reduction policy and practice accountable for the legacies of harm that Black communities and other communities of color have experienced.

Limitations

This study has the following limitations. We used purposeful and targeted sampling methods, and therefore findings are not representative of all PWUD in Maryland counties, nor are findings generalizable to other populations or geographic locations. Compared with the larger statewide study, the 5-county sample from which our analysis draws is comparatively small. Nonetheless, consistent with best practices in qualitative research,[16] this limitation is mitigated by the fact that qualitative data are intended to provide deep, contextualized information about a topic of interest that cannot be captured quantitatively.

Another limitation of our study is that we did not yield data on participant's access to medication for opioid use disorder (MOUD), partially because of our focus on the emergent infrastructure, such as syringe service and overdose prevention. Research has indicated that racial inequities in access to MOUD persist[41] and that it is beneficial to consider the incorporation of MOUD into trusted harm reduction service spaces.[42] Our theoretical framework can be useful in considering how to examine the similar unmet obligations in MOUD linked to historic racialization, social exclusion, and legacies of trauma among Black PWUD and other PWUD of color in those clinical spaces. These issues will need to be addressed in any future hybrid harm reduction and MOUD spaces to mitigate racial disparities.

Public Health Implications

The public health implications of our study and theoretical framework are numerous. Our findings demonstrate that the implementation of harm reduction initiatives are a first step but that we must assess how initiatives operate in real time and what structural dynamics are at play in their implementation for diverse communities with unique histories and experiences. Furthermore, our ethnographic methodology is critical in demonstrating the complexity of the overdose crisis, how behavioral variables captured quantitatively provide an incomplete picture of people's real-world engagement with harm reduction infrastructure, and how racial disparities are perpetuated in it. This research also helps to illuminate a key paradox in the current era of the implementation of harm reduction

policy nationally: progressive policy is implemented and tireless frontline providers deliver services, yet the overdose crisis escalates in communities where various forms of racialized exclusions are firmly entrenched. Indeed, Maryland is an example of a state with substantial and growing harm reduction infrastructure, yet recent data show an escalation in overdose mortality in Black communities. This research opens avenues for continuing to strategize for an explicitly antiracist harm reduction agenda that confronts historically unmet obligations of harm reduction infrastructure to bring this infrastructure to its full potential and create equitable protections based on the existing public health evidence base. AJPH

ABOUT THE AUTHORS

Andrea M. Lopez, Matthew Thomann, Zena Dhatt, Julieta Ferrera, and Shane Sullivan are with the Department of Anthropology, University of Maryland, College Park. Marwa Al-Nassir and Margaret Ambrose are with the Center for Substance Abuse Research, University of Maryland.

CORRESPONDENCE

Correspondence should be sent to Andrea M. Lopez, PhD, Department of Anthropology, University of Maryland, 1111 Woods Hall, Room 0107, 4302 Chapel Rd, College Park, MD 20742 (e-mail: lopez@umd.edu). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

PUBLICATION INFORMATION

Full Citation: Lopez AM, Thomann M, Dhatt Z, et al. Understanding racial inequities in the implementation of harm reduction initiatives. *Am J Public Health.* 2022;112(S2):S173–S181.

Acceptance Date: January 23, 2022.

DOI: https://doi.org/10.2105/AJPH.2022.306767

CONTRIBUTORS

A. M. Lopez designed the study and led the study team. A. M. Lopez, M. Thomann, and J. Ferrera conducted analysis. A. M. Lopez, J. Ferrera, M. Al-Nassir, M. Ambrose, and S. Sullivan conducted study activities. Z. Dhatt coordinated analysis. M. Al-Nassir, M. Ambrose, and Z. Dhatt coordinated study activities.

ACKNOWLEDGMENTS

This assessment was supported through the Maryland Department of Health and the Centers for Disease Control and Prevention (CDC; award CDC-RFA-TP18-1802).

We are grateful to all the participants who shared their experiences and expertise about managing drug use, services, and the issues affecting their communities. We are grateful to community members who shared time, resources, and spaces with us and to staff at the Maryland Department of Health.

Note. The contents of this article are solely the responsibility of the authors and do not necessarily represent the official views of the CDC or the Maryland Department of Health.

CONFLICTS OF INTEREST

The authors have no conflicts of interest to declare.

HUMAN PARTICIPANT PROTECTION

The University of Maryland institutional review board approved these study activities (project #1300187-1).

REFERENCES

1. El-Bassel N, Shoptaw S, Goodman-Meza D, Ono H. Addressing long overdue social and structural determinants of the opioid epidemic. *Drug Alcohol Depend.* 2021;222:108679. https://doi.org/10.1016/j.drugalcdep.2021.108679
2. Cano M. Racial/ethnic differences in US drug overdose mortality, 2017–2018. *Addict Behav.* 2021;112:106625. https://doi.org/10.1016/j.addbeh.2020.106625
3. James K, Jordan A. The opioid crisis in Black communities. *J Law Med Ethics.* 2018;46(2):404–421. https://doi.org/10.1177/1073110518782949
4. Kunins HV. Structural racism and the opioid overdose epidemic: the need for antiracist public health practice. *J Public Health Manag Pract.* 2020;26(3):201–205. https://doi.org/10.1097/PHH.0000000000001168
5. Lippold K, Ali B. Racial/ethnic differences in opioid-involved overdose deaths across metropolitan and non-metropolitan areas in the United States, 1999 – 2017. *Drug Alcohol Depend.* 2020;212:108059. https://doi.org/10.1016/j.drugalcdep.2020.108059
6. Furr-Holden D, Milam AJ, Wang L, Sadler R. African Americans now outpace Whites in opioid-involved overdose deaths: a comparison of temporal trends from 1999 to 2018. *Addiction.* 2021;116(3):677–683. https://doi.org/10.1111/add.15233
7. Centers for Disease Control and Prevention. Drug and opioid-involved overdose deaths—United States, 2013–2017. *MMWR Morb Mortal Wkly Rep.* 2018;67(5152):1419–1427. https://doi.org/10.15585/mmwr.mm675152e1
8. Centers for Disease Control and Prevention. Racial/ethnic and age group differences in opioid and synthetic opioid-involved overdose deaths among adults aged ≥ 18 years in metropolitan areas—United States, 2015–2017. *MMWR Morb Mortal Wkly Rep.* 2019;68(43):967–973. https://doi.org/10.15585/mmwr.mm6843a3
9. Dayton L, Tobin K, Falade-Nwulia O, et al. Racial disparities in overdose prevention among people who inject drugs. *J Urban Health.* 2020;97(6):823–830. https://doi.org/10.1007/s11524-020-00439-5
10. Rowe C, Santos GM, Vittinghoff E, Wheeler E, Davidson P, Coffin PO. Predictors of participant engagement and naloxone utilization in a community-based naloxone distribution program. *Addiction.* 2015;110(8):1301–1310. https://doi.org/10.1111/add.12961
11. Khatri UG, Pizzicato LN, Viner K, et al. Racial/ethnic disparities in unintentional fatal and nonfatal emergency medical services–attended opioid overdoses during the COVID-19 pandemic in Philadelphia. *JAMA Netw Open.* 2021;4(1):e2034878. https://doi.org/10.1001/jamanetworkopen.2020.34878
12. Jones A, Brathwaite N. Racial disparities task force presentation: Inter-Agency Heroin & Opioid Coordinating Council. January 26, 2021. Available at: https://governor.maryland.gov/ltgovernor/wp-content/uploads/sites/2/2021/01/Presentation-to-IACC..Racial-Disparities-Task-Force-1.26.21.pdf. Accessed February 12, 2022
13. Maryland Department of Health Behavioral Health Administration. Maryland Opioid Operational Command Center. 2020. Available at: https://beforeitstoolate.maryland.gov/wp-content/uploads/sites/34/2020/09/Second-Quarter-OOCC-Report-2020-Master-Copy-9-21-20-Update.pdf. Accessed February 10, 2022.
14. Lopez A, German D. Statewide Ethnographic Assessment of Drug Use and Services (SEADS). Available at: https://anth.umd.edu/project/statewide-ethnographic-assessment-drug-use-and-services-%28seads%29. Accessed February 10, 2022.
15. Lopez A. Statewide assessment of drug use and services: preliminary findings in region 5. Paper presented at: Regrounding Our Response: Regional Opioid Forum. Solomons, MD; August 22, 2019.
16. Sangaramoorthy T, Kroeger KA. *Rapid Ethnographic Assessments: A Practical Approach and Toolkit for Collaborative Community Research.* London, UK: Routledge; 2020. https://doi.org/10.4324/9780429286650
17. Bernard HR. *Research Methods in Anthropology: Qualitative and Quantitative Approaches.* 6th ed. Lanham, MD: Rowman & Littlefield; 2017.
18. Corbin J, Strauss A. *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory.* 4th ed. Los Angeles, CA: SAGE; 2014.
19. López AM. Necropolitics in the "compassionate" city: care/brutality in San Francisco. *Medical Anthropology.* 2020;39(8):751–764. https://doi.org/10.1080/01459740.2020.1753046
20. Lopez AM, Abbey-Bey M, Spellman T. Resisting overdose: in Washington, DC, people who use opioids confront the epidemic and intervene to stop death. *Anthropology News.* 2018;59(1):e50–e56. https://doi.org/10.1111/AN.742
21. Getrich CM. "People show up in different ways": DACA recipients' everyday activism in a time of heightened immigration-related insecurity. *Hum Organ.* 2021;80(1):27–36. https://doi.org/10.17730/1938-3525-80.1.27
22. Beletsky L, Cochrane J, Sawyer AL, et al. Police encounters among needle exchange clients in Baltimore: drug law enforcement as a structural determinant of health. *Am J Public Health.* 2015;105(9):1872–1879. https://doi.org/10.2105/AJPH.2015.302681
23. Friedman J, Syvertsen JL, Bourgois P, Bui A, Beletsky L, Pollini R. Intersectional structural vulnerability to abusive policing among people who

inject drugs: a mixed methods assessment in California's central valley. *Int J Drug Policy.* 2021;87:102981. https://doi.org/10.1016/j.drugpo.2020.102981

24. Burris S, Blankenship KM, Donoghoe M, et al. Addressing the "risk environment" for injection drug users: the mysterious case of the missing cop. *Milbank Q.* 2004;82(1):125–156. https://doi.org/10.1111/j.0887-378X.2004.00304.x
25. Bourgois P. The moral economies of homeless heroin addicts: confronting ethnography, HIV risk, and everyday violence in San Francisco shooting encampments. *Subst Use Misuse.* 1998;33(11):2323–2351. https://doi.org/10.3109/10826089809056260
26. Rhodes T, Wagner K, Strathdee SA, Shannon K, Davidson P, Bourgois P. Structural violence and structural vulnerability within the risk environment: theoretical and methodological perspectives for a social epidemiology of HIV risk among injection drug users and sex workers. In: O'Campo P, Dunn J, eds. *Rethinking Social Epidemiology: Towards a Science of Change.* Dordrecht, The Netherlands: Springer; 2012:205–230. https://doi.org/10.1007/978-94-007-2138-8_10
27. van der Meulen E, Chu SKH, Butler-McPhee J. "That's why people don't call 911": ending routine police attendance at drug overdoses. *Int J Drug Policy.* 2021;88:103039. https://doi.org/10.1016/j.drugpo.2020.103039
28. Latimore AD, Bergstein RS. "Caught with a body" yet protected by law? Calling 911 for opioid overdose in the context of the Good Samaritan Law. *Int J Drug Policy.* 2017;50:82–89. https://doi.org/10.1016/j.drugpo.2017.09.010
29. Schneider KE, Park JN, Allen ST, Weir BW, Sherman SG. Knowledge of Good Samaritan laws and beliefs about arrests among persons who inject drugs a year after policy change in Baltimore, Maryland. *Public Health Rep.* 2020;135(3):393–400. https://doi.org/10.1177/0033354920915439
30. Zadoretzky C, McKnight C, Bramson H, et al. The New York 911 Good Samaritan Law and opioid overdose prevention among people who inject drugs. *World Med Health Policy.* 2017;9(3):318–340. https://doi.org/10.1002/wmh3.234
31. Koester S, Mueller SR, Raville L, Langegger S, Binswanger IA. Why are some people who have received overdose education and naloxone reticent to call emergency medical services in the event of overdose? *Int J Drug Policy.* 2017;48:115–124. https://doi.org/10.1016/j.drugpo.2017.06.008
32. Moallef S, DeBeck K, Milloy MJ, Somers J, Kerr T, Hayashi K. Knowledge of a drug-related Good Samaritan Law among people who use drugs, Vancouver, Canada. *Health Educ Behav.* 2021; Epub ahead of print. https://doi.org/10.1177/1090198121999303
33. Moallef S, Hayashi K. The effectiveness of drug-related Good Samaritan laws: a review of the literature. *Int J Drug Policy.* 2021;90:102773. https://doi.org/10.1016/j.drugpo.2020.102773
34. Hansen HB, Jackson JF. Addiction, drug policy, and Black clinical innovations. In: *Black Mental Health: Patients, Providers, and Systems*. Washington, DC: American Psychiatric Association Publishing; 2019:309.
35. Mendoza S, Hatcher AE, Hansen H. Race, stigma, and addiction. In: Avery J, Avery J, eds. *The Stigma of Addiction.* Cham: Springer; 2019:131–152. https://doi.org/10.1007/978-3-030-02580-9_8
36. Cooper HL. War on Drugs policing and police brutality. 2015;50(8–9):1188–1194. https://doi.org/10.3109/10826084.2015.1007669
37. Alexander M. *The New Jim Crow Mass Incarceration in the Age of Colorblindness.* New York, NY: New Press; 2020.
38. Hansen H, Netherland J. Is the prescription opioid epidemic a White problem? *Am J Public Health.* 2016;106(12):2127–2129. https://doi.org/10.2105/AJPH.2016.303483
39. Hansen H, Parker C, Netherland J. Race as a ghost variable in (White) opioid research. *Sci Technol Human Values.* 2020;45(5):848–876. https://doi.org/10.1177/0162243920912812
40. Netherland J, Hansen HB. The War on Drugs that wasn't: wasted Whiteness, "dirty doctors," and race in media coverage of prescription opioid misuse. *Cult Med Psychiatry.* 2016;40(4):664–686. https://doi.org/10.1007/s11013-016-9496-5
41. Hansen HB, Siegel CE, Case BG, Bertollo DN, DiRocco D, Galanter M. Variation in use of buprenorphine and methadone treatment by racial, ethnic, and income characteristics of residential social areas in New York City. *J Behav Health Serv Res.* 2013;40(3):367–377. https://doi.org/10.1007/s11414-013-9341-3
42. Fox AD, Chamberlain A, Frost T, Cunningham CO. Harm reduction agencies as a potential site for buprenorphine treatment. *Subst Abus.* 2015;36(2):155–160. https://doi.org/10.1080/08897077.2015.1011820