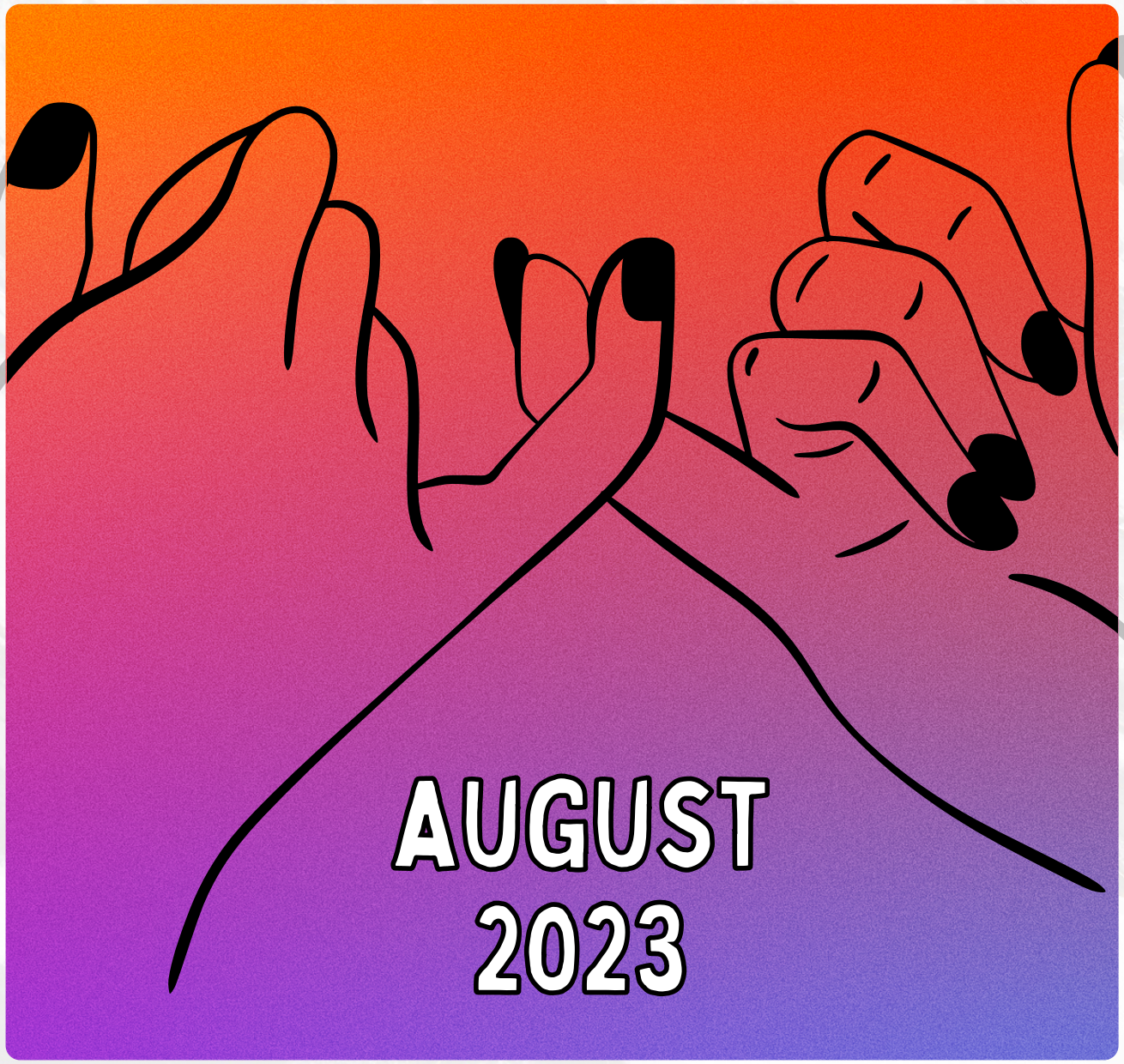
OUR LIVES, OUR CARE

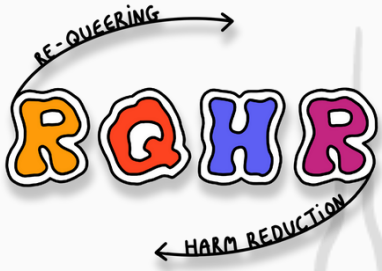
The Report & Recommendations of The Re-Queering Harm Reduction Project



NATIONAL HARM REDUCTION COALITION

LIGHTHOUSE LEARNING COLLECTIVE

EXECUTIVE SUMMARY



The Re-Queering Harm Reduction (RQHR) Project's report and recommendations, Our Lives, Our Care, is an appraisal of the state of care for queer and transgender people who use drugs and/or do sex work (QT-PWUD/SW).

The necessity of RQHR emerged from the awareness that our needs as QT-PWUD/SW are largely not being met by the harm reduction and addiction treatment industries. RQHR proceeds from the premise that industry organizations allow profit-driven insurance companies, cost-cutting public insurers, and elite foundations to arbitrarily determine what care can and can not be provided. In contrast, RQHR is rooted in the principle that the actual recipients of services—here, QT-PWUD/SW—must wield the decisive power to collectively determine their infrastructures of care. Here lives the purpose of RQHR: to incite a movement that re-designs our infrastructures of care by expanding upon, deepening, refining, and empowering the means and methods of care already devised by QT-PWUD/SW.

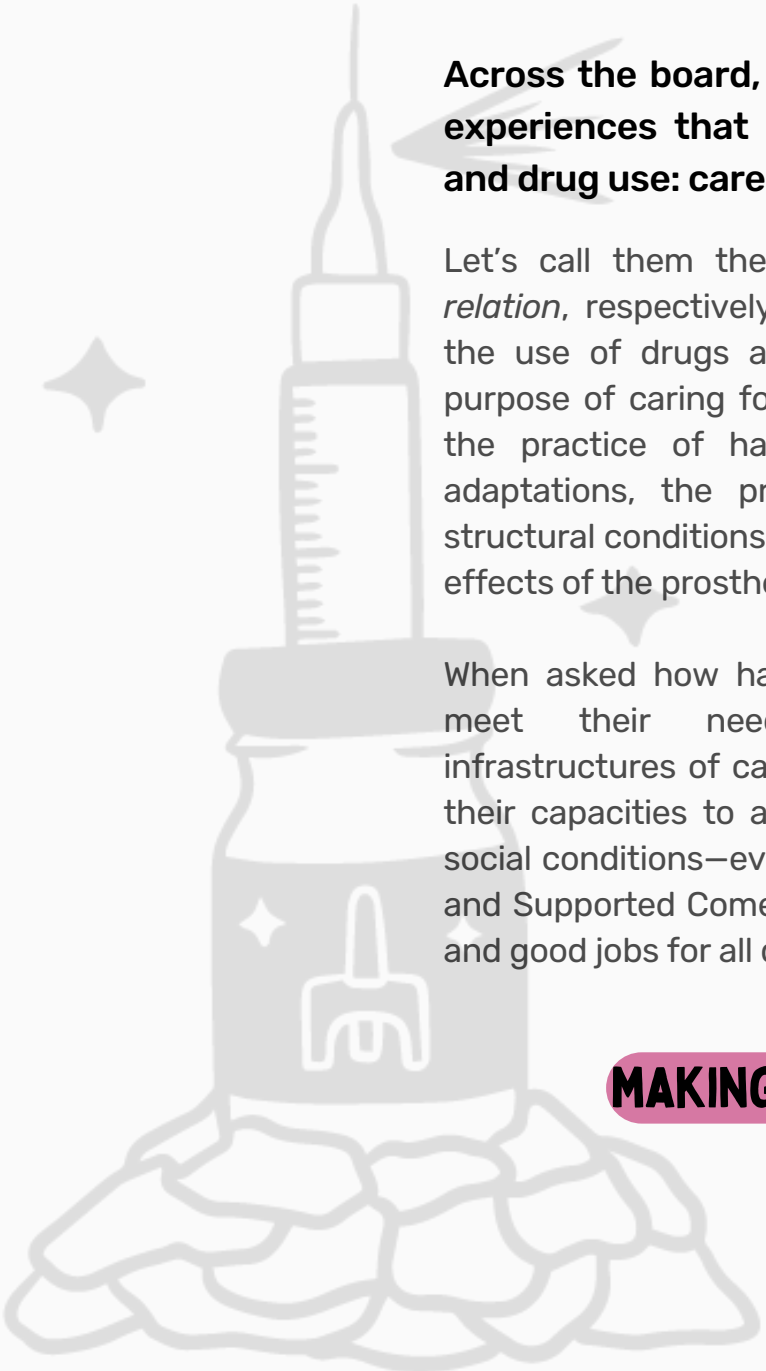
Therefore, RQHR brought together QT-PWUD/SW based in New York City[1] to reflect upon and imagine the possibilities of two questions, respectively: "**How do QT-PWUD/SW take care of themselves?**" and "**How can New York City harm reduction and addiction treatment organizations empower, expand, and deepen the embedded care practices of QT-PWUD/SW?**"

PREPARED BY
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[1] The funding from the New York State Department of Health that made RQHR possible circumscribed participant eligibility to the five boroughs of New York City. The irony of such limitations for a project aspiring to liberate QT-PWUD/SW harm reduction from the dictates of funders is not lost on RQHR.

EXECUTIVE SUMMARY



Across the board, all 13 RQHR Participants described experiences that reveal two relations between care and drug use: care as drug use, and care for drug use.

Let's call them the *prosthetic relation* and the *remedial relation*, respectively. In practice, the prosthetic relation is the use of drugs as **tools**, as *narco-prosthetics*, for the purpose of caring for oneself, while the remedial relation is the practice of harm reduction. The two relations are adaptations, the prosthetic in response to antagonistic structural conditions, the remedial to the unintended harmful effects of the prosthetic itself.

When asked how harm reduction organizations can better meet their needs, RQHR Participants imagined infrastructures of care that empower, enhance, and expand their capacities to adapt to psychosomatic, economic, and social conditions—everything from stimulant agonist therapy and Supported Comedown Spaces, to Sex Worker Waypoints and good jobs for all drug users and sex workers, and to

MAKING HARM REDUCTION FUN AGAIN.

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I. INTRODUCTION



Whenever I hit the streets in lower Manhattan to do outreach as a peer for a syringe exchange, I always asked people I served what they needed—like truly needed. And the answer was always the same: "Money," and "Someone nice to talk to." Usually, they had already made clear another need in response to my offer of safer use supplies: "There better be drugs in there!"

But the harm reduction services I was tasked with providing as a peer worker were not designed to, nor were institutionally capable of, meeting participants' self-identified needs, regardless of whether they were queer or trans. Instead, cost-cutting government agencies and elite foundations have dictated to self-interested nonprofits what may be rationed to the underclass. The mere means of survival have been laundered as healthcare.

When the harm reduction movement emerged, survival was indeed front of mind: policymakers were leaving drug users, sex workers, and queer & trans people to die from AIDS. People who used drugs and exchanged sex had no other choice but to design their own **infrastructures of care**, here defined as networked relations between people, material resources, and knowledge, which together make care possible. The fruits of their fight to survive ripened into the harm reduction principles and practices that structured New York City's first syringe exchange programs, founded by grassroots social-movement champions, like ACT UP![2] *Nothing about us without us* and *Meet us where we are*—such are the tenets of our movement.

[2]See Sessi Kuwabara Blanchard, "What We Can Learn From Harm Reduction's Defeats," The Nation, February 15, 2022, www.thenation.com/article/culture/maia-szalavitz-undoing-drugs; Shira Hassan, Saving Our Own Lives: A Liberatory Practice of Harm Reduction (Chicago: Haymarket Books, 2022); Maia Szalavitz, Undoing drugs: The Untold Story of Harm Reduction and the Future of Addiction (New York: Hachette Go, 2021); Travis Lupick, Fighting For Space: How a Group of Drug Users Transformed One City's Struggle with Addiction (Vancouver: Arsenal Pulp Press, 2018).



But in recent years, the power of drug users and sex workers to collectively determine the institutional character of harm reduction has been eroded by an opportunistic public health establishment.

Activist-founded organizations—like my former employer, the Lower East Side Harm Reduction Center—have been absorbed by larger nonprofits that many in the movement consider to be closer to revenue-hungry businesses than people-centered groups accountable to those they serve. The lurch away from the movement's origins is well known to New York City peers—a class of essential harm reduction workers who use or used drugs, many of whom are currently or formerly unhoused and are survivors of the carceral state. Our collective dismay was cemented when we learned around 2021 that a Bronx harm reduction provider—whose tax filings show its CEO's salary leaped to nearly a half-million dollars that same fiscal year—had simply fired most of its peers. The grassroots contingent of harm reduction has faltered in making good on our movement's radically-democratic promise.

My commitment to genuinely building an infrastructure of care that actualizes the ideals of the harm reduction movement is what animated the creation of the **Re-Queering Harm Reduction (RQHR) Project**. I had been requested by the Lighthouse Learning Collective—a queer and trans outgrowth of the National Harm Reduction Coalition and a group of which I am a member—to produce a report with recommendations on how our movement could better meet the needs of queer and trans people who use drugs and do sex work (QT-PWUD/SW).



RQHR has been guided by the principle that QT-PWUD/SW—and anyone, for that matter, struggling to survive in a country enriched by their slow death—are always already finding ways to care for themselves and each other despite insufficient support.

Some may (misleadingly, I believe) call this *self-care*. RQHR instead dubs it ***embedded care***. Self-care, as a term, attempts to capture a non-professionalized quality, but in doing so it wrongly suggests that humans are capable of caring for themselves independently and individually. Instead, care requires interdependence and collaboration.[3] ***Embeddedness***[4] describes care that is provided through social relationships based on solidarity and kinship, whereas ***disembeddedness*** refers to commodified care sold on the market by the healthcare industry for the purpose of profit.

RQHR endeavors to illuminate the limits of the disembedded care provided by the harm reduction industry—if they are not already apparent. The spirit of grassroots harm reduction demands a revitalization and re-foregrounding of embedded care within the movement. Such a task demands **exnovation**: the exploration and empowerment of the *mundane, implicit routines of care, the invisible but necessary aspects of care work that promote quality*, which thereby enacts *justice to the creativity and experience of the actors involved*, as healthcare researcher Jessica Mesman has theorized.[5] Exnovation of QT-PWUD/SW's embedded care requires collaboratively building upon our collectively-devised strategies in the pursuit of a just, effective infrastructure of care.

Therefore, RQHR brought together QT-PWUD/SW based in New York City[6] to reflect upon and imagine the possibilities of two questions, respectively: *How do QT-PWUD/SW take care of themselves?* and *How can New York City harm reduction and addiction treatment organizations empower, expand, and deepen the embedded care practices of QT-PWUD/SW?*

[3]Peter Danholt and Henriette Langstrup, "Medication as Infrastructure: Decentring Self-care," Culture Unbound 4, no. 3 (2012): 513-532, https://journal.ep.liu.se/CU/article/view/2017.

[4]The concept of embeddedness mobilized here is indebted to sociologist Karl Polyani. See Karl Polyani, The Great Transformation (Boston: Beacon Press, 2001), 1-360.

[5]Isabel van Helmond, et al., "What makes for good collaboration and communication in maternity care? A scoping study," International Journal of Childbirth 5, no. 4 (2015): 210-223, https://cris.maastrichtuniversity.nl/ws/portalfiles/portal/75435904/Mesman_2015_What_makes_for_good_collaboration.pdf

[6]The funding from the New York State Department of Health that made RQHR possible circumscribed participants' residential eligibility to the 5 boroughs of New York City. The irony of such limitations for a project aspiring to liberate QT-PWUD/SW harm reduction from the dictates of funders is not lost on RQHR.



Analysis of responses to the first question found two simultaneous relations between care and drug use that pervade Participants' experiences. One relation is **prosthetic**: care as drug use. In practice, the prosthetic relation is the use of drugs as tools, as **narco-prosthetics**, for the purpose of caring for oneself, a strategy described by all 13 RQHR Participants. The other relation is **remedial**: care for drug use. It is essentially the practice of harm reduction. The two relations are adaptations, the prosthetic in response to antagonistic structural conditions, the remedial to the unintended harmful effects of the prosthetic itself.

In response to the second question, RQHR Participants imagined infrastructures of care that empower, enhance, and expand their capacities to adapt to psychosomatic, economic, and social conditions, as well as to the **surplus effects**, those unintended harmful consequences, of their own adaptations. **Psychosomatic resilience**, **economic power**, **social solidarity**; these are the principles animating the spirit of Participants' vision for the future they need.

RQHR could have recommended a laundry list of the both novel and tried-and-true interventions identified by its Participants and presented throughout the Insights Section of the Report. But to reduce the visions of RQHR Participants to particular interventions instead of structural transformation would be a disservice. Some of their identified needs are indeed unique to the particularities of their lives as queer and trans people. But as readers will see, what RQHR Participants have endured and what they know they need are surely shared by cisgender, straight, white drug users and sex workers. The means of living well are universal.

So RQHR makes a single recommendation: **democratize harm reduction organizations**. Every harm reduction worker is indispensable; their bosses are not. The true needs of participants are exclusively known by the participants themselves; funders do not have a clue.



For some, it may seem odd that a report of the Re-Queering Harm Reduction Project makes a recommendation that will undoubtedly empower the straight and cisgender along the way.

To re-queer harm reduction, though, is not to simply narrow the scope of services to the particularities of individuals identified as lesbian, gay, bisexual, transgender, queer, intersex, et cetera. To re-queer harm reduction is not to tinker with the current mode of service provision that rations temporary band-aids to select members of the underclass.

Rather, to re-queer harm reduction is to shatter the consolidation of power over the means of life hoarded by the likes of nonprofit management, funders, and policymakers. To re-queer harm reduction is to pursue a horizon where bosses are abolished and workers manage themselves together; where funders' monopoly over financial power is liquidated to the participants who will determine their own care themselves. To re-queer harm reduction is to actualize the infrastructure of care we have always needed and deserved, the one the harm reduction movement has long promised and that which we must finally deliver.

Sessi Kuwabara Blanchard



II. APPROACH



The Report is a product of Constructivist Grounded Theory[7] and its methodology. Instead of seeking to prove a pre-formulated hypothesis, the Grounded Theory method, generally, proceeds with no expectations of what the collected data may disclose, instead exercising a careful process of coding ideas present in the data and recoding them, categorizing codes by their commonalities and recategorizing them, all until nothing more can be further abstracted, leaving the researcher with a so-called grounded theory.

What is characteristic of the Constructivist tradition is the understanding that each researcher, whether she likes it or not, can not help but season her analysis with her own experiences, circumstances, principles, desires, and commitments. The Constructivist researcher—which, in the opinion of the tradition, is every researcher, whether they recognize it or not—can only ask the interview questions her expertise formulate; can only see, in the data, the ideas her eyes permit; can only generate the codes her vocabulary contains; can only abstract categories her mind imagines; and can only accept the arrival of a grounded theory once her gut tells her it is time.

Constructivists view data as constructed rather than discovered, and we see our analyses as interpretive renderings not as objective reports or the only viewpoint on the topic, wrote Professor Kathleen Charmaz,[8] the now-deceased sociologist who is nonetheless the leading Constructivist. *We construct research processes and products, but these constructions occur under preexisting structural conditions, arise in emergent situations, and are influenced by the researcher's perspectives, privileges, positions, interactions, and geographical locations.*

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[7] Kathy Charmaz, *Constructed Grounded Theory* (Thousand Oaks, CA: Sage, 2014).

[8] Kathy Charmaz, "Shifting the Grounds: Constructivist Grounded Theory Methods," in *Developing Grounded Theory: The Second Generation*, ed. Janice M. Morse (New York: Routledge, 2016), 131.

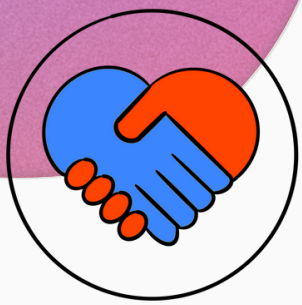


So in the Constructivist spirit, readers should understand who conducted RQHR's inquiry: a white-ish transgender woman who uses drugs—particularly heroin, fentanyl, and crystal methamphetamine—who has done full-service sex work, and is prescribed buprenorphine and stimulant agonist therapy. My own personal experiences were undeniably present in the shaping of the RQHR Project. But perhaps more consequential for the Report and my approach were the lessons learned from those with whom I have organized as a community organizer, to whom I have served as a service provider, and about whom I have reported as a journalist.

Participants were recruited through social media promotion, namely by way of the Instagram and Twitter accounts of the Lighthouse Learning Collective, and my own Twitter; emailed announcements to the Lighthouse Learning Collective listserv and other contacts; and purposive phone-based invitations to contacts I have made from organizing a Users Union, working as a peer at a syringe exchange, and simply living as a person who uses drugs and used to do sex work.

Data was first collected through an Initial Questionnaire administered using Google Forms. Questions inquired about respondents' demographics, drug use and sex work, the benefits and harms of their use, current 'self-care' strategies and those they aspire to practice, and the institutional resources, services, and care they know they need and actually want. Also posed were questions necessary to obtain the information required to generate a unique anonymizing code. In total, 36 submissions were made using the Initial Questionnaire.

The majority of data was collected through one-on-one Interviews conducted in person or by Zoom. The Interviews were semi-structured: some pre-set questions were posed to all RQHR Participants, and others were uniquely pre-formulated for each interview by utilizing the participant's Initial Questionnaire responses, while others were spontaneous follow-up questions that facilitated interviewees' further elaboration.



Individuals interested in participation first completed and submitted the Initial Questionnaire along with signed consent forms. Next, a Screener by phone or over Zoom was scheduled and conducted to determine eligibility.

RQHR required that Participants: A) currently reside or spend the vast majority of their time in the five boroughs of the City of New York; B) have used drugs without prescriptions within the past year; and C) identify with at least one of the following: same-gender attraction, attraction to people who identify as transgender, or transgender identity itself.

Screeners were not conducted when Initial Questionnaire respondents failed to schedule or attend them. Some interested individuals who completed their Screeners were determined to be ineligible and so they were not accepted as RQHR Participants, while a few who completed their Screeners and were in fact determined to be eligible were still not accepted as RQHR Participants due to time and resource limitations.

All 13 individuals accepted as RQHR Participants completed their Interviews, constituting the data that was analyzed. Upon completion of their interviews, RQHR Participants received two one-way MetroCards and a $75 Visa Gift Card.

Data analysis began by coding each set of Interview transcripts. Coding was done on an incident-by-incident basis,[9] versus a sentence or paragraph basis. Codes were compiled in a Codebook recursively developed as more transcripts were coded. The first two completed Interviews were coded alongside one another, and then the other eleven were reserved for coding once they all had been conducted, at which point they were coded in descending alphabetical order based on the first two characters of each RQHR Participant's unique anonymous identification code. Each time I coded an additional Interview transcript, I first reviewed the latest iteration of the Codebook so my analysis would build upon earlier analyses and so that I did not duplicate codes. Every Interview was coded in a round of coding, and each round produced a Codebook. In total, two rounds were conducted.

[9] "Incidents are the empirical data (the indicators of a category or concept) from which a grounded theory is generated." Passage from Judith A Holton, "The Coding Process and Its Challenges," Grounded Theory Review 9, no. 1 (2010), https://groundedtheoryreview.com/2010/04/02/the-coding-process-and-its-challenges/.



After completion of the second round, over 600 unique codes had been generated. For the sake of practicality and to ensure the most salient ideas surfaced, I weighted codes by commonality.

To qualify, a code must have been mentioned at least once by about a third of, or four, RQHR Participants, and at least one Participant must have mentioned it more than one time; 101 *common-codes* were identified. Additionally, codes just below the common threshold were included for categorization to ensure crucial emergent nuancing themes were not overlooked. To ensure the consistency of their identification, *nuancing-codes* must A) have been mentioned at least once by three participants; and B) elaborate upon a common-code, raise a novel concept, or both. The resulting Codebook thus included both common-codes and nuancing-codes.

Next, the Codebook was categorized by grouping similar codes together. Groupings were then themselves grouped together. Categorization's re-grouping process continued until no more appeared possible. Two axes of groupings appeared. One concerned broad domains: *psychosomatic*, *economic*, *social*.

The first of the aforementioned domains requires clarification. My use of *psychosomatic* emerged as I increasingly noticed the limits of *health* as a concept to categorize the nuances of RQHR Participants' experiences. *Health* suggests that there is a definite, stable, and natural state of being that is morally good. What I was hearing from Participants, however, was much more ambiguity about what it means to be alive in one's body and mind. Like health, the term psychosomatic invokes a physiological and psychological context, but elides the suggestion of a right, and a wrong, way of being.



Where the first axis of grouped categories pertained to broad domains, the second regarded factors shaping care: *structural conditions*, *adaptations to structural conditions*, the *surplus effects* of those adaptations, and the needs of an *infrastructure of care*.

Once categorization was completed, I synthesized the relationship between the axes of categories, and analyzed what they said about the primary inquiry—*How do queer and trans people who use drugs and/or do sex work (QT-PWUD/SW) care for themselves?*—and the secondary inquiry—*How can New York City harm reduction and addiction treatment organizations empower, expand, and deepen the embedded care practices of QT-PWUD/SW?* What was generated was RQHR's tentative grounded theory. I then tested the explanatory power of the tentative grounded theory by posing potentially-contradictory codes, quotes, and hypotheticals. I amended the tentative grounded theory according to any invalidations.

III. THE RQHR PARTICIPANTS



Thirteen people participated in the RQHR Project. All Participants: A) currently reside or spend the vast majority of their time in the five boroughs of the City of New York; B) have used drugs without prescriptions within the past year; and C) identify with at least one of the following: same-gender attraction, attraction to people who identify as transgender, or transgender identity itself.

AGE	# OF PARTICIPANTS	PROPORTION
15-19	2	15%
20-24	4	31%
25-29	2	15%
30-34	3	23%
35-39	0	0%
40-44	0	0%
45-49	2	15%

RQHR Participants are not representative of the overall population of queer and trans people who use drugs and/or do sex work (QT-PWUD/SW), so the project's insights should not be generalized to all New Yorkers of such experience.

RQHR Participants tended to be young. A third, or four, were between the ages of 20 and 24, the most common age range. A total of eight were under the age of 30, while five reported being older. The youngest age represented is 19, with two Participants reporting so. The oldest is 47 years old, with a 46-year-old close behind.[10]

[10]The age ranges used here are recommended standardizations published by The Lancet. See Theresa Diaz, et al., "A Call for Standardised Age-Disaggregated Health Data," The Lancet Healthy Longevity 2, no. 7 (2021): e436-e443, https://www.thelancet.com/journals/lanhl/article/PIIS2666-7568(21)00115-X/fulltext.



Overall, the majority of RQHR Participants represented marginalized demographics among QT-PWUD/SW.

Nearly two-thirds of, or eight, RQHR Participants identified as people of color, self-identifying as *Black, African American, Latino, Hispanic, Puerto Rican,* and *Dominican/(Afro-)Latino*. Most RQHR Participants are transgender or non-binary. More than three-quarters, or 10, said they have transitioned to a gender other than the one they were assigned at birth, describing their genders as *trans woman, transexual woman, transsexual, non-binary, transgender male, trans man, transmasc & gender non-conforming, male and no binary,* or *genderqueer or transmasculine*. Sex workers are almost just as common among Participants. Two-thirds, or nine, reported experience with exchanging sex; one of them identified as a client of sex workers who himself had never done sex work. The proportion of RQHR Participants who are currently or formerly homeless is nearly double the rate that the city government has found LGBTQ New Yorkers to experience.[11] More than a third of, or five, RQHR Participants are or have been in NYC shelters, and nearly just as many—four—have been unsheltered.

RQHR Participants reported use of a wide range of drugs. The most commonly used is amyl nitrates, also known as poppers, as eight, or a little more than 60 percent, reported. The next two runners-up are powdered cocaine—used by half of, or seven, RQHR Participants—and methamphetamine—used by more than a third, or five.

[11]Bureau of Policy and Research, "Results of a Survey of LGBTQ New Yorkers," Office of the New York City Comptroller Scott M. Stringer, June 2017, https://comptroller.nyc.gov/wp-content/uploads/documents/Results_of_a_Survey_of_LGBTQ.pdf.



DRUGS	# OF PARTICIPANTS REPORTING USE	PERCENT
Amyl nitrates (AKA Poppers)	8	62%
Powder Cocaine	7	54%
Methamphetamine	5	38%
Unprescribed amphetamines (including Adderall, Vyvanse, Ritalin, etc.)	5	38%
Ketamine	4	31%
MDMA/ecstasy/molly	4	31%
Unprescribed benzodiazepines (including Xanax, Klonopin, etc.)	4	31%
Psilocybin	4	31%
GHB/GBL	2	15%
LSD	2	15%
Crack Cocaine	1	8%
Heroin/Fentanyl	1	8%
Unprescribed Opioids (including OxyContin, Dilaudid, Tramadol, etc.)	1	8%
Synthetic cannabinoids/Spice/K2	1	8%
Tuci	1	8%
2-CB	1	8%
Nitrous Oxide	1	8%



In the Initial Questionnaire, RQHR Participants were asked whether the negatives of their drug use outweighed the positives. For shorthand, the drug use of those who selected *Yes* will be described here as *problematic.* The vast majority, or 11, did not affirm their use to be problematic. The two who did were both individuals who, according to their Interviews, struggled with methamphetamine. Although nearly all did not describe their use as problematic, it would also be inaccurate to characterize their use as problemless. In fact, of the 11 participants not reporting problematic use, five selected that they were *Not Sure*, instead of *No*. And perhaps contrary to expectations, eight of the 11 Participants who did not indicate problematic use still reported they would like to change their relationship with or use of drugs.

Overall, the majority of RQHR Participants reported having never utilized harm reduction or addiction treatment providers.

Only four indicated use of harm reduction programs, and just a single RQHR Participant recounted accessing safer use supplies; in his case, they were needles and syringes to be used for his gender-affirming testosterone, not for psychoactive drugs. There was a sole RQHR Participant who reported receiving services from an addiction treatment provider, which she specified in her Interview to be an Opioid Treatment Program, commonly called a methadone clinic.



IV. INSIGHTS



1. TOWARDS PSYCHOSOMATIC RESILIENCE

A. Structural Psychosomatic Conditions

The most common structural condition reportedly challenging the psychosomatic resilience of RQHR Participants was medical gatekeeping and its consequences, namely the reliance on the unregulated supply of prescriptionless or unprescribed drugs.

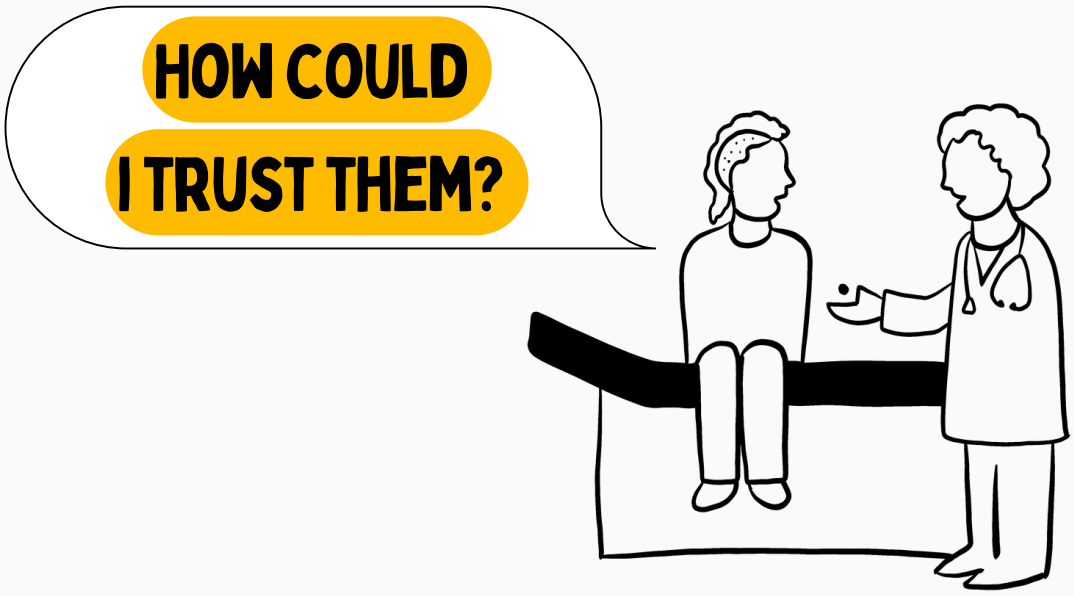
A quarter of RQHR Participants have faced significant **barriers to accessing prescription drugs**, perhaps a defining feature of medical gatekeeping for patients like themselves—those who use drugs without prescriptions.

For Participant H, addiction treatment providers refused to provide what she needed. *For my ADHD, I've had it diagnosed since childhood and even had Adderall prescribed before going to rehab.* But the prescribers there *revoked* her prescription for Adderall, as well Xanax, which was also *prescribed to me prior to rehab, where it was revoked.* Participant H's Opioid Treatment Program, colloquially called a methadone clinic, similarly refused to meet her needs: *At the clinic, they already have a bias against me. How am I going to get ADHD medication when they know me as someone who buys stuff off the street?* Participant H tried seeking care from a psychiatrist outside the often-stigmatizing field of addiction medicine, and yet: *I haven't been able to find one.* When Participant H did land an appointment, stigma seemed to animate her provider's decision to not meet her medical needs. *I've been black-balled. I went to a nurse practitioner in the neighborhood. I told him my official diagnoses from my previous psych and the medications he gave me. I go in and he told me, 'I see you take methadone.'* The consequence? *The asshole said he wouldn't treat me.* The medical gatekeeping has not stopped for Participant H even when she has secured other prescriptions. In the case of methadone, the clinic erects logistical barriers at seemingly every turn. *I'd miss days at the program from being sick. I'm immunocompromised. I have to bring my whole discharge paperwork and they have to call to make sure. They lower your dose. The program has no trust in you.*

Distrust between provider and patient, RQHR Participants explained, is a prevailing interpersonal dynamic that, in part, drives medical gatekeeping and erects barriers to prescription drugs.

A third of them reported their own distrust in care providers, and, to a lesser extent, they described prescribers' apparent distrust in themselves as patients. *I had been putting too much trust into medical situations. That doctor doesn't know me. They see me for five minutes and are going to prescribe whatever*, said Participant C. For him, as well as others, Participant C's distrust stemmed, in part, from prescribers not trusting him. *I have chronic pain. I dealt with a lot of doctors not believing it. By the time they started to recognize it, I'd been with it for so long, I didn't think I could get help from them.* To contextualize Participant C's experience: prescribers operate within a culture of cynical vigilance and a presumption of deception that has been stoked by the Drug Enforcement Agency and the authorities it has propagandized, like medical schools, licensing boards, and health departments, among others.[12]

Distrust held by both provider and patient can also be shaped by the longstanding tradition of medical paternalism. *They kept trying more SSRIs after I had horrible experiences. I knew my body and they kept asking me to do it*, Participant C recognized. *I lost trust in them.*



[12]See Sessi Kuwabara Blanchard, "How Fear, Misinformation, Stigma Have Devastated US Pain Patients," Filter, April 29, 2021, https://filtermag.org/pain-patients-opioids-fear/.

The **institutional policies and practices** driving medical gatekeeping seemed to be apparent to RQHR Participants.

The carceral state's role, for one, was obvious to Participant H: *I feel like a lot of medications are getting locked up and it's all because of stupid hearsay, fearmongering, and the police.* Similarly, Participant G noticed that prescribers *think they could get arrested* for prescribing drugs to patients who otherwise use them without prescriptions, a trend substantiated by research.[13]

Another institutional enabler of medical gatekeeping observed by an RQHR Participant is the healthcare financing regime engineered by policymakers and administered by profiteering enterprises or cost-cutting public agencies. *I knew my insurance wouldn't cover ketamine therapy*, Participant C reasonably predicted. For context, insurance companies have succeeded in usurping the authority of prescribers to arbitrate which drugs a patient needs through tactics like prior-authorization requirements and the exclusion of off-label prescriptions.[14] Without coverage, there was no way Participant C could access the drug: *It's pretty expensive.* Exclusion from regulated medicine leaves people like Participant C with no other option but to get what he needs from the criminalized market.

Medical gatekeeping itself is troublesome enough. But accessing care is made all the more difficult when patients are juggling the many other issues faced by people who use drugs without prescriptions. Or there is the simple fact that people like Participant J *have a habit of procrastinating and not doing what I'm supposed to*, he said, referencing his struggles accessing healthcare. The experiences of Participants C, H, and J are only a preview of the many harms of medical gatekeeping. *If you're around people who use drugs enough, you'll hear horror stories*, Participant C noted. The injustice of it all is far from lost on RQHR Participants. *It makes me hate them more. They cause me so much harm,* Participant H said. Participant J put it even blunter. *My PCP sucks ass.*

[13]See Cara L. Sedney, et al., "The DEA Would Come In and Destroy You": A Qualitative Study of Fear and Unintended Consequences Among Opioid Prescribers in WV." Substance Abuse Treatment, Prevention, and Policy 17, no. 1 (2022): 1-10, https://link.springer.com/article/10.1186/s13011-022-00447-5

[14]See Marie Louise Edwards, et al., "Physician perceptions of drug utilization management: Results of a national survey," Plos one 17, no. 9 (2022): https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0274772.

Medical gatekeeping has left RQHR Participants with the risky task of navigating an **unpredictable illicit supply** to get what they need, as a majority, or seven, described.

Participant A observed, *The problem has been: I'm accepting something and I don't know what it is. The sourcing aspect has always been contentious.* He noted, *A lot of systemic things would have to be legal to get a drug untainted.*

Participant B recognized, *I'm old school. I'm not used to these new things. What's on the street: you don't know what it is. It's a lot of chemicals. It's scary. A lot of bad things are on the street right now. I've had negative reactions because of scary unknown things*, which she says does not happen with the *real stuff.*

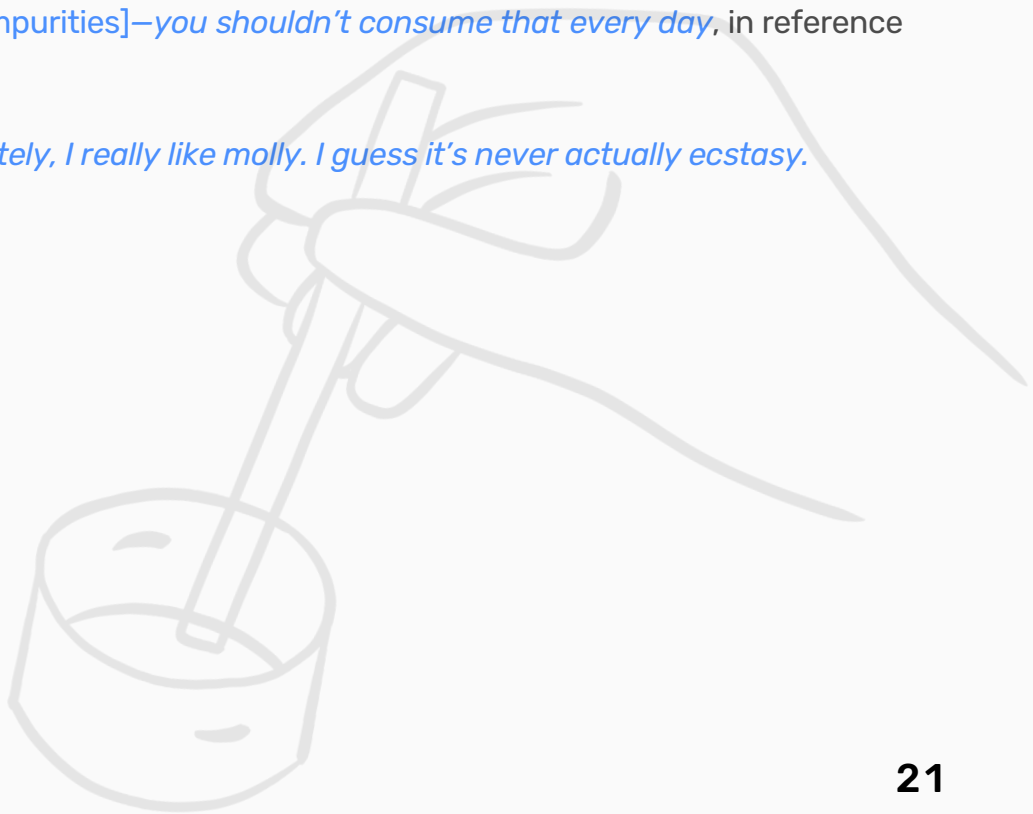
Participant D is concerned that *fentanyl is in* his unprescribed Xanax.

Participant H warned, *Dope can get very risky because of the supply. The xylazine…I'm constantly looking out for something that might taint it.*

Participant I said, *I don't see myself having any soon because I don't have a safe connection for it. Fentanyl being on the streets is crazy.*

Participant J said, *All the* [impurities]*—you shouldn't consume that every day*, in reference to crystal meth.

Participant M recounted, *Lately, I really like molly. I guess it's never actually ecstasy.*



B. Psychosomatic Narco-Prosthetics

In the face of medical gatekeeping and the unregulated supply, RQHR Participants have found coping strategies that contribute towards their psychosomatic resilience—here defined as the capacity to adapt to constant changes inside and outside the body and mind. Wielded by all 13 of them are narco-prosthetics, prescriptionless or unprescribed drugs used to enhance the capacities of the body & mind, and to thereby adapt to psychosomatic changes.

I use not to escape, but as a tool to assist me, Participant C explained. Participant H echoed the sentiment: *Drugs are there as tools.* The prosthetic aim of their drug use was largely therapeutic in nature. A sense of empowerment permeated the RQHR Interviews, exemplified by Participant C's declaration that self-medicating meant *taking control of my health.*

Two-thirds of RQHR Participants characterized their use as **self-medicating**. Not only an adaptation to medical gatekeeping, self-medicating reportedly offered benefits otherwise out of reach to patients taking prescribed drugs under medical supervision. For example, Participant H has found substances for which prescriptions cannot even be written to be **therapeutically superior to their prescribable counterparts**. *Sometimes dope just feels therapeutic. It calms me*, she said, referring to what tends to be a mixture of prescriptionless heroin and fentanyl analogues.[15] Prescribed *methadone doesn't compare in terms of effects.* Although *calming* like dope, *it doesn't help with sleep, pain. It just blocks the receptor. It's not therapeutic.* In another example, Participant M has found respite from sexual trauma suffered during sex work through a drug yet to be prescribable, despite its well known therapeutic power: MDMA.[16] Having read online about *how ecstasy is used as treatment for PTSD*, she has seen just how effective it is. *I can't even reach a place of feeling sexual unless I'm rolling. It's been transactional for so long.*

[15]Participant H detailed how she treats her pain and sleeplessness with unprescribed and prescriptionless drugs. *I use heroin for sleep and some pain issues I have, and for calming down if I can't access benzos*, also noting she specifically takes prescriptionless fentanyl analogues for reduction in certain chronic pain. *But when there is no supply available for fent or H, I use them* [unprescribed opioid pills, including Tramadol, oxycodone, hydrocodone] *to prevent withdrawal or for muscle-relaxing properties, for targeted pain management.* Similarly, she will take unprescribed Xanax to *help with withdrawal from opioids, to help me sleep.*

[16]See Jennifer M. Mitchell, et al., "MDMA-Assisted Therapy for Severe PTSD: A Randomized, Double-Blind, Placebo-Controlled Phase 3 Study," Nature Medicine 27, no. 6 (2021): 1025-1033, https://www.nature.com/articles/s41591-021-01336-3.

Differently, the therapeutic benefits unique to self-medicating were attributed by Participants C and G to the **autonomy** of using drugs without prescriptions.

It was very important to me to have more control over my life, said Participant C, expressing a sentiment apparent across RQHR interviews. Self-medicating with unprescribed ketamine allowed Participant C to *still be able to connect with people*, adding, *I can be around people I want to be around, not be in a clinic*, where ketamine therapy is usually administered. *I've done enough of my medical shit.* The importance of social connection for drug use is explored at greater length in Section 3.

Mental health concerns were a common object of self-medicating for RQHR Participants, one-third of whom characterized their use as supportive of their mental health.[17] Ketamine, in particular, was recognized by three RQHR Participants to do so. *I understand the purpose that ketamine has. For me, that means it's provided a lot of positive mental health effects*, said Participant G. The sentiment was echoed by Participant C: *My use of K is about my health*, in reference to mental health, as well as bodily pain. The unique ways ketamine improves mental health were specified by Participant L. In his case, it *lets the other voices be a little quieter. The part of me that's making narratives in real time is quieted by K, consensually. I'm not repressing it. It feels okay. I find it with poppers, too. I feel more present with K. Sound. Motion in my body. It gets me out of one part of my head and into other parts.*



[17] Researchers have found other people who use stimulants report similar mental health benefits of using stimulants. See Liam Patrick et al., "'The drugs did for me what I couldn't do for myself': A qualitative exploration of the relationship between mental health and amphetamine-type stimulant (ATS) use." Substance Abuse: Research and Treatment 15 (2021): 108. https://journals.sagepub.com/doi/pdf/10.1177/11782218211060852.

Half of, or seven, RQHR Participants reportedly self-medicated to relieve psychological distress.

For Participant H, *heroin-fentanyl just relaxes my body. When I get stressed out, I hold it in my body*, she said. *Using has totally helped me learn how to relax my muscles and learn where I'm holding stress in my body.* Just as some enjoy a glass of wine after work, heroin-fentanyl, for Participant H, *helps me wind down after a stressful day.* In addition to unprescribed benzodiazepines, cannabis was a commonly-reported destresser among RQHR Participants. *I use weed to deal with my anxiety. I catastrophize. I use weed to take a breath*, said Participant I. Such a sentiment is shared by Participant F: *Since being in New York City, I'm not gonna lie, I see it as my only safe haven. When I smoke, it brings me back down to reality*—and that includes synthetic cannabinoids, a class of drugs colloquially called K2 and generally thought to have nothing but negative mental health effects.[18] But for Participant F, K2 *keeps me calm and collected.*

The self-medicating function of RQHR Participants' use is not limited to the treatment of existing concerns; it can prevent them before they even begin. Half, or seven, identified improved functioning as a benefit of using drugs without prescriptions. *I was always trying to prove I was smart but the tests and stuff would pile up and I couldn't do it. With the Adderall, I could finally do it*, said Participant H, recognizing that the stress of falling behind and the frustration of not being able to demonstrate her ability has been allayed by Adderall. *I could get something done in five minutes that I had been putting off for weeks. It gave me my life back.* Adderall's stigmatized cousin, crystal meth, can just as well enhance the capacity to take on the challenges of everyday life,[19] as Participant E has found. *I can be more thoughtful. I'm more functional. I can do things better. Otherwise I feel like I'm walking through wet sand*, she said. RQHR Participants' ability to function was not limited to stimulants. Participant C makes use of ketamine for improved general functioning, while Participant H self-medicates her fear of going outside. *I have agoraphobia. I take a little* [heroin-fentanyl] *and it helps me get over those apprehensions.* And other times, *when I'm sometimes afraid to walk out of my house to do basic things, it* [Xanax] *allows me to.*

[18] See "About Synthetic Cannabinoids," Center for Disease Control and Prevention, last modified March 23, 2021, https://www.cdc.gov/nceh/hsb/chemicals/sc/About.html.

[19] See C Dreams, "Prison Didn't Rehabilitate Me, But Using Meth in Prison Did," Filter Magazine, June 7, 2022, https://filtermag.org/meth-prison-studying/; and Matthew G. Kirkpatrick, et al., "Comparison of intranasal methamphetamine and d-amphetamine self-administration by humans," Addiction 107, no. 4 (2012): 783-791, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3475187/

C. Psychosomatic Surplus Effects

IT STARTED AS A COPING MECHANISM. AND THEN IT GOT OUT OF HAND.

Participant F articulated a sentiment that was widely shared by RQHR Participants: **self-medicating can slip into toxicity**. But they do, nonetheless, adapt, optimizing their use of drugs by practicing embedded harm reduction techniques independent of service providers.

Participants' experiences illuminate the fundamental contradiction of drugs, defined by what's called the **pharmakon**,[20] the capacity of all substances to become medicinal or toxic, depending on a multiplicity of situational factors. Just as many expressed that using drugs without prescriptions treated their anxiety, stress, and ability to function, so too did two-thirds, or eight, describe **negative impacts on their mental health**. But bear in mind: only two affirmed in RQHR's Initial Questionnaire that the overall negatives of their use outweighed the positives in the past year.

Notably, all six RQHR Participants who use crystal meth reported associated mental health concerns.

Participant E is one of them: *Sometimes it makes my mental health issues worse. I can get paranoid. It's a lot of internal battles. Using crystal consistently, my mental health is worse. It's hard to gauge what's really real. Seeing things. Like right now, I have a floater, a little black dot. I'm like, 'Is that real?'*

Participant B feels similarly: *Just take a couple blows, it drives you anxious, drives you crazy. It's not just me. I think all the people using this substance have depression.*

And Participant J: *Discovering it was magical. I jerked off for seventeen hours straight. It's not the same as that anymore. Is my brain damaged? Are my dopamine receptors ever gonna be the same?*

[20] See Jacques Derrida, "Plato's Pharmacy," in Disseminations, trans.Barbara Johnson (London: The Athlone Press, 1981), 61-172; andRob Shields, "The Force of the Intoxic –The Addict Saint," Rhizomes: Cultural Studies in Emerging Knowledge 36 (2020), http://www.rhizomes.net/issue36/shields/index.html

Paranoia, in particular, was a common concern, mostly for RQHR Participants who smoke crystal meth, but also for a Participant who sniffs cocaine. For Participant K, the paranoia tends to kick in after staying up for nights on end smoking. The longest is three to four days. *I see shadows*, they said.[21] Participant J, in fact, was experiencing paranoia in the middle of our RQHR Interview. He paused, looked behind himself, and then turned back around to share that he *just heard sounds in the stairs, scenarios that are not even there.*

The suffering that crashes down on RQHR Participants after using crystal meth—generally called a **comedown**[22]—was identified by those who use the stimulant as a significant concern. *The comedown is so hard: can't sleep, can't eat, get dehydrated. I passed out in the street and was hospitalized*, said Participant E. Similarly, Participant K tends to become *very moody*, *tired*, *dehydrated*, and *not hungry*. Additionally, Participant K expressed another, perhaps less recognized, element: shame. *When I'm coming down* [...] *and then when I'm in the bed,* [...] *in my head it's like 'Why did you do that?' I feel disgusting. Stupid.*

Cravings are another challenge that emerges after crystal meth use. Participant J shared that he wants to change his relationship with crystal, but what comes after he puts down the pipe is what brings him back: *I've tried stopping five times. They* [the cravings] *haunt me like a motherfucker. If I gotta do something—meet my lawyers—it's so hard. The cravings are so bad. The seventh day, I manage to find some ice shards and went and bought a pipe and butane, and lit that bitch up. I felt like I came up from underwater. I felt like I could breathe again.*

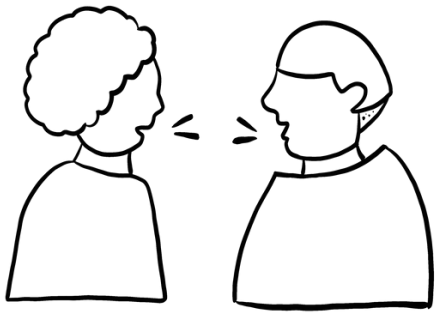
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[21] Participant K shared: *I'm scared you could get stuck in the paranoia from meth-associated insomnia.* Their concern suggests that people who use crystal meth could benefit from accessible, tailored education about its mental health consequences, as well as strategies to prevent and treat them.

[22] Comedowns were reported by RQHR Participants who used drugs other than crystal meth. Overall, regardless of drug type, half, or seven, indicated experiencing some sort of come-down. Participant F's K2 and cannabis comedown: *The hardest part is getting past the first few days of having not used. Also, it's very hard to sleep and eat. I slept maybe four hours last night.* Participant D's psychedelic comedown: *There's much more of a comedown with LSD. You don't want to fuck up your brain if you're not careful.* Participant M's MDMA comedown: *The crashes have been horrible. I will probably spiral.* Participant H's cocaine and Adderall comedowns, respectively: Because of the comedown, *it's more of a negative in my life more than anything else* and *No one can prepare you for that despair.*

The **imperative to self-moderate** when self-medicating is a formidable challenge, as Participant J exemplified and half of, or seven, RQHR Participants expressed overall. How the challenge is navigated can mean the difference between 'self-care' and unintended 'self-harm.' Like in Participant G's experience with ketamine: *It's hard sometimes to incorporate it healthily. Like a friend I don't like to hang out with all the time. Especially because I love it.* Part of what makes self-moderation so difficult, as experts have explained,[23] is the **ambivalence** people often feel about their use, something characterized by a third of, or four, Participants. Like Participant G, Participant J described the nuances and contradictions of enjoying yet suffering from his relationship with crystal meth:

> I'M ADDICTED TO THE FEELING OF BEING HORNY AND ADDICTED TO BEING A CHASER. IT'S NOT ONLY THE SEX PART. IT'S AN ADVENTURE. I LOVE THAT SHIT. IT'S NOT VERY HEALTHY. I DON'T GIVE TIME TO MY FRIENDS. I GIVE IT PRIORITY. 'FUCK MY DOCTOR'S APPOINTMENT, I'M GOING TO GO TO THE BRONX AND FUCK THIS GIRL AND BE HIGH AS A KITE.'



[23] See Patt Denning, Jeannie Little, and Adina Glickman, Over the Influence: The Harm Reduction Guide for Managing Drugs and Alcohol, Guilford Press, 2003.

D. Psychosomatic Harm Reduction

Despite the challenge of self-moderation and the confounding nature of ambivalence, RQHR Participants do indeed find ways to manage their prosthetic use of prescriptionless & unprescribed drugs, and ways to reduce their harms.

RQHR Participants outlined a variety of practices that can be categorized as **autonomous use-management**, a person-directed, collectively-strategized approach that is **embedded**—meaning it is integrated into one's personal habits and non-transactional social relationships. The **disembedded** form of use-management is what prescribers call 'medication management.' Autonomous use-management seeks to maintain the desired coping functions and therapeutic outcomes of drugs, doing so, in part, by maximizing the benefits and minimizing the harms. In this way, it includes, but exceeds, typical conceptions of harm reduction. One of the indicators of RQHR Participants' practice of autonomous use-management comes from the results of the Initial Questionnaire: more than half of, or eight, Participants affirmed that they want to change their drug use—whatever that may mean for them—but they do not believe the negatives of their drug use outweigh its positives.

The most common autonomous use-management practice reported by RQHR Participants was **moderation**. Three-quarters, or 10, spoke to moderating **quantity**, and two-thirds, or nine, to **frequency**. One reported approach is to pre-identify, then stick to, a dosing plan. *I try to take drugs in small quantities*, said Participant A, adding, *I use in shifts.* Participant C thinks similarly: *Keep it calculated in terms of frequency and dose.* A variation of moderation, called titration,[24] has helped Participant E to mitigate the worst of comedowns. *I moderate when I'm coming down. I make sure I have enough to come down slowly.*

Two-thirds of, or nine, RQHR Participants stressed the importance of **using with intention** for effective moderation. Avoiding thought patterns like, *'I'm just going to say I feel like it and do it,'* Participant C recommended, *Have a purpose for it.* Without one, Participant I warned, *If you're not watching yourself, you can feel yourself feeling the need to take a hit.* Participant F has adapted to that urge: *I try to make sure I'm using in moderation and keeping track of my high and asking myself, 'Do I really need more? Is the level of high I am right now good enough?'* So, given that Participant C's purpose of ketamine is to self-medicate, Participant C decided to go *about it the most medical way, without medical institutions.*

[24] See Sessi Kuwabara Blanchard, "What You Need to Know About Meth Withdrawal," Healthline, October 26, 2021, https://www.healthline.com/health/substance-use/meth-withdrawal.

Maintaining clarity about why one is using is far easier said than done. Nonetheless, three RQHR Participants stressed its value in moderating their use.

Self-reflection is key for Participant G: *Even if I make bad decisions, I try to reflect.* The outcome he has enjoyed? *Being attached to something and being able to recognize why—that can be healing.* So is **self-understanding**. *There's a lot of power in knowing yourself and knowing what not to use*, said Participant C. There are consequences of not doing so, Participant G has learned. *That's the thing: if you don't know who you are going into substances, you're going to have an awful time.* An example of such consequences was shared by Participant I, particularly in the case of using psychedelics. *You can't run away from what your mind wants to focus on in the trip*, he said, explaining, *While you're under the influence of shrooms, you can't exactly push down on something you're welling on unconsciously because it'll just bring it to the surface.*

Moderation involves the recognition that there is a **time and place for, and for not, using**, as raised by Participant I—*I shouldn't smoke before sleep because I'll become congested*—as well as by Participant L—*The only type of boundaries with substances that work for me is time and place; using only at certain times of the day.* This intentional boundary-setting seems to require an understanding—recognized by a third of, or four, RQHR Participants—that one can love drugs but know they're not needed all the time. *I know I can't consume every day. I'm an all-day person. If you have to have it in your life, you have to figure out why you can't use it everyday*, said Participant G. In the particular case of MDMA, Participant M acknowledged that *it doesn't sound like a drug you can use forever. I'm kind of navigating that right now*. Participant H learned that the hard way with heroin-fentanyl: *There was a really nice time when I started dope and I would just take it and watch movies. I naively thought I could keep this going without this escalating to becoming a burden.* But Participant H has adapted, learning that breaks are needed for heroin-fentanyl to function as she intends it to. *There are days I don't use. I take breaks. Just to chill out. I'll have a detox day. Just to reset it.* So too does Participant I with LSD: *I try not to use it for a month after using. I would set a date a month away as a minimum for when I use it next.*

In addition to considerations of when and how much, moderation includes decisions about what to use. Some RQHR Participants maintain vigilance about the **quality** of the drugs offered to them by others. Without widely available drug-checking technology, other techniques have been developed to ascertain the substance's relative safety. In the context of using with a stranger, *let them do a lot and I do a little*, said Participant A. To avoid the bad reactions suffered from adulterated crystal meth, Participant B has learned to pay attention to certain characteristics of the crystal meth itself. *I try to identify the real stuff. In my experience, it smells so bad. That's not right. It just turns to a mass. That's how I know.* [25]

Beyond moderation, autonomous use-management can mean **renourishing** the body, according to RQHR Participants' accounts, especially when the drugs used to self-medicate may disrupt eating, hydrating, and resting. It is no wonder, then, that the most detailed reflections on renourishment came from RQHR Participants who use crystal meth. As they described, renourishing after using drugs, especially crystal meth and other stimulants, is no simple matter.

Learning how to renourish one's body is a process, some RQHR Participants explained. For Participant E, it was a hard one: *I was dehydrated and I passed out on Sixth Avenue at six in the morning. Now I'm a lot more aware if I'm going out somewhere. I try to be a lot more aware, a lot more hydrated.* Participant B observed, *So many people don't eat or don't like to eat.* She outlined her hard-learned tips that she shares with other trans women who use crystal meth: *I try to tell them, 'You can drink a shake from the delis.' Just buy one of the shakes or a meal. Whatever your stomach can accept. If you don't have appetite, your stomach will not accept solids. So: drinks. For food, it begins with shakes, or drinks completely with protein. After I take that and take a nap, I can accept solid food.* In Participant J's experience, *I take vitamins, drink water, and eat foods—that helps with anxiety.*

Renourishing is more than just what is consumed, noted some RQHR Participants. It is also about **setting aside the time** for the body and mind to rest. *I take time for getting better: try to sleep, get some food–the body needs food*, said Participant B. Similarly, Participant M said, *I try to make sure I have time to recover from the inevitable crashes*, during which *I eat lots of fruits and vegetables. In the past it was difficult. Now that I have it, EBT is a blessing. I used to eat a lot worse and that didn't help with the crashes.*

[25] Some of the techniques practiced by Participant B have been elaborated at great technical lengths by online drug user communities, like on Reddit, but such posts appear to have been deleted since I last read them.

Tak[ing] my medication, in the words of Participant B, is another strategy to recover after using. For some, that looks like **self-medicating side effects** with another drug.

Consider the experience of Participant J. He enhances his use of crystal meth by additionally self-medicating with phenibut, an unregulated drug chemically similar to GHB and that is available online. *Drugs give me anxiety but they also help. I take phenibut and it helps. I take that everyday and it's a god-send*, adding that it *takes my anxiety away and gives me euphoria and makes me horny. It makes me able to smoke meth. If I didn't take it, meth wouldn't be as enjoyable.* For Participant H, a patient at an Opioid Treatment Program, methadone is part of how she manages her use. *It just helps with lessening use to something manageable until I can figure out something manageable. I am enrolled so if I can't access anything, I won't get sick.*

A product of medical gatekeeping, the harm endured by RQHR Participants is largely preventable. They have adapted to structural hostility by practicing embedded harm reduction strategies on their own and in community. In effect, people who use drugs without prescriptions have already laid a foundation upon which the harm reduction industry can expand. Yet what is offered as services today is out of step not only with how RQHR Participants are already caring for themselves—but with what they need.



E. Infrastructure for Psychosomatic Resilience

RQHR Participants imagined profound transformations of what and how harm reduction and addiction treatment organizations can support their psychosomatic resilience.

Visions range from radically novel infrastructures for stimulant agonist therapy, safe supply, and Supported Comedown Spaces; as well as enhancements and expansions of existing infrastructures for moderation support, drug-checking technology, and therapy.

Moderation support is the most common need identified by RQHR Participants for psychosomatic-resilience infrastructure. *I knew tolerance was a thing, but didn't know how to control it*, said Participant F. The existing resource for moderation support most widely identified—observed by half, or six—is easily-accessible, drug-specific **education and tools for safer dosing**. For example, what Participants G and H have already found helpful, and of which they would like to see more, include, respectively, *information on how to use these drugs and how to do it safely*, as well as *those little spoons* that Participant H feels *are really helpful to meter your dose out. I realized it's really important to dose it out.*

Support with setting and working towards drug-use goals is another potential part of a moderation support program that a third of, or four, RQHR Participants identified. The autonomy of self-medicating can be therapeutic in and of itself, as presented earlier in this section, but it can nonetheless be difficult to manage alone. That's why Participant G would like care providers to offer him *more accountability* for sticking to their goals, and Participant F expressed wanting *just encouragement and better coping skills*. Moderation support should attend to more than just drug use in the cases of people like Participant J, who is active in the Party 'n' Play scene[26] and wants support with *control[ling] my sex drive*, *which drugs make go through the roof*. For someone like Participant D, a moderation support program could be an alternative to traditional addiction treatment. *I don't need rehab, just services that help me get rid of* what he considered to be his excessive use of unprescribed benzos.

[26] See Sessi Kuwabara Blanchard, "A Guide to Chemsex: What Is It, and How Can You Make It Safer?," Healthline, July 1, 2021, https://www.healthline.com/health/substance-use/chemsex.

Undoubtedly, dosing education and tools, as well as goal-setting support, would enhance RHQR Participants' autonomous use-management. But some feel strongly that the most powerful option is to simply prescribe the substances otherwise used without prescriptions—and the same number endorsed that it would be therapeutic if provided by trusted medical practitioners. *If all those things could be prescribed under the supervision of a doctor*, Participant H began, referring to unprescribed amphetamines and benzodiazepines, as well as prescriptionless heroin-fentanyl, *and someone could help me with dosing and making sure it's helping me with what I want to do with myself, that would be ideal. That would be a great change to my life.* After all, the whole reason drugs are even prescribed is because medication management requires pharmacological expertise. It is also because people have busy lives and should not have to bear the burden alone. *I saw that there was a benefit of the medicalization of it. You don't have to be the person in control, like you're not the one who has to stay in control*, said Participant C.

Two RQHR Participants were specifically interested in **stimulant agonist therapy**,[27] the practice of prescribing amphetamines, like Adderall or Vyvanse, to substitute, or at least support the autonomous use-management of, crystal meth or cocaine. Participant E, herself, shared that unprescribed *Adderall in the past helped me function with crystal*. Participant J's crystal meth use has also been stabilized by a similar pharmaceutical amphetamine: unprescribed *Vyvanse helped tremendously*. *Only one pill: that's all it takes. Adderall wasn't as good as Vyvanse. Vyvanse is just as strong and extended.* But neither were prescribed the amphetamines by their medical providers. Participant J's doctor—who, according to him, *sucks ass*—had never informed him that it could be prescribed for anything other than ADHD. With no medical monitoring, Participant J suffered harm that could have been avoided if a prescriber set his dose and educated him on the risks of taking more than prescribed. On one recent occasion, he took three Vyvanse capsules a couple of hours apart. *I felt a jolt, one heartbeat like 'Boom!' My heart rate was fast as fuck. And my blood pressure was high as fuck. I called an ambulance. They took me to the hospital. It went down and they took me back. And then it came back. I went back to the hospital.*

[27] See V.S. Tardelli, et al., "Prescription psychostimulants for the treatment of stimulant use disorder: a systematic review and meta-analysis," Psychopharmacology 237 no. 8 (2020): 2233–2255, https://pubmed.ncbi.nlm.nih.gov/32601988/.; and Masoumeh Amin-Esmaeili, et al., "Patterns of reduced use and abstinence in multi-site randomized controlled trials of pharmacotherapies for cocaine and methamphetamine use disorders," Drug and alcohol dependence 226 (2021), https://www.sciencedirect.com/science/article/abs/pii/S0376871621003999.

Both RQHR Participants did not mince words about the life-changing promise of stimulant agonist therapy. For Participant J: *A supervised Vyvanse prescription would help. It would help anyone. It helps with the cravings and gives me the energy. It has to be supervised because a dumb-ass like me takes three and goes to the hospital twice.* The benefits would extend beyond just moderation support in Participant E's case; it would maintain her overall health. *A prescription would help. Get me out and function. I would be less pressed to sell my HIV meds to buy tina.*

Prescribers agreeing to meet RQHR Participants' needs is half the battle. The other is changing how they engage their patients. **Medical providers need to build trust**, a third of RQHR Participants recommended. Breaking down the medical profession's paternalistic attitude is key, suggested Participant C: *The doctor being direct, open, saying 'I have no agenda to make you stop.' Part of the issue is the medical world is so vague. If they were just saying directly what was happening to me, there wouldn't have been any issues.* Two Participants spoke directly to the need for providers to demonstrate that they have the patients' best interests at heart—and therefore will not punish them for simply being upfront about their lives. *It's so important to be honest, but we're so scared of being discriminated against. We're so scared of not getting the prescriptions I need. I'm scared to tell them about my Adderall use because I'm afraid I'll be seen as addicts*, said Participant G. Similarly, for Participant H, it's important *having one doctor who isn't biased and knows about addiction medicine and keeps up with the literature; and isn't bigoted so I can be honest with them; so I can say I've used things and not be seen as a liar and then actually be prescribed* what she needs. Her advice to doctors?



BELIEVE PEOPLE ABOUT THEIR PAIN.

Four Participants were familiar with and called for the **establishment of safe supply programs.**[28] Participant H stated, *I would like to be a part of a safe supply program that's not gatekept. [...] I could do a safe supply of fentanyl for sure. I would feel strongly about the availability of heroin, either as a powder, pill, tincture, but nothing intravenous.* She is *not sure about getting Dilaudid*, as Canada has offered for nearly two decades.[29] She envisioned her ideal safe supply program functioning as a *one-stop shop for your needs*.

Participant A said, *If drugs were legal, I'd have trust in it. If I could get crystal, I'd feel good about where it came from.*

Participant D advised, *Provide a safe supply and allow for titration* when people no longer want it.

Participant L proposed, *Decriminalize and safe supply.*

The RQHR Interviews made apparent a vast unmet need: support for coping with stimulant comedowns. None of the Participants who use crystal meth had accessed, much less knew of, any care providers offering tailored services. Two Participants spoke to the dearth of education available. Crystal meth and the struggle of its comedowns *should be more broadcast. They don't talk about tina, especially in the LGBT communities and organizations. It's not talked about*, said Participant K, sharing that the programs in which they do participate *don't really talk about it* unless they're in a group. *But a lot of people don't speak about it.* Participant C concurred with regards to unprescribed Adderall, lamenting: *The comedown—nobody ever told me how bad it is.*

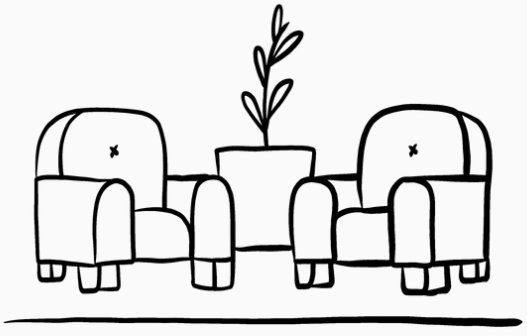
[28] See B. Pauly, et al., "A concept mapping study of service user design of safer supply as an alternative to the illicit drug market," International Journal of Drug Policy 110 (2022): 103-849, https://www.sciencedirect.com/science/article/pii/S0955395922002651.; and"THE D.U.L.F. AND V.A.N.D.U. EVALUATIVE COMPASSION CLUB AND FULFILLMENT CENTRE FRAMEWORK," Drug User Liberation Front and Vancouver Area Network of Drug Users, February 28, 2023, https://www.dulf.ca/framework.; and"SAFE SUPPLY: Concept Document," Canadian Association of People who Use Drugs, February 2019, https://www.capud.ca/capud-resources/safe-supply-projects.

[29] See Nadia, Fairbairn, et al. "Injectable opioid agonist treatment for opioid use disorder: a national clinical guideline," Cmaj 191, no. 38 (2019): E1049-E1056, https://www.cmaj.ca/content/191/38/E1049.short.

Two-thirds of, or four, RQHR crystal users indicated a personal need for comedown support resources. Participant K imagined a novel model: **Supported Comedown Spaces**. *If I had someone there, it would be less depressing. Just the presence. Being able to distract myself*, said Participant K. Having a safe space to go to while coming down would not only help them cope with the negative mental health impacts, but also the insomnia. They believe they could *fall asleep if I were with someone*, explaining *it's about comfortability*—something that they see Supported Comedown Spaces providing.

The four RQHR crystal users, in their own ways and to varying extents, imagined a place to 'land' as an individual and as a community, where they could rehydrate, sleep soundly, get a hot meal, and socialize in a calm environment. Above all, *You have a safe space. You probably meet people and connect*, Participant K described, adding, *My dream comedown center: weed, a meditation spot, a game room, nap room. LoFi music in there. A food room. A playroom, a bounce house. It's giving dreamcore. Music like 'Men I Trust', Kali Uchis.*

Programmatically, RQHR Participants envisioned Supported Comedown Spaces being equipped to support people however they may show up. Dehydration, malnourishment, and sleep deprivation would be common.[30] To be cared for, too, is the toll of comedowns on mental health. So Participant K reminds Spaces-to-come that they must be prepared to support potential participants who may *feel suicidal*. They also recommended that *of course, people who used to do* drugs—particularly those who are *empathetic, non-judgemental; people who want to be there*—should be leading and staffing Supported Comedown Spaces. At minimum, New York City should have *one in every borough, so everyone can get to it*, Participant K said.



[30] Recommendations from RQHR Participants for dehydration and malnourishment included: supplying an abundance of nourishing food, water and other rehydrating electrolyte-rich low-sugar beverages; keeping sugar consumption to a minimum when using stimulants, especially crystal meth and crack cocaine, to support dental health.

The co-location of a Supported Comedown Space with an **overdose prevention center** (OPC), as safe use sites are called in New York, was considered by Participant H, in fact the only Participant who expressed a personal interest in participating in an OPC. (A few others supported it conceptually, but could not see themselves going to one.)

She saw the two models as complementary: *You could go to the other place where you don't have to see people using,* she said. *Like a meditation room, a quiet room. You can go where you need to go to bring yourself to baseline.* Similar to Participant H's description, the two existing authorized brick-and-mortar OPCs in New York have drop-in centers, and one has a peaceful holistic health space, but they are far from full-fledged Supported Comedown Spaces, as Participant K had imagined them.

Participant H was at first skeptical of OPCs: *I'm on the fence because it feels so sanitized.* When asked how the uncomfortable atmosphere could be avoided, she replied: *Not a bunch of rules. It would be very organic. If you wanted to, just sit down on a couch.* Similar to Participant K, she was adamant about the staff having current or past experience with drug use.

Imagining innovative interventions was just as much a part of the RQHR Interviews as was affirming the value of tried-and-true psychosomatic infrastructures of care, and the need for their expansion and enhancement. **Drug-checking technology** was one such resource, its utility endorsed by a third of, or five, RQHR Participants. One Participant desired the *general ability to access testing* for their prescriptionless drugs, two specified *fentanyl test strips*, and another appreciated *the ability to have those Dance Safe kits*[31] [...] *to make sure you're taking what you're taking*. Participant G expressed interest in the more advanced tech that New York City[32] and other regional governments[33] have been, or are going to be, offering through harm reduction programs—but they want *not-clinical drug checking*, preferring a user-managed model genuinely embedded in community.

[31] See "Ready to #TestIt?," DanceSafe, https://dancesafe.org/drug-checking/

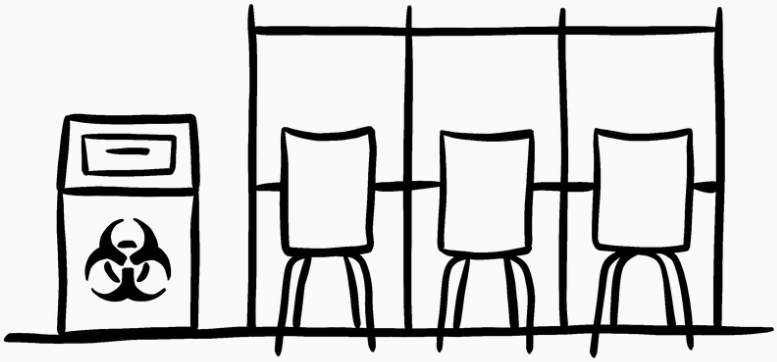
[32] See "Mayor Eric Adams Takes Action to Curb Opioid Overdoses by Expanding Access to Tools to Test for Fentanyl, Other Lethal Substances," New York City Office of the Mayor, August 5, 2022, https://www.nyc.gov/office-of-the-mayor/news/575-22/mayor-eric-adams-takes-action-curb-opioid-overdoses-expanding-access-tools-test-for.

[33] See Abdulla Shihipar and Alexandra Collins, "To Combat the Overdose Crisis, Expand Drug-Checking Programs," WIRED, May 31, 2023, https://www.wired.com/story/to-combat-the-overdose-crisis-expand-drug-checking-programs/.

Talk therapy was affirmed by half of, or seven, RQHR Participants as critical for their psychosomatic resilience. *Therapy was super important. Therapy once a week, therapy in groups—I knew I wasn't by myself*, recounted Participant A. But therapists able to provide the care drug users need have been hard to find for Participant M, while Participant B feels uncomfortable diving into her drug use with hers: *I'm not talking about all the things with my therapist, I don't know it's not a person who's competent. He's a professional but not close with me.* Another shortcoming of most community-based mental health providers is that they are not designed for acute psychiatric crises, as Participant H knows all too well:

I'VE HAD DEPRESSION WHERE I'VE NEEDED TO GO TO THE HOSPITAL BUT COPS WERE CALLED. I'D LIKE TO BE ABLE TO GO THERE AND SAY I NEED HELP WITHOUT HAVING LAW ENFORCEMENT THERE.

The infrastructure of psychosomatic resilience that RQHR Participants need spans a diverse range of novel and long-developed models that are both rooted in the autonomy and self-knowledge of their patients and participants. People who use drugs without prescriptions must lead the design processes and make the final decisions about the care they will be receiving. After all, they are the experts; experts whose expertise was acquired as a matter of necessity in the face of medical gatekeeping and the unpredictable illicit supply.





2. TOWARDS ECONOMIC POWER

A. Structural Economic Conditions

Economic disempowerment was by far the most widely and most deeply discussed structural condition among RQHR Participants.

Two-thirds, or nine, expressed that their **economic position conditioned the risks** they face in their lives. Sex work and its accompanying drug use are functions of some's **exclusion from employment**. Participant B began selling sex because it was necessary, she said, noting her circumstances as a transgender woman of color: *No job. I was looking for a job for a long time. I had no opportunities. Applying for restaurants, manicure [salon]. no one would give me the opportunity to work*. Similarly, exclusion from above-ground work pushed Participant M, a white trans woman, to sell sex: *I started sex work after being fired from a nonprofit.*

In addition to unemployment, **exclusion from housing** is a form of economic disempowerment reportedly shaping the risks confronted by RQHR Participants. *It's part of the token of being homeless: a lot of the locations do not have a baseline level of safety*, Participant I observed, drawing from his first-hand experience. Such hostile conditions demand survival tactics that themselves engender risk: *When I didn't have a home*, said Participant A, *I'd have to stay up all night* outside.

Participant A's ability to self-determine both where he sells sex and where he uses drugs had been undermined when he was unhoused. *In the past when I have done sex work, I was in a survival mode*, Participant A said, recalling a particular moment when his economic precarity determined the risks he had to take: *It was snowing and I had to make moves to get a coat, and I did something I wouldn't usually have*. Without permanent housing, self-determining his own drug use was at times unrealistic, Participant A explained, recalling, *If I was couchsurfing*, smoking crystal meth *would be a requirement of the environment. If you're in someone's apartment, you're gonna be around it. My ability to manage that situation would be totally different* if housed.



Exclusion from housing leaves people who sell sex and are homeless, like Participant D, with few other options but to accept risky clients. *If someone came up to me, I would do it*, he said, predicting his response to a street solicitation. Unemployment has also put Participant D in vulnerable positions. At one point, he was able to get a job through a sexual transaction—but it turned violent. *I met a girl who worked at Chipotle. We met up before and she said, 'We can have sex and I'll get you a job there.' I was essentially raped. It was consensual and felt like rape. She pulled hair, was physically abusive. I shut my eyes.*

The setting in which a sex worker is able to see a client, or in which a person is able to use drugs, can make the difference between safety and danger, according to three-quarters of, or 10, RQHR Participants. The **lack of access to safe private spaces**, including a home of one's own, narrows sex workers ability to protect themselves. *I was homeless*, Participant A recounted, *I didn't have that power* to self-determine whether to *go to Eighth Avenue* [...] *and see what happens versus* a more economically-empowered strategy, like by *going on an app or someone hitting me up to be talent* in porn. Participant E has faced first-hand the harms of having nowhere to go to do sex work: *I started at twenty-four, working the street. I got arrested*, adding, *When I was working out on the street, I was just braving the elements*.

Without a suitable place to conduct an incall—a term for hosting clients––sex workers' other option is an **outcall**, a riskier one where clients host on their own familiar turf. The vulnerability of outcalls for sex workers, in part, stems from the material imbalance of power. *If you have an apartment, but I don't*, sex workers like Participant A can be coerced into accepting unpleasant offers he would otherwise not take, like if *you want me to walk around naked*, he said.

Participant B is fearful of all the unknowns that outcalls spell. *Sometimes I go to apartments. I have no choice. They just tell me to come. I just go and do my job. Especially when I do outcalls at these places, it might be unsafe. I'm scared for many things about the client, the place; I don't know who's there.* Fear plagues Participant M, as well: *With Grindr, I'm concerned about outcalls, especially when it was far, that would freak me out; far into Queens or in Long Island. When you walk out and you're in fucking eery, eery places.*



The **demands of survival sex work**, and the underlying fact of economic disempowerment, have troubled RQHR Participants' ability to independently decide whether or not to use drugs with clients.

THESE GUYS ARE USING THEM. IF I DIDN'T USE THEM, I WOULDN'T HAVE A JOB, SAID PARTICIPANT B.

Participant E has had a similar experience: *A client introduced me to it: 'Come on come and try it.'* Some feel pressured to smoke crystal meth, in particular, with clients. Straightforward coercion can be at play. *We have no choice sometimes. Sometimes the clients are forcing you to use it*, Participant B explained. There's also a financial incentive. If you're using drugs, she has found, she will *get the best pay from the client. Sometimes it's just that, I have to accept money and accept drugs.* The promise of bonus cash played a role in Participant K's introduction to crystal meth: *When I was 16, in 2017, a Caucasian man in Connecticut 'put me on.' He paid a little extra.*

The risk generated by **economic disempowerment can be undone by economic power.**

NOW IT'S DIFFERENT. IF I DIDN'T HAVE A HOME, I'D HAVE TO STAY UP ALL NIGHT. NOW I DO. GET A HOTEL. BUT BEFORE I WAS HOMELESS, I DIDN'T HAVE THAT POWER. I CAN GET IN A LYFT IF I'M NOT FEELING WELL. BUT I USED TO TAKE THE TRAIN OR THE BUS AND GO BACK TO THE THE SHELTER, SAID PARTICIPANT A. AS MY ECONOMIC SITUATION IMPROVES, I CAN BE MORE SELECTIVE IN WHAT I CHOOSE.



B. Economic Narco-Prosthetics

RQHR Participants are survivors, not victims, of economic disempowerment. Although the structural condition indeed shapes their use, they nonetheless wield drugs as narco-prosthetics for economic survival, similar to how drugs have been elaborated above as tools of psychosomatic coping despite medical gatekeeping.

Drugs are critical tools, particularly for sex workers, to make a living. Nearly every RQHR Participant who sells sex—to be exact, eight out of nine of them—expressed variations of what Participant B made explicit: ***Substances are necessary in sex work***. For one, using stimulants **enhances the capacity** of sex workers to do their job, as nearly all RQHR Participants who use crystal meth reported. Participant B is one of them, and she smokes it *mainly for the energy*. It also *makes me awake a long time*, enabling her to *get more clients, to do more clients*, and to *bring in more money*. Cocaine has similarly boosted Participant M's stamina: *There would be some really messy nights where I'd see three clients and I'd do a lot of coke.* Additionally, crystal meth, as well as coke and unprescribed Adderall, have given Participant M the boost needed to secure clients in a cutthroat online market. *With Grindr*, Participant M explained, *you need energy to sift through the bullshit. You need to be really quick. Uppers helped me with that.* Participant A needs the induced energy to stay alert. *Crystal allows me to be in the present environment*, he said. *If I'm around it, it keeps my senses keen. Take a pull; it allows me to exist in the environment.*

The sex expected by clients can be challenging. Workers use drugs to make it less so, the majority of sex-selling RQHR Participants reported. Drugs can **lower inhibitions**, empowering sex workers to still secure their bag, as it were. In Participant A's experience, crystal meth *loosens you up*. *It helps me relax,* especially when he is asked to do something he would not usually do with his personal partners. *If someone wants to do rimming, I can do it and relax*, thanks to crystal meth. Participant L, a trans man, is also expected to step out of his comfort zone by clients. *I honestly don't bottom for the majority of my sex life*, he said. *I use poppers more in sex work than in my sex life*, he said, attributing it to *the type of sex*, specifically getting topped by the client. Poppers are also *helpful* for him because *it's icebreaking in the way sharing most substances is. It's a way to make people feel comfortable*. Participant L is far from alone in appreciating poppers' assistance in getting the job done; in fact, a third of RQHR Participants expressed similar reasons for their use of them. *Of the times I've had poppers, those have been the better experiences*, said Participant F. With the head rush of poppers, Participant M feels that *I don't have to think about the dysphoria. I need it to get off.*



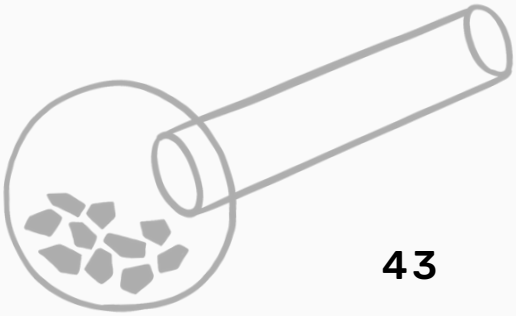
Drugs can also make sexual labor **more bearable**. A third of RQHR Participants described their use as a coping strategy for sex work.

> **I DON'T LIKE TO HAVE SEX WITH CLIENTS, SAID PARTICIPANT K, BUT SMOKING CRYSTAL MAKES ME MORE COMFORTABLE.**

Participant F echoed the sentiment. *If I'm not high or not attracted to you, it's really hard to do it. The whole time in my head, I'm like, 'It's the longest hour of my life*,' he said. *But if I have smoked*, either cannabis or K2, *it's easier.* Likewise, for Participant D, *the benzos helped me get through it, especially 'jellies*,' a street term for Xanax. At stake in tolerating a session until the end is economic survival, as Participant M pointed out, explaining the necessity of drugs in sex work: *I have to disassociate to get through an experience to make rent.*

Just like the psychosomatic uses of drugs, their economic applications are similarly ruled by the contradiction of the pharmakon: what has proven instrumental can become harmful. Participant M exemplifies the duality of stimulants. *Without them, I'd have panic attacks at my make-up vanity if I didn't have something to push me through that*, she said, referencing her preparation to see a client. But as is the nature of the pharmakon: *Sometimes they'd bring on panic attacks. Does a really nervous person need something to make them energetic?*

Responding to her own rhetorical question, the reality of economic disempowerment and the necessity of drugs for economic survival, despite the pharmakon's inevitable descent into toxicity, is embodied in Participant M's answer: *Sometimes no, but sometimes I needed it to just do what I needed to do.*





C. Economic Surplus Effects

RQHR Participants' drug use and sex work empowered them to make a living despite structural conditions of economic disempowerment. But the contradiction of economic narco-prosthetics can be found in their surplus effects, those excesses of their drug use and sex work that sour the deal.

Purchasing prescriptionless or unprescribed drugs bled the bank accounts of RQHR Participants, a problem expressed by the majority of those among them who do sex work. Responsible for such avoidable economic harms are the **criminalized-market prices artificially inflated** by the policies and carceral enforcement of prohibitionist laws, namely the Controlled Substances Act.[34] Nearly half of, or six, RQHR Participants discussed the **harms of the high costs** of drugs. *The financial aspect is bad*, Participant H said of her heroin-fentanyl purchases, lamenting that she was *spending money I don't have, going into debt.* The harm of such prices reaches beyond Participant E's economic position and to her psychosomatic wellbeing.

> AFFORDING TINA CREATES ISSUES. I STRUGGLE TO BE CONSISTENT WITH MY HIV MEDS. I SELL THEM SOMETIMES. I NEED THE EXTRA MONEY FOR CONDITIONER, SHAMPOO—BUT MOST OF IT GOES TO TINA.

Participant F's ability to care for himself has also been undermined by the artificially-inflated prices. His mental health, in part, relies on him using drugs to cope with sex work, but he often struggles to afford them. Participant H made clear the implications of policymakers' decisions to needlessly inflate the prices of drugs sold on the criminalized market. *For me personally, if there weren't these systemic things that cause problems—like the financial burden of, or the risks of, an unregulated supply*, she said, her use of drugs would be *more of a net positive.*

[34] See Jeffrey A. Miron, "The Effect of Drug Prohibition on Drug Prices: Evidence From the Markets for Cocaine and Heroin," National Bureau of Economic Research, Working Paper 9689 (2003): 1-43, https://www.nber.org/system/files/working_papers/w9689/w9689.pdf.



The economic position of RQHR Participants, including their ability to earn an income, can be undermined by their use of drugs. Even though crystal meth reportedly helped every RQHR Participant who uses it to cope with sex work, Participant K, like others, reported that the stimulant's surplus effects—such as the *comedown, not wanting to do anything*, and *feeling sick*—consequently ***stops my ability to work***. They also fear such effects will impinge on their economic prospects after sex work. *Crystal will stop my future goals from happening*, Participant K feared, which for them include, *to have money, to be stable, to do cosmetology or to be a nurse.* They added, *It will affect my ability to participate* in the job training program in which they are currently enrolled. Similarly, Participant H, who does not do sex work, shares the fear that her drug use will impact her employability. But Participant H's concerns are not about whether her use of heroin-fentanyl will incapacitate her. Instead she worries about the legalized discrimination against people who use drugs without prescriptions.[35] By using heroin-fentanyl, Participant H reasonably believes that it *bars me from certain employment that I know I might enjoy doing 'cause I know they'll be testing.*

Doing sex work itself is a tool for economic survival, but it nonetheless can have **psychosomatic consequences**, as nearly half of, or six, RQHR Participants have reportedly experienced. Participant B's use of crystal meth during paid sex has posed an issue for her adherence to psychiatric medication. *I was diagnosed with PTSD, so I get regular medication for depression and anxiety. So when with clients and when I'm high, I stop using my medication.* Differently, the very experience of sex work, for Participant M, troubled her sense of self.

AFTER LEAVING SEX WORK, I'M FEELING ALMOST ASEXUAL. I WAS PRETTY SEXUAL BEFORE GOING INTO SEX WORK. BUT I STARTED PUTTING UP A LOT OF WALLS WHEN PEOPLE STARTED FLIRTING WITH ME. I SHUT THEM OUT, SHE SAID, ADMITTING, I HAVE A LOT OF UNPACKING TO DO. I'M CONFUSED WHERE I'M AT WITH MY BODY. I HAVE TO GO TO THERAPY.

[35] The Americans with Disabilities Act, and the Human Rights Laws of New York City and New York State, all exclude substance use disorder patients who continue to use unprescribed or prescriptionless drugs from protection against discrimination by employers. In effect, policymakers have legalized anti-drug-user discrimination.

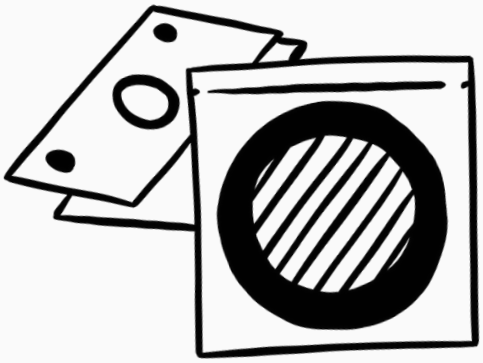


Sex work takes a toll on the body. Participant L has endured an intense embodied strain:

MY BODY WAS BREAKING DOWN.
THE WAYS IN WHICH THE JOB IS PHYSICAL CAN BE DIFFICULT.
I CAN`T DO FULL-SERVICE FULL TIME.
IT`S TOO MUCH ON MY BODY,
TOO MUCH ON MY MIND.

Clients already exhausting sex workers' bodies sometimes become violent, especially in the context of economic disempowerment, as Participant E suffered: *One year I had 3 concussions from clients. A client pissed on me and shit on me and wouldn't let me leave. I had a concussion and was covered in human feces.* Participant B put it bluntly:

CLIENTS PUT ME ON SOME TRAUMA.





D. Sex Work Harm Reduction

Anticipating and responding to the harms of economic disempowerment, RQHR Participants have developed harm reduction strategies for sex work.

As elaborated earlier, RQHR Participants have adapted to economic disempowerment by using drugs. They have also adapted to the risks and harms of of sex work and its associated drug use. For half of, or five, of sex-working Participants, one such tactic is **drawing boundaries** between paid-sex's necessitated drug use and their personal lives—an approach surely familiar to any above-ground employee who leaves work at the office. Crystal meth *gets me through it*, said Participant A, adding, *I wouldn't use it in my personal life.* Participant K's line is not as hard and fast: *I use tina almost exclusively in the context of sex work—occasionally socially with the girls, but almost entirely in sex work.*

Much of reducing the risks of sex work and its associated drug use, for more than a third of, or five, RQHR Participants, has to do with being intentional about spatial **setting**—which is of course easier said than done when economically disempowered. **Vigilance**, though, can be practiced regardless of who chooses the setting. *Be aware of your surroundings. Know where you're going, who the person is*, Participant K recommended. Participant L maintains vigilance through moderation of use. *I don't want to be high all the time*, he explained, *because I want to be on guard.*

Participant A used to be homeless and had little say in where he saw clients. But things have changed now that he is housed and employed: *I try to **tailor my location** when someone's gonna bring* crystal meth. In his experience, tailoring settings can make a *big difference: having control and having no control, walking into your environment with your drugs, being in safe environments.* A third of, or five, RQHR Participants framed **hotels as safer settings** for sex work. *I used to like outcalls. Depends on if I'm going to a hotel or their home*, said Participant E, explaining, *If you go to their house you have to deal with someone potentially coming home. The hotels are nicer.* Participant M considers *hotels* to be *neutral ground*.



When hotels are too expensive and outcalls otherwise seem too risky, sex workers are left with in-calls, which received mixed reviews from RQHR Participants. Participant M weighed the pros and cons: *During the pandemic, hotels were shut down and I had to host. It was hard and I had to convince my roommate to let me. I became less precious about my bed*, she said. *At first it felt out of necessity, but over time I liked the control. I generally enjoyed outcalls, but there was a bit of ease with incalls.* In contrast, Participant K's stance towards in-calls is straight-forwardly disinterested. *Meeting up at my house or their house?*, they posed. *I prefer going to them. I'm very spiritual. I don't like the energy. It stays in my house.*

Harm reduction strategies for the surplus effects of economic narco-prosthetics help, but they are not a solution. *It's hard working in certain spaces. There has to be a level of comfort. You gotta pick your environment,* said Participant A. He intimately knows what it is like to not be able to. Not all RQHR Participants have been able to secure housing and legalized income, as he has done. People need options, he believes.





E. Infrastructure for Economic Power

Transforming the conditions of economic disempowerment into an infrastructure for economic power demands bold interventions, as RQHR Participants explored.

Although RQHR Participants have found ways to survive despite the hoarding and price-hiking of private property in New York City, sex workers need affirming, empowering spaces of their own. Perhaps that is why an RQHR Participant who does sex work re-imagined traditional drop-in centers into a novel model: **Sex Worker Waypoints**, spaces where they can gather together before or after sessions for social-emotional support, access to resources and services, and the opportunity to prepare for or unwind from seeing clients. Sex Worker Waypoints are compelling for Participant M because she sees them as an antidote to *the alienation I feel going home after a session.*

Echoing Participant K's sketch of a Supported Comedown Space, as presented earlier in the subsection on Infrastructure for Psychosomatic Resilience, Participant M imagined the possibilities of a Sex Worker Waypoint in a strikingly similar stream-of-consciousness:

There would be decent amenities to draw you there that isn't a bar post-session. An in-house masseuse. All sorts of things to take care of your body: yoga mats, those rolling things over your body, everything easy on the body. Food, a kitchen, fridge. We could take turns stocking it full of fresh stuff. Whoever is there could take turns: 'Who's doing the cooking, cleaning?' I'm thinking about TV, music, and a nice sound system.

PLACES TO SLEEP IN ADDITION TO COMFY FURNITURE.

SAFE SEX AND HARM REDUCTION SUPPLIES, STI TESTING.



The idea of Sex Worker Waypoints emerged from an initial exploration of **Safer Sex-Work Sites**, where workers could see clients with dignity, security, discretion, and autonomy. Participant M's preference for Sex Worker Waypoints over Safer Sex Work Sites stems from a strongly held stance. *I firmly believe in a separation from where clients go. No clients allowed*, she said, explaining: *There's something called 'client mode' which sex workers enter when you're around them. You can butt heads when you're going for the same.* She has navigated client-mode herself. *Times I've bought rooms with other girls: I don't want to be fighting with who's using the bed. The last time I did it, I wasn't able to see a client. If it was bigger and there were multiple rooms that could be cool.*

Participant K had concerns about Safer Sex Work Sites too, but not because of potential competition with fellow sex workers. *I like to be discreet. It could be a bit messy*. For that reason, Participant K felt like they *wouldn't use it.* But then they started thinking more about it: *It should be a discrete location, tints on the window, like a strip club. Clients go in the back.* With the right approach, they ended up selling themself on it. *If it was a hotel site, that would be lit. I would do that. A nice hotel. Comfortable, clean. My own bathroom, my own room. TV. LED lights. Free services, bongs and pipes*. Participant K endorsed Safer Sex Work Sites offering harm reduction services as well as *a plug service for anything*, resonating with RQHR Participants' earlier endorsement of a legalized safe supply of drugs.





Novel models serving the particular needs of specific populations were affirmed by RQHR Participants, but they emphasized with far greater urgency the imperative to secure for themselves and their communities the **fundamental economic resources** that all humans need to live well. For Participant B, *the most important thing with me* is having the opportunity to have *another job*, regardless of whether she continues to do sex work. Some Participants have been able to secure their basic necessities. As a result, they are able to refuse the risks of sex work they once had to accept. *Now that I have stable housing and make more money, it's more supplemental than for survival*, said Participant A, explaining, *If people had more access to more resources than just a little food stamps, they wouldn't have to make choices they don't want to make with their backs against the wall.* **Dignified well-paying jobs** provide the most hope for Participant B and her community of fellow trans women of color who do sex work and use crystal meth. *I believe all my sisters doing sex work, if they have opportunities for a good job, they'll take it. We're doing sex work because we don't have it, she said. We have a better future for our community with good jobs, with good payment. We'll be going out of the street.*

RQHR Participants described a number of **psychosomatic benefits offered by good jobs**. After years of full-time full-service sex work, Participant M was recently able to transition to a job about which she is passionate. She has already seen **improvements in her quality of life**: *I think my body has been getting stronger. Sex work has led me to being sedentary too much. If I'm not working I'm not doing anything. This job gets me out of the house. I've been eating more.* Good jobs, as two RQHR Participants elaborated, are an effective means to **restore sex workers' ability to self-manage their drug use**. Participant B experienced it first-hand: *Having another job at another company has helped me so much with stopping substances. In my opinion, if we have more jobs, if you're busy working, you don't have time to do drugs. That happened with me. When I was working*, she said, *I was using less. With those two jobs, I had to compromise: I couldn't use. It was only recreational, socially. It is much much less than* [when] *doing sex work and using. If we have more spaces in jobs, we stop using substances*. Good jobs stand to benefit all drug users, as attested to by Participant H, who does not do sex work. *Work would decrease my use. It's hard to be discreet. You have no time. You're always working with someone who knows. My brain would just be preoccupied. My use would probably decrease.*



There is much that would need to change to create an infrastructure of good jobs freely available and accessible to all drug users and sex workers. Participant D called for ***less discrimination in jobs***. Another exclusionary force is **poverty wages**. Sex workers can make hundreds, even thousands, in just one hour of labor. Such a wage is unheard of for the vast majority of US workers. *What fucks me up: this new job, what I made in an hour I make in a week*, Participant M noted. *Those numbers just don't work. That fucks me up. I try to remind myself that this is where I'm starting. Capitalism feels really fucked up. This has felt like my best option. But it's an insane amount of work. I'm now questioning if I'm making the right choice.* To recruit and retain sex workers, they—and everyone else, for that matter—deserve to be paid more than just a survival wage. Drug users' exclusion from the workforce is also shaped by **a lack of accommodation** for their everyday struggles, as Participant H has experienced:

> I HAVEN'T BEEN ABLE TO FIND ANYTHING SOLID SINCE THEN. I'VE BEEN HOME DOING WHAT I CAN TO SURVIVE, ODD JOBS, FREELANCE, THINGS I CAN DO FROM HOME. I'VE GOTTEN SICK AGAIN SO MANY TIMES. THERE'S A VERY BAD TIME LAST YEAR WHERE I GOT INCUBATED. I WANT TO KEEP IMPROVING MY HEALTH. AT LEAST PAY THE BASICS.



RQHR Participants envisioned labor justice for drug users and sex workers—and their vision extended to jobs at harm reduction and addiction treatment organizations. Their take? **Pay drug users** to provide psychosomatic care to others within their own organic networks, as a third of, or four, Participants recommended. To be clear, what they are proposing should not be conflated with existing peer programs, in which drug users tend to be paid poverty wages, given no job security, and sidelined from decision-making processes,[36] as Participant M pointed out. *I saw peers being misused in nonprofits. These people are doing the on-the-ground work and they don't get paid well.* Proposing a transformation that would, by definition, end the plight of peers, Participant G strongly advocated that harm reduction organizations shift to being drug-user run. He knows the interest and demand is there: *I think a lot of people already have these desires but don't have the money. I know people who would want to make this their job. We need to start taking control of our drug consumption because we're the ones who are using the drugs.* Participant A believes harm reduction organizations can only stand to be more effective by *taking the aspect of the underground and bringing it to the forefront.* But Participant G was hesitant to endorse completely folding drug users into nonprofit organizations, a type of entity they see as deeply flawed and burdened by its legal limitations. Participant G, instead, prefers *collectives* that are genuinely and deeply embedded in community, such as the one they are a part of that distributes harm reduction supplies and convenes social gatherings, among other things.

IT'S INDEPENDENT.

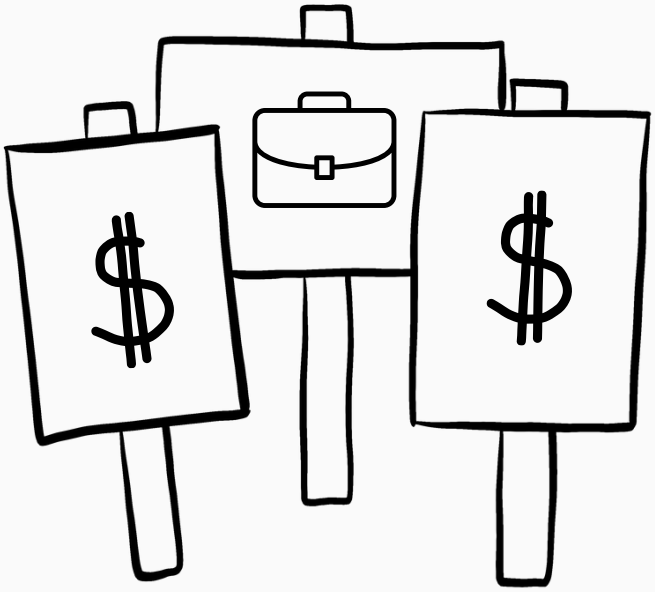
WE'RE DOING IT BECAUSE

IT NEEDS TO GET DONE.

[36] See "Equity & Inclusivity for NYC Peer Workers," Peer Network of New York, June 2022



It can not stop there, though. Two-thirds of, or eight, RQHR Participants demanded service organizations **commit to justly investing significant amounts of money in supports that drug users and sex workers actually find useful**. It should be noted that no participant mentioned utilizing or expressing the need for more access to safer use supplies. (Granted, no participant disclosed injection drug use.) For one, sex workers and drug users need support in making the career shift. Two RQHR Participants, both of whom are trans women, identified the need for **effective job training programs** that meet them where they are. *If there was a training program for sex workers, that would be cool*, Participant M said. At the time of her interview, she had recently completed a woodworking apprenticeship, describing it as having *married technical skills with soft skills.* For a program to be effective, sex workers and drug users need to be equipped with knowledge and skills that go beyond writing a resume—though that is important. *If the program was just soft skills it wouldn't be that effective*, Participant M explained. *It's more potent when it's married with technical skills.* Participant K is currently enrolled in a program that facilitates acquiring both, including by *help[ing] you get into trade schools and internships.*





There was a pervasive sense among RQHR Participants that harm reduction and addiction treatment organizations were **failing to recognize the significance of and address the economic disempowerment** faced by those they serve. Some Participants were acutely aware of the disparity between the revenue reaped by service organizations and their own participants' economic disempowerment. *The organizations are making a lot of money. These organizations need to put resources for sex workers, for substance users, for housing and food*, said Participant B. *But they don't. They owe us a lot of money.* Zeroing in on the Opioid Treatment Program industry, Participant H similarly diagnosed the profiteering and called for greater investments in what patients like herself need to live. *I don't think the methadone clinic is designed right now to help people. It's to funnel money to a small number of people. The social workers have to know that there's something they're doing that's not working. The revolving door. The abstinence-only is infuriating. The focus on take-homes is draconian. Help us find education, jobs, help us with appointments.* Participant H additionally urged, *There should be someone making sure you're not food insecure. They should make sure you have Medicaid. They have the money to do this but they don't. You're doing it yourself but they're getting paid. They just print out numbers to call and tell you to call them*. Even smaller economic resources offered by harm reduction and addiction treatment organizations could go a long way, Participant A believes, like *Vouchers for barber shops. 'Here's a phone, now you don't have to pay for a phone.' Financial instruments.*

RQHR Participants envisioned an infrastructure of care that prioritizes building economic power, a demand rarely made of the harm reduction and addiction treatment industry and one that warrants their urgent and authentic engagement. Participant H put forth something of a challenge to which those committed to supporting people who use drugs and do sex work can aspire:

> **I WANT TO SEE A WORLD WHERE USERS DON'T GET LOCKED OUT OF WORK OPPORTUNITIES, OR HOUSING OPPORTUNITIES, AND LOCKED OUT ON THE STREET, OR HAVE SOME CONDITION THAT COULD HAVE BEEN FOUND YEARS AGO. GETTING LOST IN THE CRACKS IS SO EASY.**



3. TOWARDS SOCIAL SOLIDARITY

A. Structural Social Conditions

Alienating social norms structure the experiences and outcomes of drug use, according to RQHR Participants.

The ways in which Participants felt with those around them determined, in part, the risks they faced, a factor coming in second to economic conditions as RQHR Participants' most frequently and widely discussed structural risk factor, with two-thirds, or nine, doing so.

The social norms of the drug scene unique to New York City have shaped some RQHR Participants' use. A third, or five, characterized **stimulants as central** to queer and trans social networks in the city, and to a lesser extent, ketamine within a more niche sect of the community. The use of crystal meth by Participant K escalated upon arrival to the city. They had done *a little bit* of crystal in their hometown, but once in the Bronx, it *became more used out here* for them, in part because *a lot of people do it in the city.* Participant G had a similar experience, but with ketamine. *New York changed my relationship with drugs and my boundaries with drugs, in good and bad ways,* said Participant G, who is active in Brooklyn queer rave culture. *So ketamine: there's no way around it. When you're in nightlife here, you're going to run into it. It's so normalized. The amount and frequency I was using was so normalized.* Participant G attributed some problems he developed with drugs to the **normalization of unmoderated use**.

> WHEN I HAD THAT ISSUE WITH KETAMINE, IT WAS BECAUSE I WAS AROUND OTHER PEOPLE WHO HAD THAT, HE SAID, ADDING, YOU JUSTIFY IT BECAUSE MY FRIEND DID THAT, AND THEY'RE FINE. SO MUCH OF DRUG CULTURE IS 'MY FRIEND DID IT AND THEY'RE FINE.'

Structural social conditions were less discussed in the RQHR Interviews than psychosomatic and economic conditions. But, as elaborated in the following subsections, social relationships were nonetheless consequential for how Participants care for themselves and each other.



B. Social Narco-Prosthetics

The importance of social connection pervaded RQHR Participants' conceptions of care and their drug use.

Just as was characterized with regards to psychosomatic and economic narco-prosthetics, drugs proved to be instrumental tools facilitating the formation and strengthening of bonds between Participants and their networks. According to nearly half, or six, drugs **enhance social connection.** *I didn't have a lot of social interaction with people my age growing up. I didn't know how to have one-on-one interactions when people go from strangers to friends*, Participant I recounted. Social alienation could have set in for him, but instead, he has found that *weed helps me get out of my own worries. I'll feel more inclined to talk about my problems.* Others also endorsed the instrumental use of drugs to strengthen their ability to connect with people. *Cocaine makes me more sociable*, said Participant H, also noting that it helps her *focus a little bit more in social situations.* In Participant G's experience, ketamine *helps with my connection and has lowered my inhibitions socially.* Social drug use, for Participant L, *has improved my nights out*, but the benefits did not stop at the end of the night: *Using has absolutely improved my life.*

Working both ways, drugs have the power to **remedy social alienation**. *Drugs can bring people together*, said Participant L. Take Participant M's experience navigating trauma from sex work. She had been struggling to tolerate the intimate connections she nonetheless desired to find at the club. *I'm a nervous wreck and can't fully engage with the dance floor,* she said. But MDMA gave her relief. *I felt fucking great. I could dance. I was flirting with this guy and it felt really great. I'm not doing this to secure the bag. I'm just talking to this guy*, Participant M recounted. *We just had a nice conversation. I could see in the near future turning to molly to have a gratifying sexual experience.* Also in the context of queer nightlife, drugs have helped Participant G buck the standoffishness felt at clubs or parties:

> **JUST BECAUSE I HAVE A BUMP—I NEVER WOULD HAVE TALKED TO THEM—WE BECAME BEST FRIENDS. THERE'S SOMETHING VERY INTIMATE ABOUT THAT.**



Cocaine helped Participant H connect with others at a time when everyone was self-isolating. *I've been pretty depressed. During COVID, everyone was*, she said. *With casual use, I was able to open up to people in a social sense more.* In addition to cocaine helping her overcome disconnection, Participant H has found that heroin-fentanyl fostered for her a sense of community that facilitated her emotional healing. Ironically, the opioid often stereotyped as the drug of loneliness[37] had instead

HELPED ME FIND PEOPLE I CAN GRIEVE WITH. AND NOT BE ALONE WITH TRAUMA.

Using drugs helped Participant I move on from a childhood of social alienation. *I wasn't getting the proper social stimulation I needed growing up. Until becoming homeless, I've lived in a box my whole life .* Things changed when he left home. Unhoused and presented with an abundance of social opportunities, Participant I has increasingly used cannabis and it has helped him to connect with others in a way he had not been able to earlier in life —and with whom he would have otherwise struggled to engage.

WEED HELPS ME TALK TO PEOPLE. WEED HELPS ME LET GO OF MY ANXIETY, IF AT LEAST FOR A MOMENT, AND RAMBLE ABOUT THE STUPID LITTLE HOBBY THINGS I'M INTO.

[37] "In popular depictions, bonds of family and friendship are turned away from and the person gradually finds themselves alone, together only with the substance. Characterisations such as these have extensive roots in historical understandings of addiction, with substance use and social relationships having been positioned as mutually exclusive since at least the late 1700s." Excerpt from Laura Roe et al., "Isolation, Solitude and Social Distancing for People Who Use Drugs: An Ethnographic Perspective," Frontiers in Psychiatry 11 (2021): 1.



C. Social Surplus Effects

Just as drugs can be a tool for bringing people together, their surplus effects can keep people apart.

Nearly half of, or six, RQHR Participants reported that their drug use has at times undermined their social connections. **Struggling with autonomous use-management** has distanced some RQHR Participants from others. Participant L recalled his routine experience of *feeling shitty and just coming home and smoking and watching TV.* It's complicated for him: *the act of isolating myself feels better in the moment but hurts more in the long run.* Participant H's *depression and social isolation* seem to stem from her use of prescriptionless fentanyl analogues, in particular, she said. Her goal is *to have a normal relationship with them, where they're not affecting my relationships.* Forging affirmative connections when struggling to manage drug use is a struggle of its own, Participant G shared: *You have to have a lot of strength to find those* [supportive] *people. It's so hard if you're engaging in drugs unhealthily.*

For other RQHR Participants, **drug use itself can socially alienate** them from others. For example, Participant B said she chooses not to use crystal meth when with her uninitiated loved ones—in effect, isolating herself, to an extent—out of fear of how it might impact their lives. *I prefer not to use with friends. It's something I don't want to share with people I love. It's difficult: I don't want to pass the addiction*, she said. *I can't bring someone new into this world. I have to separate it from people I love.*



Even as RQHR Participants enumerated how drugs can bring out the best in people, some have seen how drugs can **amplify the worst.** *They'll poison your dog*, said Participant E, recounting a time when *a guy fed him crystal. I won't have them there without me. They've done things to my computer.* Consequently, her social life has declined; crystal meth *impacted a lot of friends*, she said. *I don't have a lot of people coming. People can't be trusted.* Participant K has become guarded as a result of friendships spoiled by altercations relating to crystal meth. *Guys are just messy. Especially on the drug. It showed me more about people, about so-called friends,* they said, recalling a particular instance: *One of the guys does tina. He wanted to have sex, and I didn't want to. But we didn't have sex. When I left he called me and was calling me names after the fact. Now I don't talk to people because of that.* They don't want to deal with some of the qualities they have encountered among some in the crystal meth scene:





D. Social Support as Harm Reduction

Overwhelmingly, RQHR Participants described experiences that frame social support as a vital means to optimize their psychosomatic well-being.

Nearly half, or six, characterized **social use as harm reduction.** *With K, I want to be with other people even if they're not using,*[38] said Participant L, asserting that he takes care of himself by *using with people I know, not using alone.* What he is describing has been captured by the popular harm reduction maxim, *never use alone*, which Participant A explicitly referenced as a strategy he uses. Usually recommended to prevent overdoses, 'never use alone'[39] is *more of a habit-forming prevention* tactic for Participant L. Similarly, only using drugs socially or occasionally, according to Participant F, is a way for him to get a handle on drug use with which he is already struggling. Participant I has taken a similar approach: *I've tried to dwindle down on having to use it all the time. And make it social.* Using with trusted people can also reduce immediate harm. *It helps quite a bit that I have someone with me*, Participant I said, in reference to psilocybin trips.

> IT'S ALWAYS GOOD TO HAVE SOMEONE THERE WHO FEELS COMFORTABLE. A TRIPSITTER WOULD TYPICALLY KNOW HOW TO DERAIL FROM WHAT YOU'RE FOCUSING ON.

[38] Participant L did qualify their social use, suggesting sometimes it was not needed: *I do trip on shrooms alone.*

[39] The phrase 'never use alone' is a general mantra of harm reduction. It also became the name of an overdose prevention hotline for people to call and stay on the line with while they are using drugs. If the caller becomes unresponsive, the hotline operator can contact EMS. See Never Use Alone, https://neverusealone.com/.



One-third of RQHR Participants emphasized the importance of **non-transactional social support**; that is, care driven by mutuality, not money.

> **TRY TO TALK HOW YOU FEEL WITH SOMEONE, SAID PARTICIPANT B. I HAVE A FRIEND, VERY CLOSE FRIEND. I AM MORE COMFORTABLE TELLING HER THINGS THAN MY FAMILY. IF YOU HAVE SOMEONE, TELL THEM. TO LET ALL THOSE THINGS INSIDE YOU OUT.**

Effective social support must be **non-judgmental**, asserted a third of RQHR Participants. For friendships to be supportive, Participant C explained, *it takes a degree of openness*. Having affirming social support changed Participant A's life. *I was able to get out of the situation because I had a community, a non-judgemental community.* So too is the case for Participant I—but only after he lacked it for years. *I lived with my mother who is not supportive. I'm Dominican and come from Hispanic culture which doesn't value mental health and even being gay is not heard of. I was the only trans person in my family I know of, and even if there was, they would have been ostracized, he said. I've been better without my family. I put myself around people who uplift me, people I want to surround myself with.*

The care Participant B receives from friends is far different from what paid providers are able to offer. *I'm not talking about all the things with my therapist. I don't know*, she said. *He's a professional but not close with me.* Instead, Participant B turns to her friend. *I take my phone when I'm having a bad moment. She talks me down. She knows me. She knows about substances*. Similarly, for Participant M, having a friend who has a shared experience has made all the difference. *I don't have words for where I'm at sexually,* she said, explaining that *When you're a former sex worker, it's a common trend to go from very hypersexual by necessity, to not sexual.* She also went from feeling alone to feeling heard: *Talking to a friend has been really helpful. She is very similar.*

The importance of **friends sharing similar drug-use goals** was recognized by RQHR Participants. *You have to have people around you who have a similar relationship with drugs*, Participant G asserted. Through those connections, he has received *guidance with my friends in my community about how I'm using to hold me accountable.* Similarly, *finding people who could meet me there* was essential for Participant C. Not everyone is able to find those people though. *It was so much easier in high school, middle school to make friends*, said Participant K, specifying that they *don't want friends who do tina. Getting older is hard.*

The combination of shared experience and commonly-held drug use goals is part of why **online drug user communities** have proven themselves to be invaluable resources to some RQHR Participants. *There's a subreddit: DIYtk.*[40] *It's for self-medicating with ketamine*, Participant C referenced. Joining it, he learned tips and tricks from other members who *make their own nasal sprays.* Reddit was also where Participant J learned about a drug he now uses to self-medicate the effects of his crystal meth use: *I found on Reddit phenibut*[41] *and it's been my right hand man.* A culture of non-transactional social support can be found on the website, too. *People on there were saying, 'Have people in your life who you can talk to so they make sure you can help control it,'* Participant C recalled. For him, it boils down to



[40] "Do It Yourself Therapeutic Ketamine," Reddit, https://www.reddit.com/r/DIYtk/.

[41] Phenibut is a drug similar to the naturally-occurring neurotransmitter GABA, reduces anxiety, is unregulated in the United States, and can be purchased online without a prescription. See Elizabeth Svoboda, "What Is Phenibut? About the Russian Cosmonaut Drug People Take to Reduce Anxiety," Discover, October 20, 2020, https://www.discovermagazine.com/health/phenibut-the-russian-cosmonaut-drug-you-can-buy-online-to-reduce-anxiety.

Non-transactional social support can itself be enhanced by formal services. For example, Participant L has been able to support his friends by utilizing harm reduction resources. *I got helpful education about harm reduction for a friend who uses fent as a drug of choice,* he said, adding, *I've also ordered naloxone from the New York City Health Department and passed them out to friends.* Trainings can also equip drug users to show up for their friends and others most effectively. *If people can take the mental health first aid course, it is very good. If you take it, you can help,* said Participant B, noting that she took it with a friend, too.

Participant B made clear the power and the imperative to provide social support:

WE HAVE TO CONNECT WITH OUR SISTERS, TO TAKE TIME TO HEAR WHAT THEIR PROBLEM IS. IF YOU SEE A SISTER WHO HASN'T TALKED [IN] NO TIME, YOU DON'T KNOW WHAT'S GOING ON WITH THEM. YOU PICK UP THAT PHONE. TAKE THAT TIME. BELIEVE ME, THAT CHANGES LIVES.



E. Infrastructure for Social Solidarity

Queer and trans people who use drugs and do sex work (QT-PWUD/SW) effectively forge social support and connection despite potentially-alienating social norms and other structural conditions.

But a broader infrastructure is necessary to cultivate the ideal of social solidarity. As one approach, RQHR Participants urged harm reduction and addiction treatment providers to invest in **facilitating the formation of non-transactional relationships** among those they serve. The need is there. *My number one wish: good people in my life. Give me a reason to keep going*, said Participant D, adding that his LGBTQ homeless drop-in center *needs to provide more opportunities to meet like-minded people.* Participant H shared that she is hoping harm reduction organizations can support her in broadening her social horizons:

> I WANT TO START MAYBE, PERHAPS, GOING TO SOME [HARM REDUCTION PROGRAM] TO SEE WHAT THEY HAVE, AND HOPEFULLY MAKE SOME CONNECTIONS TO PEOPLE THERE SO I DON`T FEEL SO ALONE WHEN I GO AROUND HERE FOR SERVICE.

But some existing service providers seem to be **out of touch with their participants' fundamental need for social solidarity,** observed a third of RQHR Participants. *There's always such funny outgoing people who go to these programs and it just gets stifled by the rules and bureaucracy or security guards stopping people from talking to each other, and mandating reporting is so outdated*, said Participant H. *It prevents people from connecting with each other.* The asociality of some service providers was a decisive barrier for Participants C and G. *I love the idea of psychedelic therapy. But it's very formal*, said Participant C, who instead chose to self-medicate so they can take ketamine while still being with *a friend and partner.* Participant G also identified *what scared me away from ketamine therapy* was its required administration in a clinic that prevented him from experiencing the drug how he desired: *Being able to hug someone I love. Telling someone I love them. Act how I wanted to. Be able to be around who I wanted.* The takeaway for him? *We can't make it a clinical focus. It has to be holistic.*



Half of RQHR Participants voiced their desire for **drug user support groups.** Two explained in detail what can make them work well.

> For Participant B: *We have taken groups for trans community. We talk about substances. We share experiences. We have connections with our community, we know what's happening with these things. Especially with sex workers, we have a connection with Queens community. We have some conversation. How we can help each other. Sharing experiences.*

> For Participant K: In the substance use group at [their emergency housing provider], *it's cool. We just talk about life. Their workers there facilitate it.* What works: *They just have a chill vibe. Non-judgemental. Want to be there. Curious, want to learn stuff—because people who talk about drugs are maybe not that open. People always feel good when the person is interested in what they're talking about.*

Harm reduction and addiction treatment providers can help facilitate social solidarity by **making their spaces truly comfortable—**the importance of which was stressed by the majority of, or eight, RQHR Participants—and have a familiar **'living room' atmosphere**, as a third recommended. *Making places more comfortable, having a couch, having a seating area, not these chairs. 'Oh, we don't want them to sleep.' But that's what someone needs,* Participant A recommended. He used to work at a harm reduction program as a peer and he recognized that *a lot of times we discourage sleep. We had a couch where I last worked. People could go to sleep for 2 hours. Just making the places more comfortable.* Participant H had something similar in mind, suggesting her ideal harm reduction organization would feel like *a more homey environment* and offer *a recreation room, a TV, games, fun events held on Fridays*; in her opinion, *any and all*

NICE FUN THINGS TO DO, NOT JUST HEAVY STUFF, BUT NICE FUN THINGS TO BRING PEOPLE TOGETHER AND BE HUMAN.

V. RECOMMENDATIONS



1. OVERVIEW

The RQHR Project demonstrated that queer and trans people who use drugs or do sex work (QT-PWUD/SW) are brimming with rich insights that diagnose the present shortcomings of harm reduction in New York City. But they did not stop there. Participants charted a path towards a revival of the original, grassroots, participatory spirit of the city's movement.

"Our Lives, Our Care" presents an account of how QT-PWUD/SW adapt to hostile structural conditions through the use of psychosomatic, economic, and social narco-prosthetics; and how they adapt to the unintended surplus effects of narco-prosthetics through embedded harm reduction practices. *"Our Lives, Our Care"* presents RQHR Participants' visions of an infrastructure of care that cultivates psychosomatic resilience, economic power, and social solidarity for all.

To simply recommend a reiterated laundry list of the novel or revamped services articulated by RQHR Participants would be a disservice to them, other QT-PWUD/SW, and every other person who needs care. Over and over, it was expressed that care providers are hostile to, distrustful of, or dismissive of their voices, their requests, their pleas. If the very organizations and practitioners are already failing to listen to those they serve, is it not a fantasy to expect them to heed, much less read, any recommendations presented here?

Therefore, the RQHR Project proposes a strategy that can be pursued by QT-PWUD/SW themselves, as well as by current care providers. It unlocks all of the possibilities they proposed while ensuring far more QT-PWUD/SW—and frankly all drug users and sex workers—have the opportunity to design infrastructures of care that are responsive to the particular demands and challenges of their unique lives.



The single recommendation of the RQHR Project is to **democratize infrastructures of care,** ensuring the care participants need is the care participants get. To develop the psychosomatic resilience, economic power, and social solidarity of QT-PWUD/SW, harm reduction providers must form, or convert to, **worker** and **consumer care cooperatives,** abandoning the prevailing structure of hierarchical entities undemocratically governed by an elite Boards of Directors, led by overpaid and out-of-touch CEOs, and constrained by the restrictions on services imposed by funders. In a proposed **Harm Reduction Care Cooperative** (HRCC), QT-PWUD/SW would collectively **own, staff, coordinate, and manage** the organizations from which they themselves receive care. A detailed guide for the legal formation and governance of HRCCs is under development and will be published independently of this Report.

Perhaps the greatest departure from the traditional model of harm reduction organizations is the financing of HRCCs. It is imperative to break with existing harm reduction nonprofits' tendency to allow the range of their services to be determined by what Medicaid will reimburse or by what private and public grantmakers will fund. HRCCs can afford themselves greater freedom to provide what their members actually need by **mobilizing the community-based financial resources** of their members and other patrons. One model is sliding-scale membership dues, as utilized by cannabis social clubs in Uruguay and Spain.[42] Another is inspired by headshops, in which safer use supplies, food and drinks, cannabis and kratom, and other goods are sold at no-cost, or low-cost, to members, as well as to non-member patrons at fair prices that are still sufficient to maintain the HRCC. Developing such a community-based financing model does not preclude grants and reimbursements; rather, combining all of them could make for a powerful HRCC.

[42] See Tom Decorte et al., "Regulating Cannabis Social Clubs: A comparative analysis of legal and self-regulatory practices in Spain, Belgium and Uruguay." International Journal of Drug Policy 43 (2017): 44-56. doi.org/10.1016/j.drugpo.2016.12.020.



The profiteers of the existing nonprofit industry, and those they have propagandized, likely regard a call for collectively-managed care as a radical, unrealistic proposition. Such a sentiment betrays their own ignorance. Worker-owned, consumer-coordinated health care cooperatives exist today all around the world: Venezuela's Cecosesola;[43] Argentina's La Federación Argentina de Entidades Solidarias de Salud;[44] Spain's La Fundación Espriu;[45] Japan's Japanese Health and Welfare Co-operative Federation;[46] and India's Lok Swasthya Mandli;[47] among many others. In March 2023, the United Nations General Assembly even affirmed the power of health care cooperatives in its first resolution to embrace "the social and solidarity economy."[48]

Despite what potential skeptics of the RQHR Recommendation may think, care cooperatives are nothing new for the United States—and poor workers struggling during the Depression are to thank. By 1949, reportedly over a hundred rural health cooperatives were formed[49] and one of the first, a "cooperatively owned and operated hospital"[50] for poor farmers in Oklahoma, was founded in 1929 by the radical doctor Michael Shahid, a migrant from what is now Lebanon. Despite a flourishing movement, the Depression-era and postwar health cooperatives faced enormously powerful opposition—spearheaded by none other than the profit-oriented American Medical Association, arguably the biggest[51] adversary of patients' control over the means of care. Healthcare cooperatives still exist today, but the actualization of anti-capitalist worker-patient ownership and governance seems to have been left behind in the early twentieth century.

To finally end the overdose crisis and mass socioeconomic exclusion, QT-PWUD/SW must inaugurate a care cooperative revival within the harm reduction movement.

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[43] See Cecosesola, https://cecosesola.org/red-de-salud/.
[44] See FAESS, http://faess.coop/
[45] See Fundación Espriu, https://www.fundacionespriu.coop/
[46] See "The Basic Philosophy of Health and Welfare Co-ops," HEW, http://www.hew.coop/english/
[47] See "About Organization," Lok Swasthya Sewa Trust, https://lokswasthyasewatrust.org/about-organization
[48] See "Promoting the social and solidarity economy for sustainable development," United Nations General Assembly, adopted April 18, 2023, https://unsse.org/wp-content/uploads/2023/05/A_RES_77_281-EN.pdf
[49] See Helen L. Johnston, Rural Health Cooperatives. US Government Printing Office, 1950, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1997106/pdf/pubhealthreporig01179-0001.pdf
[50] See Glenna L. Huls, "Shadid, Michael Abraham," The Encyclopedia of Oklahoma History and Culture, https://www.okhistory.org/publications/enc/entry.php?entry=SH001.
[51] See Farid S. Haddad, "Michael Abraham Shadid: A Lebanese Precursor of Prepaid and Cooperative Medical Care," Lebanese Medical Journal 58, no. 1 (2010): 45-49. https://platform.almanhal.com/Files/2/19807

VI. GLOSSARY

TERM	DEFINITION
adulterated illicit supply	prescriptionless drugs supplied by criminalized manufacturers and distributors who have not registered with federal and state regulatory agencies, the quality and contents of which is incorrectly or misleadingly marketed to consumers
autonomous use-management	a person-directed, collectively-strategized approach to maintain the desired coping functions and therapeutic outcomes of drugs; in the professionalized medicine, prescribers call it 'medication management'
comedown	an assortment of symptoms following the cessation of a central nervous system stimulant, including but not limited to: depression, anxiety, fatigue, agitation, appetite changes, sleep habit changes, vivid or unpleasant dreams, et cetera
disembedded	that which is commodified and transacted across markets, including by the healthcare, harm reduction, and addiction treatment industries
economic	relating to economies, as conceptualized within the tradition of political economy
economic disempowerment	the organized deprivation of, and obstruction from obtaining, the ability to self-determine the conditions of life, its reproduction, and the expansion of its possibilities

GLOSSARY

TERM	DEFINITION
economic power	the collectively-secured capacity to determine the conditions of life, its reproduction, and the expansion of its possibilities
economic survival	the practices required to meet one's material needs
embedded	that which is integrated into one's personal habits, and across their non-transactional social relationships that are rooted in solidarity and kinship
exnovation	the collaborative refinement, enhancement, and expansion of existing embedded practices
harm reduction	the practice of adapting to the pharmakon; that is, the remediation of toxic surplus effects and the recovery of the desired function of drug use and sex work
infrastructure	a relational network of humans and technologies that enhances the capacity of its constituents
medical gatekeeping	the structural condition of medical practitioners, other healthcare workers, and service providers maintaining exclusive control over the means of care, thereby undermining the psychosomatic self-determination of their patients and participants
narco-prosthetic	prescriptionless or unprescribed drugs used to enhance the capacities of the body and mind, and to thereby adapt to psychosomatic, economic, and social changes

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TERM	DEFINITION
Overdose Prevention Center	a harm reduction program that prevents and responds to overdose by maintaining a space for medically-supervised drug use, as well as by offering a suite of health and social services
pharmakon	that which has the dual capacity to become medicinal or toxic, instrumental or detrimental
psychosomatic	relating to the interdependent integration of mind and body
psychosomatic resilience	the capacity to adapt to the constant changes inside and outside the mind and body
psychosomatic coping	the practices required to cultivate psychosomatic resilience despite medical gatekeeping and the adulterated illicit supply of drugs, among other structural conditions
remediation	the adaptive practices that reduce or remedy the surplus effects of narco-prosthetics; simply, harm reduction
Safer Sex Work Site	a Harm Reduction Care Cooperative providing spaces for sex workers to see clients within an environment designed to prevent or respond to violence, exploitation, drug-related harms and emergencies, among other potential harms
Sex Worker Waypoint	a Harm Reduction Care Cooperative providing space, resources, and services for sex workers to prepare for and decompress after sessions

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TERM	DEFINITION
social	with regards to human relationships
social alienation	the feeling of disconnection from loved ones, peers, colleagues, and society writ large
social solidarity	interdependent social relationships
social support	social relationships that enhance one's ability to care for oneself
stimulant agonist therapy	using prescribed stimulants—namely Adderall, Vyvanse, and Ritalin—with the support of a medical practitioner for the purpose of managing the use, or non-use, of prescriptionless and unprescribed stimulants
structural condition	institutional arrangements determining the possibilities of psychosomatic, economic, and social life
Supported Comedown Space	a Harm Reduction Care Cooperative providing space, resources, and services for people who are coming down from stimulants to care for themselves and each other
surplus effect	the unintended excess effects of a drug, often those of which are harmful

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