CHAPTER EIGHT

Bringing Harm Reduction to the Black Community

There's a Fire in My House and You're Telling Me to Rearrange My Furniture?

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IMANI P. WOODS

PERSONAL HISTORY:
HOW I CAME TO SUPPORT HARM REDUCTION

People look at me like I'm crazy when I go to the black community to explain harm reduction. I am accused of supporting a policy that makes peace with genocide. How can one talk about "reducing harm" to a people under siege? The scourge must be lifted; the villain must be vanquished. Harm reduction is seen as settling, giving up, accepting failure, and bargaining with the devil. The comments come fast and furious:

> "Who's going to pay for my stolen TV?"
> "I've been taking care of my little grandbaby for 8 years. Don't you know my son and his woman in jail because of that mess?"
> "We're being robbed and knocked down in the street for drugs, and you want to talk about giving out needles and keeping people alive?!"

Invariably, comparisons are made:

> "White folks' kids get jobs even after they do all that!"

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And, finally:

> "Who are those white folks trying to come in our neighborhood with needles? They just trying to kill us. And you missin' it!"

It's difficult for me to defend my position when all around us is the wreckage of lives damaged by the use of illicit drugs. The high unemployment of community members results in a greater use of these drugs, as well as an increased participation in the drug economy. The presence of numerous addicted individuals leads to an increase in crime as they attempt to secure the outlawed substances. The criminal acts perpetrated upon the community by those who profit from the sale of these substances are legendary. The mass media attest to their real and imagined brutality. Merchants are preyed upon; mothers are beaten; schools become battlegrounds. Prisons bulge with community members accused and convicted, rightly or wrongly, of countless offenses. Children lose their parents to jail, addiction, violence, and premature death. Families lose their houses due to the activities of one of their tribe. Young drug-addicted mothers lose their children and end up in shelters for the homeless or in transient hotels. Children are born addicted and, try as they might, have trouble keeping up with their classmates or calming their jitters. And if that were not enough, drug-related HIV disease disproportionately affects the black community.

"There's a fire in my house and you're telling me to rearrange my furniture?" The fact that I am African American and have lived and worked in the community all of my life does not win me any converts or even any ready listeners. As Derrick Bell (1994) writes in *Confronting Authority: Reflections of an Ardent Protester,* "The hostile response of friends and associates is complex, unexpected and far more devastating than enemies' predictable attacks" (p. 133). I have found this to be true as, over the years, I have become an "ardent protester" in support of harm reduction.

It was not always so, however. I first heard of the concept of harm reduction during my training at the Narcotic and Drug Research Institute in New York in 1986 (the term "harm reduction" would not be used regularly until 1988, when Alan Perry of Liverpool began sharing what was being done in parts of England). I met Edith Springer at the institute. Edith, a trainer who taught a variety of workshops, motivated me through her obvious dedication to issues related to the association of HIV/AIDS and substance abuse. I took every class Edith offered. I was impressed with Edith's training style. Her unadulterated manner conveys an integrity and a sense of "oneness" that she easily transfers to her students. During her workshop on AIDS and substance abuse, Edith introduced the idea of harm reduction. Constrained by the then-current political and professional climate, Edith delivered a compelling harm reduction proposition. During this time Edith spoke more of harm reduction in theory rather than actual

practice. Also, she was training counselors and needed to insure that certain counselor training specifications were met. In 1986 I was a card-carrying abstinence proponent! Fortunately, Edith and I would meet again.

In 1987, the Association for Drug Abuse Prevention and Treatment (ADAPT), a nonprofit organization founded by Edith Springer and other drug treatment specialists, received a grant (service contract) from the New York City Health Department. A colleague had recruited me to apply for the newly created position of ADAPT's director of education. To my understanding, this was the first project of this kind in the United States. I was very enthusiastic and longed to become involved in any effort that would address the problems of injection drug users (IDUs) in New York City. In her capacity as ADAPT's board secretary, Edith Springer was one of my interviewers for this position. My educational experiences regarding the associations between HIV and substance abuse, coupled with 5 years of direct services to homeless persons, served me well. During the interview I demonstrated my program design skills, specifically regarding the topics of outreach and intervention. As a result, I was offered the position. I decided to accept the position, but as fate would have it, there were contractual disagreements that could not be resolved so I remained with the Human Resources Administration, hesitant to leave the security of civil service employment for what appeared to be a precarious undertaking. ADAPT went on to be recognized nationally for its outreach efforts. Throughout my tenure at the Human Resources Administration, I continued to be a vocal opponent of needle exchange and other harm reduction strategies. Things would soon change, however.

November 1989 marked a very significant occurrence: I was moving to Seattle, Washington. I had watched my soul brother, Keith, a former IDU, succumb to a 5-year battle with HIV, never relenting in his opposition to needle exchange. The two of us would laugh about what a ridiculous idea giving clean needles to addicts was—ineffective, immoral, crazy, ridiculous. I sought escape after Keith died on August 7, 1989, and visited Seattle. Because Seattle had just been voted "America's most livable city," I figured this would be a good place to rest and to grieve.

As I always do whenever I visit a new city, I quickly made my way downtown. I wanted to see where the action was. Standing on the corner of Second and Pike—one block from the famous Pike's Place Market, Seattle's number one tourist attraction—I was shocked to see a man set up a table and display needles. I started to move away, not wanting to be associated with such a shady operation. I hadn't come 3,000 miles to get arrested, I reasoned, and I was sure this man would be handcuffed and carted off at any moment. But something quite different happened. People I deemed to be career addicts approached the table and dropped contaminated needles into a sharps disposal. They began talking to the man, Carlton Clay (known as "Chilly"), and taking literature from his table along with bleach packets, condoms, and clean needles. I was stunned. I

was standing there dumbfounded when something inside me clicked. "That's effective outreach," I thought, "and that's harm reduction." Back in New York, I had heard harm reduction ridiculed as ineffective—indeed, I had participated in the ridicule—and vilified as genocidal, but I had never actually seen it in action. I went over to the table and talked to Chilly. He worked for the health department. I was impressed. We exchanged information. He told me that there was a job opening in a nationally funded AIDS education and prevention outreach demonstration project. I applied for and got the job. This was the beginning of my conversion from being an outspoken opponent of needle exchange to being a firm supporter.

In New York City in 1989, a scenario similar to the one I have described above played out on a grand level, only with a different outcome. New York's fledgling needle exchange program was under attack, and many of its most prominent opponents were African American. The city's needle exchange program was operating out of a government building in downtown Manhattan commonly known as 125 Worth Street. The program was not successful, as addicts were not likely to seek help in a government building. This did not remove the controversy, however. I had then, as I do now, tremendous admiration and respect for the many renowned black addiction specialists living and working in New York. The Black Leadership Commission on AIDS was composed of my heroes. They considered needle exchange to be a flawed strategy in working with people addicted to drugs, and characterized the program as evidence of the city's unwillingness to allocate the kind of resources necessary to support drug treatment programs. Drug treatment in New York City, as in all major U.S. cities, is sorely underfunded. Culturally relevant services are extremely scarce in our communities. Needle exchange was seen as a quick fix—a bandage approach, a service by default, Novocain for the irretrievable.

Shortly after becoming Mayor, David Dinkins, under pressure from New York African American leadership (including the Black Leadership Commission on AIDS), ordered the New York City needle exchange program dismantled. I should have felt vindicated. However, by now I had too much information about needle exchange. The consequences would compromise the lives of the very persons the black leadership hoped to save! I knew that thousands of drug users would needlessly get infected with HIV. I had been a very vocal opponent of needle exchange during my tenure with the Human Resources Administration. "They're trying to kill us" was not only a phrase I had heard others use, but one I employed myself whenever the occasion warranted it. I had now come full circle. I was a firm supporter of and advocate for harm reduction.

This chapter illustrates the importance of sensitivity and community involvement in approaching the black community in regard to harm reduction. In addition, I emphasize the need to be mindful of the complexities involved in individual responses to the problems associated with

substance abuse. I explore the realities of substance abuse in African American communities—the realities that make this topic such a difficult one. I also take a look at the unreality of many expectations regarding substance users. And I demonstrate how harm reduction can help an individual user by "breaking the fall" into self-destruction. Along the way, and especially at the end of this chapter, I suggest strategies I consider invaluable if harm reduction is to become a viable and widespread option in the black community.

HISTORICAL BARRIERS TO HARM REDUCTION IN THE BLACK COMMUNITY

The Effects of Slavery and Its Aftermath

What are the realities that cause many people in the African American community to reject the concept of harm reduction and to renounce the suggestion that anything other than full eradication of drug use, drug activity, and drug availability might be acceptable as a goal or strategy? To begin with, the very real history of slavery, and black Americans' consequent distrust of white Americans' strategies, play a very big role.

The "peculiar institution" of slavery involved the most brutal and ongoing massive torture, killing, family dislocation, degradation, and terror ever known; it was quite similar, in fact, to the history of American Indians after European contact and colonization. Many Africans arrived in the "free" America, packed side by side in the bowels of a slave ship and then sold as animals branded and belonging to other human beings. After decades of this, almost all traces of our languages disappeared. Families were separated to ensure the negation of kinship, and our ancestors were forced to depend on the white "massa" for food, clothing, and shelter—all of which were discarded, the throwaways and garbage of white households. We were forbidden education and the right to worship. These restrictions carried on until legislation was enacted in an attempt to protect some small portion of the liberties of African Americans.

After the Emancipation Proclamation, a concerted effort was made by the white majority to damage our self-concept, self-image, and self-esteem. This was planned in anticipation of any self-sufficiency blacks might ponder. This effort was effected through the mass media and by all forms of propaganda. African Americans were, and too often still are, characterized as lazy, ignorant, sex-hungry, ugly, and animal-like. The societal consensus imposed on all Americans who were not black resulted in a desire to distance themselves from the designated demons. So began the struggles of Black folks among black folks; many of us are not sure whether we want to be black folks. Drug use is seen by the majority culture as one characteristic of those who are a disgrace to the race, without a deeper understanding of why some black Americans use drugs.

Earl Ofari Hutchinson (1990) writes in *The Mugging of Black America*:

> The drug plague is the single greatest cause of the escalation of crime and violence among African Americans during the past decade. Blacks, like white Americans, often take drugs to escape personal pain, problems and pressures of daily life. Unlike the white middle and upper classes, they also take drugs to escape the stress of racial and class oppression. (p. 99)

To Hutchinson's remarks, I would add that drug users of African descent suffer disproportionately from an array of drug-related adverse effects: unemployment; substandard housing; homelessness; family dislocation; police brutality; incarceration and recidivism; poor educational outcome; inadequate health care in response to disproportionate incidence of disease; and high rates of mortality and morbidity. These disparities can create a barrier of mistrust that prevents the African American community from even considering, much less embracing, programs seen as imposed on it by the majority culture. Before I discuss these factors, however, one specific aspect of African American history needs to be described: the fact that the African American community has been the target of some misguided, highly unethical treatment in public health programs.

The Black Community's Victimization by Public Health Programs

Among the most significant realities remain the appalling early interventions and programs of the U.S. Public Health Service (PHS). The best-known of these is the PHS's syphilis experiment at Tuskegee, Alabama—a shameful part of U.S. history. In 1928 the PHS, with the support of black church and community leaders, plantation owners, and the Tuskegee Institute (an institution with a history of service to African Americans), began a prospective study on the effects of untreated syphilis. African American men were offered much-needed medical care, food, and transportation in return for participating in the study. However, none of the men were told that they were infected with syphilis. The participants were either treated or not treated. During World War II, the draft board agreed to exclude study participants from the traditional requirement for treatment for syphilis. This study continued until the 1970s, and local health departments continued to work with the PHS to keep study subjects from receiving treatment. This study was finally brought to a halt when a venereal disease interviewer and investigator for the PHS told the story to an Associated Press reporter.

The syphilis study at Tuskegee remains an outrageous example of disregard for basic ethical principles, not to mention absolute lack of compassion and humane behavior. The suspicion and fear resulting from

this study are still apparent today. Many African Americans do not trust hospitals or other community health care service providers. The Southern Christian Leadership Conference surveyed 1,056 African American church members in five cities in an AIDS awareness project; 35% of the respondents believed that AIDS is a form of genocide, and 44% believed that the government is not telling the truth about AIDS (Jones, 1981). Is there any wonder why the African American community remains highly suspicious of services offered to them from agencies outside the black community?

Brothas and sistas in the neighborhood caution me:

> "You say harm reduction is a public health model! This public health system here in the U.S.! Those are the same people that used us for 40 years!"
>
> "Imani, think about it, they used us to find out how to keep themselves *alive*! They didn't want us to have penicillin, so why *now* do they want to give us clean needles?"

My passionate pleas fall on the ears of skeptics. And why should they believe me? I could be the Nurse Rivers of harm reduction. (Nurse Rivers was an African American nurse affiliated with the Tuskegee study, who went to black communities to conduct study procedures. She is believed to have been convinced of a long-term benefit to African Americans, despite the unethical nature of the project.)

UNEMPLOYMENT AS AN ISSUE IN THE BLACK COMMUNITY

Unemployment as a Key Factor in Drug Abuse

According to Farai Chideya (1995) in *Don't Believe the Hype*:

> Socioeconomic and neighborhood type are a much better predictor of drug use than race. Poverty, despair and drug use go hand and hand. For both blacks and whites, unemployed people are over twice as likely to be current drug users as individuals with jobs. Fully 28 percent of unemployed African Americans and 23 percent of unemployed whites use drugs. (p. 211)

Unemployment rates among African Americans of all educational levels are disproportionately high (Hacker, 1992, pp. 232–233). Drug use in poor black communities is a persistent problem. I would further argue that drug use among the unemployed is more likely to be excessive and therefore problematic; by contrast, many employed drug users function well on the job. Drug use poses a problem only when random drug screenings occur. An individual's use or nonuse of substances, however, should not be investigated unless and until drug use begins to interfere with job perform-

ance in a noticeable way. Many companies now offer confidential counseling and/or treatment for employees with a substance abuse problem. The goal of these offerings, however, is to stop all drug use, not to reduce or maintain use or to use drugs more safely. Sadly, U.S. mainstream society has skillfully used propaganda to develop unreasonable standards for what may be considered successful treatment. In addition, access to these confidential programs is contingent on employment. This is one more loop that the unemployed are left out of.

One practical component of harm reduction is that it allows some people to remain employed. An employed addict typically does less harm—to himself or herself and to others—than an unemployed one. To illustrate this point, I present an excerpt from Charles Faupel's 1991 book *Shooting Dope*:

Following is a typical day as recalled by an addict known as Little Italy for a period quite early in his drug-using career. During this time, he was working as a salesman at a men's clothing store, dealing drugs, pimping on a small-time basis.

Typical Day for Little Italy While Working at the Clothing Store

(CAPITALIZED ITEMS INDICATE DRUG/CRIME-RELATED ACTIVITIES)
7:30 am Get out of bed
SHOOT UP ("wake-up shot"—3 bags)
Get ready for work
SELL DRUGS
8:30 am Leave for work
9:00 am Begin work
1:00 PM Off for lunch
SHOOT UP (3 bags)
SELL DRUGS (most sales during this time)
2:00 PM Back to work
5:00 PM Off work
Eat dinner
6:00 PM SHOOT UP (after-dinner shot—3 bags)
Relax around the house
7:30 PM Hit the streets
SELL DRUGS
Party, gamble, etc.
SPEND TIME WITH PROSTITUTES
11:00 PM Back home
SHOOT UP (3 bags)
11:30 PM Go to bed

Contrast this with a Typical Day for Little Italy After Losing
His Job at the Clothing Store

9:00 am Get up (no breakfast)
Stay at home playing cards

Wait for drug customers
SHOOT UP (5 bags)
12:00 PM Eat lunch
SHOOT UP (5 bags)
Hit the streets
SPEND TIME WITH PROSTITUTES
6:00 PM SHOOT UP (5 bags)
Hit the streets
SPEND TIME WITH PROSTITUTES
SHOOT UP (5 bags)
11:00 PM Go to bed

It is not difficult to understand how Little Italy's drug consumption nearly doubled (from about 12 bags to 20 bags per day) after he lost his job at the clothing store. He suddenly had more unstructured time, making it much more difficult to regulate his consumption behavior. Just as cigarette smokers and coffee drinkers rely on regularly scheduled coffee breaks to gauge their consumption of nicotine and caffeine, a highly structured daily routine is essential in regulating drug-consumption behaviors of heroin users as well. (Faupel, 1991, pp. 43–47)

As your moral deity dictates, you may consider Little Italy a saint or an imp. Employed or unemployed, he represents a certain reality that it makes no sense to deny—and I, for one, prefer Little Italy working and using clean needles and condoms. The sheer numbers of people that he alone would be capable of infecting with HIV through the practice of unprotected sex and the use of dirty needles is horrifying. Black communities across America have experienced the impact that one Little Italy who is not "staying safe" can have upon a whole community for generations to come.

From Unemployment to Alternative Employment: The Rise of the Illegal Drug Trade

The interaction between unemployment and substance use, and the impact of this interaction upon African American communities, are critical because our communities have become the "distribution grounds" for all manner of illegal substances. As long as there have been black communities in the United States, whites have "crossed the tracks" to partake of every kind of "vice"—from prostitution to gambling to illegal substances. The Autobiography of Malcolm X relates Malcolm's stories of arranging for white men to visit prostitutes in Harlem to satisfy their sexual and sadomasochistic fantasies (Haley & X, 1965/1989). It is still common to find whites in "all-black" inner-city neighborhoods cruising in search of "sin." Young, wealthy whites are often seen and arrested in these neighborhoods while buying drugs, mostly heroin and cocaine (Brisbane & Womple, 1985, p. 175).

This arrangement seems to serve a practical purpose in the white U.S. psyche, allowing white Americans to associate blacks with illicit activities and desires, and causing blacks to bear the brunt of this stigma along with the consequences of being "peddlers." Hence, these very activities, particularly the tasks associated with the drug trade, come to be viewed by some in the black community as the most lucrative and therefore attractive employment available. And the fact that illegal drugs are so often filtered through black neighborhoods into the larger society causes these same communities to feel in a most direct and painful way the ill effects that some community members then attribute to the mere presence of drugs.

Legalization of currently illicit substances is seen by many black people as a plot to destroy them and their communities. This is a widely held belief and a justifiable concern. Why give us needles when we can't get an education? Is it a coincidence that throughout the United States the retail, street-level distribution of drugs is the burden of the urban poor neighborhoods? Regardless of the validity of our conspiracy worries, we are justified in our suspicions of legalization. The history and outcome of the legalization of alcohol serve as but one reminder. African Americans are now the targets of over 40% of the entire alcohol advertisement budget. We are victimized excessively by the day-to-day consequences of too much ethanol and not enough jobs, too much ethanol and no Head Start, too much ethanol and no affirmative action, and too much ethanol and too little compassion.

Ironically, as James DeVidts (1990) states, "It is interesting to note that enforcement of modern drug laws appears to target the Black population rather than the white majority[, which] is by far the larger consumer" (p. 98). This seems especially true in urban areas.

EFFECTS OF THE PRESENCE OF ILLEGAL SUBSTANCES IN BLACK COMMUNITIES

Dislocation and Disruption of Families

The presence of crack houses has a devastating effect on black communities, and heavy substance abusers are more likely than any other group to be thrown out of their homes by landlords and family members alike. Sometimes users are asked to leave because all their resources, both emotional and monetary, are exhausted in the daily routine. The nature of the presence of drugs in "the hood" dictates a compromised existence—one devoid of any reasonable positive expectations.

The presence of illegal drug activity can jeopardize an entire family's safety. U.S. President Bill Clinton recently signed a measure mandating the removal of families who are directly or indirectly involved in drug activity from public housing. This kind of random dislocation of families defeats its purpose. These days, it is not uncommon in black communities across

the nation to hear of hard-working parents and grandparents who have been put out of their homes as a result of the illegal activities of their offspring.

The violence that accompanies the illegal drug trade is another disruptive factor that many black families are forced to live with. In *Deadly Consequences*, Deborah Prothrow-Stith (1991) declares:

> Drug trafficking violence does not originate with the inability to handle anger and other emotions. It may be unrelated to the model describing a "typical" homicide—two people who knew drinking, who argue, one of whom has a gun. This form of violence is calculated rather than spontaneous and premeditated. (p. 119)

Public officials are reacting against this violence with punitive measures. Many states and municipalities now have "drug abatement" laws allowing for the seizure of property used in the manufacture or distribution of illegal drugs. Police use "battering rams" in Los Angeles to destroy the homes of purported drug dealers. Meanwhile, landlords aware of illegal activities related to drugs taking place on their property prosper. The residents, however, must live surrounded by the violence and instability often associated with heavy substance abuse. And, of course, children follow their parents into shelters, emergency housing, and homelessness.

Severe substance abuse also leads to a general breakdown in adults' ability to parent offspring. Substance abuse can result in the breakup of families, with one or both parents in drug treatment, in prison, dead, or on the streets. Children are placed in foster care or are farmed out to relatives. It is often members of these drug-addicted families who meet me with the most drastic criticism when I talk about harm reduction. They have witnessed the suffering of children as a result of parents' substance abuse; they are often the ones who have taken their grandchildren in. To these overburdened grandparents, it's difficult to justify reducing drug use rather than eliminating it. Minkler, Roe, and Robertson-Beckley (1994) state, "The mental and emotional health consequences of caring for grandchildren whose parents have been lost to the crack-cocaine epidemic, and the role of social support and social networks in mediating or buffering the stresses associated with such caregiving, deserve special attention" (p. 27). Lives end up in shambles. A mother may have been using while she was pregnant; the children may have been born addicted, premature, disabled, and disadvantaged from the start. According to 1990 census data, more than 20% of black adults are taking care of youngsters other than their own (Hacker, 1992, p. 72). Too often, drug use on the part of one or both parents has led to this reconfiguration of families.

The majority of black families living in communities pay an exorbitant price for the substance use of a few individuals. The ill effects of media stereotyping are felt by all. Yet another factor disrupting black families is

that every state in the union has skyrocketing rates of blacks in prison. blacks in Nebraska are more than 15 times as likely to be imprisoned as their white neighbors; the ratio is 13.4 in Pennsylvania and 9.5 in Michigan (Hacker, 1992, p. 236). For many in black communities, the "war on drugs" is really a "war on black people," an excuse to incarcerate increasing numbers of black men and women. The penitentiary system, which rationalizes indentured servitude and recognizes free labor as reha-bilitation, benefits from the pain of black folks. A harm reduction advocate who is unaware of these statistics marches before a black audience naked. "How can you talk about helping addicts shoot up safely? This stuff is killing us!"

Health-Related Consequences

Indeed, "this stuff is killing us," literally: An epidemic of diseases associated with substance abuse plagues America's black communities. According to Dawn Day (1995),

> At one time a person injecting illicit drugs was at risk of dying from overdose, from a reaction to the substance used to cut the drug, or from hepatitis B. Those risks continue. In addition, a person injecting drugs is now also at risk for HIV/AIDS. (p. 2)

In many African American communities, a majority of residents lack access to adequate, affordable health care, with substance abusers having the least access of any group. Since both African Americans and substance users are more likely to be unemployed, and since health care for most people in the United States is tied to employment, African American substance users are more likely to be uninsured, less likely to seek care, more apt to receive inadequate care when they do seek it (i.e., to be treated as criminals first and patients second), and far more likely to die as a result of prolonged substance abuse. By 1994, over 73,400 African Americans had drug-related AIDS or had died from it (Day, 1995, p. 1). For the most recent year that data were available, among persons who injected drugs, African Americans were almost five times as likely as whites to be diagnosed as having AIDS; in her discussion, Day (1995 p. 1) ties this fact directly to the lack of access to clean needles.

Other Effects and Interactions of Effects

Beny J. Primm (a leading expert on substance abuse in the black commu-nity) and James E. Wesley, in their discussion of the barriers to treating multiply addicted black alcoholics, have much to say about the adverse effects of substance abuse in the black community. Some of these factors

have already been discussed in this chapter, and others are discussed later, but their list is worth quoting in full:

> A partial list of socio-political and cultural factors that [affect] the multiply addicted Black alcoholic [includes] (a) the history of racism in the United States and the psychological handicap it imposes on an individual's self-esteem; (b) poverty, unemployment, lack of job and career opportunities; (c) failure of police to rid communities of drug pushers, hence easy availability of drugs in Black communities; (d) use of the lucrative economic rewards from selling drugs as alternative careers; (e) hopelessness of ghetto life; (f) life styles that reject menial or subsistence jobs in favor of hustling and the drama of drug dealing; (g) peer pressure; (h) culture and class conflicts; (i) inadequate educational preparation and the dropout syndrome; (j) rising material, social and success aspirations; (k) breakdown of family life and welfare policies that encourage single-parent households; (l) frustration from continuing discrimination and rejection; (m) constant or occasional use of alcohol by drug-addicted individuals as though alcohol is not a drug; and (n) stress. (Primm & Wesley, 1985, p. 157)

If I attempt to expand this list further, I find that I run out of letters before I run out of barriers: (o) lack of access to health care, as noted above; (p) miseducation about substance abuse; (q) increased risk for and incidence of numerous diseases, especially again as noted above; (r) isolation from family; (s) lack of support systems; (t) lack of transportation; (u) depression; (v) lack of discipline and inability to act in one's own behalf; (w) lack of culturally appropriate treatment options; (x) view of drug abuse as a moral as opposed to a public health problem; (y) the demonization of the addict in the media, community, and larger society; and (z) excess mortality. These are the realities that black communities are facing all over the United States. And this is the context in which the idea of harm reduction will be received.

UNREALISTIC EXPECTATIONS
AND UNFULFILLED DREAMS

Once we in the harm reduction community have acknowledged the acute suffering caused by substance abuse in the African American community, including the reality of devastation that substance abuse has wrought upon the users, their families, and the community at large, our work has only begun. We must then embark on an education program—not only to counter misperceptions about harm reduction, but to deal with the community's (as well as the larger society's) miseducation about substance use and substance users. This miseducation is U.S. government policy, as manifested in the "war on drugs" and the "just say no" campaign which treat substance abuse as a political, moral, and criminal justice issue instead

of a public health issue. I maintain that it is this policy, *not harm reduction,* that is crippling the ability of the black community and the nation as a whole to deal effectively with substance abuse. Because government policies and media propaganda regarding substance abuse are steeped in a racism particularly suited to political purposes, it is the black community that bears the brunt of these misperceptions, in addition to the burden of the aforementioned realities. So harm reductionists in the black community must be willing to design and implement effective drug use education programs if we wish to get past "Go" (or, in this case, "Go away!") with such projects as needle exchange programs. Any such education programs must demonstrate the limits of the abstinence model and the need for other treatment options. They must also address the unrealistic expectations black people hold of substance users, which stem from the following:

- Denial, including the denial of multigenerational substance abuse.
- Our culture as Americans, which encourages us to see everything in terms of good or evil, all or nothing.
- The need *not* to play into stereotypes of drug abuse as a black, inner-city problem.
- The strong moral ethic and deep faith of black Christians.

I briefly define how each of these factors contributes to the idea that complete abstinence and the elimination of substance use are the only ways to treat the problem of substance abuse. As long as this idea holds sway (even if it doesn't hold water), advocates of harm reduction will not make strides within the black community.

Denial and the Disease Model

Addicts seek treatment and start down the road to recovery, only to fall off the path and begin using again. Family members who live with this pattern recognize its impact but deny its implications. Some view an addict as a sinner who must be brought into the light. Others see the addict as one who is sick, who must take his or her medicine and be cured, once and for all. Both of these views, which are sometimes directly related (e.g., "God visits disease upon the sinner"), protect family members from the unthinkable: Suppose this person is always going to have this condition? Suppose his or her substance abuse is chronic and recurring, something we have to learn to live with? Suppose this child's problem is tied to generations of substance use, centering on the abuse of legal substances such as alcohol, prescription drugs, and cigarettes—problems the family has tolerated even as beloved relatives have succumbed to them? Might not programs such as needle exchange and methadone maintenance reduce some of the adverse effects of substance abuse, particularly in regard to the spread of AIDS in the black community? Even the harshest of judges who might condemn the

"sinners" to die for their transgressions would not condemn their own children, their spouses, and everyone they sleep with.

All-or-Nothing View of the World

Like other Americans, black Americans have been brainwashed into seeing the world in terms of good or evil, all or nothing. In *The Tyranny of the Majority,* Lani Guinier (1994, p. 79) has characterized ours as a "winner take all" democracy. This tendency to think in terms of extremes and polarities does not win any converts to harm reduction and contributes heavily to the view that addicts need to "hit bottom" or "ride it till the wheels fall off." In our all-or-nothing culture, it is hard for people to embrace the ideas of moderation and mitigation. It is particularly difficult for many black Americans to accept moderation and temperance as good options, because our problems are and have always been so overwhelming, and our government and fellow citizens have rarely seen fit to move with anything other than all due moderation and temperance in alleviating them. To these skeptics, harm reduction seems like one more in a long line of insincere, half-hearted, unrealistic, and racist attempts to convince us to lower our expectations and accept our abasement. Such critics do not see it as a way to stem the tide of death and disease resulting from unsafe drug use and sexual practices.

Resistance to the View of Drugs
as a Black, Inner-City Problem

Although African Americans account for only 12% of United States substance users (roughly proportional to our percentage in the population), the image persists that drugs are a black, inner-city problem (Chideya, 1995, p. 210). To counter this stereotype, community members often reject the notion that African Americans must shoulder the burden of the "war on drugs": "Why do you people always want to come up here talking about drugs? Like we're all some kind of junkies? Take those needles over to the other side of town!" When asked why he didn't take his "get tough on crime" message to black communities, Boston University President John Silber, a contender in the Democratic primary of the 1990 Massachusetts governor's race, replied, "There is no point in making a speech on crime control to a bunch of addicts" (quoted in Chideya, 1995, p. 209). How does one possibly respond to these kind of allegations, which are presented daily for political gain or entertainment value? Most people become defensive. It's a matter of pride.

Americans of African descent are cast as losers by mainstream U.S. society. Sadly, it is unlikely that this unjust characterization will ever be reversed. Y. N. Kly's 1990 book, *International Law and the Black Minority in the US,* is an in-depth discussion of the realities of inequality. Kly asserts: "There are no known examples since 'The Rise of Ethnic Awareness,'

whereby two ethnic groups starting their relationship as slave and slave master were able to create an environment of equality and assimilation" (1990, p. 63). In the light of this harsh reality, black abusers of drugs are accused of living up (or, more accurately, down) to racist expectations. Such expectations require substance users to be criminals, sinners, crack mothers and deadbeat dads. Under these circumstances, it is difficult for those who choose responsible drug use to select other profiles.

The Moral Ethic of Black Christians

"Jesus will set you free." This simple but powerful statement represents the beliefs of many in the black community. The failure of the addict to "come clean" is a failure of faith. And for the community to call for harm reduction instead of the total eradication of drugs would represent a failure of faith on the community's part—a betrayal and sacrificing of our loved ones by aiding and abetting their pact with the devil. As black Christians see it, there can be no moderation in matters of morals. Would one talk about reducing slavery, reducing racism, reducing police brutality? Is one content to reduce evil? It would be foolish to suppose that black believers will ever agree to "help somebody sin." Only when harm reduction can be presented as a useful step toward eradication, and not only as an end in and of itself, can we expect to gain credence among churchgoers. Needle exchange is to drugs what condoms are to sex: Both are a hard sell when "you're not supposed to be doing it in the first place."

In summary, it is necessary to present an education program that treats substance abuse as a public health matter, and not as a criminal justice or moral issue. We can find encouragement in the gains made by Deborah Prothrow-Stith (1991, p. 38) toward recasting violence in this manner. "Stop the violence!" is still a far more common rallying call than "Reduce the violence!", but many people are willing to concede that reducing violence and its devastating effects may be a more realistic short-term goal, and that this goal may perhaps be accomplished if we approach the problem as a public health one. Perhaps these same people will also concede that reducing the harm associated with substance use may be a more realistic short-term goal, which may be accomplished by approaching the problem as a public health issue rather than a moral or criminal one. Still, we have a long way to go among the African American community.

PHILOSOPHICAL DIFFERENCES
AMONG AFRICAN AMERICAN LEADERS

Kurt Schmoke, the present mayor of Baltimore, is a courageous and fascinating African American leader. Admittedly, the first time I heard him

I thought he must be crazy. However, what he says is pure common sense: "Unfortunately, our current national drug policy remains heavily oriented towards the criminal law and is mired in failure" (Schmoke, 1993, pp. xiii–xvi). Mayor Schmoke serves Baltimore residents with an integrity few politicians can muster. By speaking out in favor of needle exchange programs, by forcing debate on current drug policy, and by connecting prohibition with the inevitable creation of a profitable illegal market, Mayor Schmoke stands for social justice!

Where are the others? Colin Powell, Jesse Jackson, Carol Moseley Braun? We need more pundits of African American descent to speak out! Admittedly, speaking out is risky. I was honored to be present at the speech former U.S. Surgeon General Joycelyn Elders delivered at the Drug Policy Foundation Awards Banquet in November 1995. Elders was honored for her courage in speaking out on the need to "examine" the legalization of drugs and to provide young people with realistic education about safer sex practices. In 1994, Elders was forced to resign as Surgeon General—in everyday terms, she was "kicked to the curb"—just for asking folks to think!

The unfortunate truth is that black leaders' political tenure is fragile; thus, they will probably be the last political envoys to bring the drug policy discussion to the table. Ironically, a consequence of this reticence will be a polarization between drug users and nonusers in the black community. As the harm reduction movement gains favor in the United States, drug users will affiliate themselves with the harm reduction activists. As it was in the 1960s during the civil rights movement, harm reduction activists, primarily of European descent, will promote safe use to communities of color. Drug users will welcome their aid, while other community folk will feel insulted and put upon. At day's end, the enthusiastic reformers will go home to their own neighborhoods, while the drug users—now abandoned both by their neighbors and by the reformers—are left behind until the next benevolent exercise. We need black leadership to explore options and alternatives. We need leadership from within!

ISSUES IN DEVELOPING HARM REDUCTION EFFORTS FOR THE BLACK COMMUNITY

The value of harm reduction to the black community lies largely in its potential to encourage a number of characteristics and attitudes. Primm and Wesley (1985) outline some such characteristics:

> Some characteristics, attitudes, and achievements of Blacks who do not become substance addicts or self-destructive individuals are: (a) a realistic perception of the "American dream"—material possessions alone do not insure happiness; (b) the ability to solve problems rather than trying to forget them; (c) feelings

of self-worth emanating from a positive acceptance of oneself as a Black person; (d) models of physical, emotional and career fulfillment; (e) opportunities for alternative forms of relaxation or entertainment; (f) experience of success or mastery which develops confidence to overcome environmental handicaps; (g) a sense of identification with a larger group, in whose accomplishments one can take pride; (h) achievable short-range goals; (i) sources of help; (j) un-glamorized picture of drug effects and drug life-style; (k) a perception of self by standards other than normative. (p. 160)

If an addict is not stigmatized or viewed judgmentally, he or she can be seen as a person making decisions rather than a demon reacting to substances. In Primm and Wesley's terms, a user who makes securing clean needles a priority is already dealing with "(h) achievable short-range goals" (by reducing the risk of disease) and has accessed at least one "(i) source of help." The more normalized and less vilified the experience of using becomes for the drug user, the more he or she is inclined to gain a more "(j) un-glamorized picture of drug effects and drug life-styles." And the more the user is valued and accepted by those close to him or her, the more the user is likely to maintain "(c) feelings of self-worth emanating from a positive acceptance of oneself as a Black person" and to find "(d) models of physical, emotional and career fulfillment" and "(e) opportunities for alternative forms of relaxation or entertainment." In particular, those who are able to moderate their use of substances are more likely to gain and retain employment and to gain access to treatment programs.

Adopting a Shared Definition of "Harm Reduction"

How, then, can harm reduction be brought to America's black communities and not just to the few African American addicts who currently exchange their needles? How can we support the drug users in our neighborhoods? To begin with we need to adopt a workable, shared definition of "harm reduction." So many different definitions and ideas presently exist in the harm reduction movement that this lack of consistency is a problem in itself. African Americans will scrutinize and examine harm reduction efforts, searching for uniformity. In the black community, we've all got to be "on the same page" when we consider what's at stake. Alan Marlatt and Susan Tapert (1993) provide us with a workable definition:

> Harm reduction methods can be employed in three main areas: (a) AIDS prevention (e.g. safe sex and condom use programs, needle exchange for IDU's); (b) treatment of ongoing, active addictive behaviors (e.g. methadone maintenance for opiate addiction, nicotine replacement therapy for tobacco smokers); and (c) prevention of harmful addictive or excessive behaviors (e.g. controlled drinking, moderation of excessive food intake). (p. 258)

Designing Projects within a Culturally Specific Framework

Once a definition of "harm reduction" has been agreed upon, two further prerequisites must be met if harm reduction is to become a viable option in African American communities:

1. Harm reduction advocates must acknowledge and accept the reality of disproportionate adverse effects of illicit substances on black communities.
2. Harm reduction projects must be designed within a culturally specific framework—one that acknowledges the natural talents already present in the black community.

I have already explored the first of these prerequisites in some detail in this chapter; I now address the second.

The Need for Black Self-Determination in Harm Reduction Efforts

Harm reduction programs for black communities must, of course, explore the nature of addiction, demonstrate the limits as well as the applicability of the abstinence model, and identify a full range of treatment options. Over and above this, however, such programs *must* be the creations of black communities themselves. For all the reasons I have discussed above, efforts by well-meaning harm reductionists of European descent to design programs for and introduce them into African American communities will be regarded with suspicion and distrust by the members of those communities. Moreover, I have found that despite (or in some cases as a result of) their good intentions, white harm reductionists tend to reenact patterns of white dominance–black submission in their attempts to work with their black counterparts. U.S. society as a whole is being forced to reevaluate us black folks, and the harm reduction movement is no exception.

Black people and white people are not the same; we experience the world through two different sets of eyes. This is as true in the harm reduction movement as it is in any other aspect of society. My experience has been that those of us black folks who are involved in the harm reduction movement are constantly taken to task, as white folks grow impatient with our prudence and caution. Our racial authenticity is challenged as we seek the normality that transcends cultural commitment and allows for independent thinking. Our actions in proceeding prudently and thoughtfully serve not only ourselves, but the members of our community, who catch hell every day.

Meanwhile, our white counterparts require and demand the full benefit of our symbolic participation. We experience our "two-ness" as our white

counterparts' expectations become overbearing. Almost 100 years ago, W. E. B. DuBois (1903) wrote: "One ever feels his two-ness—an American; a Negro; two souls, two thoughts, two unreconciled strivings; two warring ideals in one dark body, whose dogged strength alone keeps it from being torn asunder" (DuBois, 1903, p. 3). We are constantly aware that we are not just harm reduction advocates; we are *black* harm reduction advocates—a rare but powerful commodity!

Nonacademic white harm reductionists, who are often associated with a countercultural identity, have a tendency to include transracial solidarity as a part of their image. As long as there are no shifts in power, all is well. But when black folks begin to develop their own priorities, these people begin to feel threatened. Unconsciously, some of these advocates experience and demonstrate a type of behavior that I characterize as "New Age white guilt." Convinced of their capacity to relate to the "brothers and sisters," they approach the black community with a cumbersome, patronizing, and intrusive attitude that is easily identified by persons of African descent, who have a lifetime of experience with such conduct. New Age white guilt, however, does not allow any retreat from those individuals who, because of their racial identification and experience, are the most obvious problem solvers. Those with New Age white guilt, because of their perceived familiarity with our circumstances, confront us black folks and are not afraid to take us on. They are unable, however, to forgo their tradition of setting standards that create unfriendly environments for black people. I would suggest, with all due courtesy and respect, that we black folks may have a better sense of our communities' needs and the best ways of addressing these than harm reductionists suffering from New Age white guilt may have.

The Need to Incorporate African American Characteristics into Harm Reduction Efforts

Naim Akbar (1981, pp. 6–16) has described six major characteristics of African American communicative and behavioral patterns. These six characteristics must be incorporated and interwoven into harm reduction efforts for the black community:

1. African American Language. African American language is at best a symbolic expression of the mental contents of the group. Our language has evolved based upon certain shared experiences and agreed upon symbols for the expression of these experiences. It is because of the many subtle patterns of African American language and body language that African Americans are often misunderstood when communicating with unfamiliar persons.

Harm reductionists tend to use either very technical language or a loose "Euro-slang" kind of talk that often does not translate multicultu-

rally. Our rhythmic self-expression looks for its harmonious match. Harm reduction as it presently exists is primarily a "white thing," often lacking in the expression of emotions and often responding to the heartfelt emotions of black folks with threatening behavior. Standard American English is sometimes (but by all means not always) a second language for urban blacks. Moreover, the European composure that can camouflage anger and distress is not our instinctive response. We convey our message as we "feel it."

> 2. Oral Patterns. Oral communication remains the predominant means of information transmission within the African American community. While Euro-American people demonstrate a highly developed visual orientation as is evidenced by the heavy emphasis on written material that characterizes American culture, African Americans rely much more on the spoken word than the written word. (Akbar, 1981)

A competent harm reduction effort designed for African Americans must, at the very least, allow for oral communication as a primary means of delivering the "411" (information). We Africans love to tell stories; thus, stories will be a natural context for harm reduction concepts and practices, and harm reductionists will need proficiency in speech and storytelling. The heady expression of people of African descent also requires developing a taste for direct experience and familiarity, unaccompanied by judgment and standards.

> 3. People Orientation. One very important element of the African American oral tradition which distinguished it from the visual tradition of the Euro-American culture is the centrality of a speaker in the former case and his dispensability in the latter. The crucial difference indicates another significant characteristic of the African American cultural experience. Effective communication in the African American tradition consists of a correlation between the rhythm and content of a message or the message and the medium. (Akbar, 1981)

Harm reduction efforts must be therefore transmitted in a clear and understandable format. In addition, the harm reductionist must have a sense of self and realize the potential of the message. We can't "disconnect" and teach harm reduction in the black community.

> 4. Interaction vs. Reaction. Another pattern of considerable prominence found in the African American life experience is the interaction patter of call-and-response. The spontaneous reactions and supportive statements of encouragement involve the speaker and listeners in a dialogue of interaction. This stands in contrast to the traditional Euro-American speaker/audience setting in which the speaker or expert dispenses wisdom and the audience listens attentively and reacts only at appropriately defined moments. (Akbar, 1981)

In the African American community, there is no such thing as a "captive audience." It is my job to deliver a harm reduction message that arouses kinship and recognizes oneness! I try to recreate and expand on everyday urban life in particular, while romancing the complex African American experience influenced by class differences. My advice, therefore, is to talk harm reduction last—address the basic, everyday issues first, and you are guaranteed to get an "Amen!"

> 5. African Thought. Another distinctive characteristic of African Americans is the form of thinking and problem solving that they have gained from the conditioning of their cultural and life experience. This characteristic is a strong reliance on internal cues and reactions as a means of problem solving in contrast to the reliance on external cues. There is a cultural respect for internal cues and "hunches" as a means of acquiring information and knowledge. (Akbar)

As we begin to create a harm reduction agenda for black people, those outside of our community must relax some of their rigid rituals that are presumed to present their genius. Sometimes these rituals and actions are the reasons why intervention efforts fails. African Americans trust internal cues and hunches, allowing for us to do what is right and fair in a particular situation.

> 6. Spontaneity. Another highly distinguishing characteristic of African Americans is the capacity to be spontaneous—the facility for easy, rapid adaptation to different situations. The capacity to respond quickly and appropriately to environmental changes is one of the African American's most remarkable strengths. It facilitates his/her basic comfort in most settings, where there are positive interpersonal relations. (Akbar, 1981, p. 6)

Harm reduction will be a spontaneous response. When we are aware of our predicament, those of us involved will be ready to change. We have to feel it!

In summary, without a working knowledge of African American culture, respect for the black agenda, and appreciation of the complexities involved, any harm reduction endeavor targeting the black community will fail.

Advocating for Changes in U.S. Drug Policy

Decriminalization of Drug Use

Even as harm reduction becomes recognized in the United States, its detractors will use the plight of users from the urban ghettos to rally opposition to against it. The fact that the use of most street drugs is illegal makes it extremely difficult to "undemonize" drug users. African Ameri-

cans need to consider the radical notion that decriminalization of drug use and drug-seeking behaviors could serve to unclog the criminal justice system and to halt the cottage industry of prison construction.

The notion that all drug users are pernicious demons determined to convert our children into criminals or "lazy bums" must be examined and confronted. Many an alcoholic held a job until cirrhosis of the liver took its toll. Our society encourages changes in mood and enlightening experiences. Why, then,should the government dictate which pleasures are acceptable and which should be prohibited? The parallels between drug policy reform and the civil rights struggle are based in the same law-creating processes. Drugs will never be eliminated from the international society. Ethyl alcohol was legalized in the United States after a failed attempt at prohibition in the 1920s and 1930s. Nicotine is so powerful a drug that state governments are filing suit against tobacco industries in an effort to recoup revenue spent addressing morbidity and mortality among their cigarette-smoking constituents.

In Seattle, Washington, home of the coffee craze, I meet my other drug-using buddies each morning at the drug house. Our local Starbucks coffee shop is a respectable drug den. Prior to 1990, I had never heard of a latte. By the end of that year, I was drinking a short (one-shot) latte a few times a week. By 1991, I had a real coffee habit; too little coffee resulted in headaches. From 1992 to mid-1993, I managed to quit coffee drinking. I missed the buzz, however, and despite the warnings of my physicians, I returned to my coffee, just a little bit each day. Now every day I have a grande latte, 2%, warm—not hot! I'm clear about it: I drink for effect! I "go cop" everyday, just like my illicit-drug-using sistas. It makes me feel good. My point is that drugs are here and they are here to stay, and the choice to use drugs should be an individual one.

The illegal aspect of drug use is what hurts us as black folks the most—the fact that users have to commit a crime to obtain the substance that sustains their spirit. How do drugs get to the black community? We don't manufacture them. We don't own the high-tech vehicles necessary to transport drugs. We know where the drugs are and who sells them; yet the Coast Guard can't stop drugs from coming ashore. This fact is unsettling when we ponder it: We don't control the drugs, but we go to jail for possession of the drugs. Drug availability also supports the economy in poor neighborhoods, and the government, through prohibition, offers a profitable venture for young entrepreneurs. These entrepreneurs are then incarcerated for grabbing the bait!

Legalization deserves its day in black court. We just need to examine it. Bruce Wright points out in his 1987 classic Black Robes, White Justice that "for those of the inner cities, the judges are the assembly line feeders of the prison system" (p. 13). Even judges are frustrated with this system; some are actually refusing to adhere to seemingly arbitrary guidelines such as mandatory minimum sentencing.

Other Changes

Most drug treatment programs are privately funded and unavailable to blacks because of prohibitive costs. Both private and public funding must be made available to finance programs in black neighborhoods, and neighbors must be lobbied to support such programs. Moreover, these programs should not be limited to offering abstinence-based treatment only. As Dawn Day (1995) writes,

> Drug treatment is vital and necessary. But not all people are ready for treatment. Having a needle exchange program is like having lifeguards at the beach. We need to get clean needles to persons who inject drugs so that they will not become infected with HIV/AIDS. Then, when they are ready to stop using drugs, as many will, they will have their whole lives ahead of them, not just a series of painful, expensive illnesses ending in death. (p. 5)

And if we are serious about keeping our youth off drugs, we will need to develop and fund many more programs that encourage them to develop the characteristics of blacks who do not become addicted, as outlined above in the passage I have quoted from Primm and Wesley (1985).

Approaching drug use as a public health problem would also eliminate the need for random drug testing. Only employees whose drug use results in a failure to perform their jobs would be at risk. Many substance abusers, be they alcoholics and/or drug users, are legally employed. It is unfair to target and penalize low-income and blue collar workers for drug use, provided that it does not interfere with job performance.

Educational opportunities that examine the numerous theories, styles, and opinions of the many addiction pundits should be available to drug counselors, trainers, and administrators. Prior to my exposure to harm reduction, I was ignorant of the wide array of approaches to treatment and prevention. As a trained chemical dependence specialist, I regret the biases my previous education instilled in me. My approach was often based on illusion and fantasy; I saw all attempts to examine other possible approaches as deceptions. The simple acknowledgment that there are numerous ways to treat addiction does not mean that those efforts not demanding abstinence will encourage the user to continue, or to increase, use.

Norman Zinberg's 1984 book *Drug, Set and Setting* is a recent addition to my library. Zinberg wrote: "Our culture does not yet fully recognize, much less support, controlled use of most illicit drugs. Users are declared deviant, a threat to society, or 'sick' and in need of help or 'criminal' and deserving punishment" (1984, p. 15). Back when I supported abstinence, these observations would have challenged me. I had to get real. I was not meeting the needs of the people. Rather, I was preaching and recruiting. Heroin clinics such as the experimental ones tested recently in Switzerland (see Chapter 2) may be an alternative to methadone maintenance programs. All I am saying is we must enter the debate. Imagine what

our society would be like if drug addicts who currently depend on expensive, illegal street heroin of uncertain quality could sustain themselves on legal regulated, safer, and less expensive heroin. Turf wars would diminish. Addicts would not have to use all their mental and physical resources to stay "normal." With training and support, black men could hold jobs instead of jail cell bars.

We must explore the strategies used in other countries, such as Switzerland (as noted above) and the Netherlands. The Dutch emphasize treatment and risk minimization. Communities and drug users are both priorities. Dutch drug policy provides users with medical and social services, ensures their access to treatment programs, promotes health education for both users and communities, and works to rehabilitate users regardless of their willingness to cease using drugs. The United Kingdom, Canada, and Australia are also going far beyond the U.S. model and treating substance abuse more effectively by recognizing it as a public health issue. Perhaps we in the black community, who are so plagued by the problems associated with substance abuse, could become leaders in the U.S. efforts to bring these problems under control. Harm reduction can be an important first step.

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