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Harm reduction as paradigm: Is better than bad good enough? The origins of harm reduction

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Abstract
As the articles in the recent special issue on harm reduction illustrate, the last decade has seen an impressive expansion of harm reduction in public health. Policies and programs using it have dramatically improved the formerly ignored health problems of marginalized populations. This article looks at the history of harm reduction, and the growing role that the medicalization of social and political problems plays in the governance of the margins in the neo-liberal state. It describes how the acceptance of harm reduction approaches coincided with a political need to address social disorder and reduce expense in health and legal services, and criticizes the current assumption that more harm reduction services will automatically result in a more humane society. While this paper supports those authors who urge a greater political engagement from harm reduction advocates in public health, it also urges a direct political critique of the social and legal systems that create harm, and the harm reduction research that critically examines how harm reduction, while aiming to prevent harm in the short term, may sustain systems of harm in a larger sense.

Keywords: *Harm reduction, Canada, critical public health, governmentality*

Although often described grandly as 'a new synthesis, a paradigm to guide action—in the Kuhnian sense, a scientific revolution' (Marlatt, 1998b, p. xii), harm reduction has more mundane origins and a less independent existence. The story begins with the activists, workers, doctors, programmes and policy-makers committed politically and socially to opposing the legal suppression of drug use and the oppression of drug users in the 1960s and 70s. In the mid-1980s these alternatives began to be referred to collectively as part of the 'risk reduction', 'harm reduction' and 'harm minimization' solution to the health problem of HIV/AIDS amongst injecting drug users (Vellemen & Rigby, 1990). Harm reduction has since become identified with HIV/AIDS prevention but also with addictions treatment, and is now generally defined by medical programmes, professionals and policies. Newly mainstreamed harm reduction is reluctant to engage in political criticism of drug prohibition and prefers to express opposition to the social marginalization of drug users

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in terms of medical outcomes (Heather, Wodak, Nadelman, & O'Hare, 1993). This article is an examination of the 'paradigmatic' claims through examining the current practice and politics in harm reduction. It finds reason for alarm in harm reduction's marginalization of activism and its evolving role in the professional, medical management of social problems.

The official story begins in the Netherlands. In the 1970s that government struck several commissions that recommended the police and the courts be permitted to assess pragmatically whether strict enforcement of the law for minor drug offences was in the best interests of that law, the society and the individual involved. This was the 'balance of harms' approach (Cohen, 1997; Ministry of Health Welfare and Sport, 1997; Spruit, 1998; van de Wijngaart, 1990). The social costs of drug prohibition were acceptable while they fell disproportionately upon a relatively small group isolated from society. But as drug use became prevalent in all social strata, drug law enforcement itself became a social and political problem.

In Canada in the 1990s, public health officials and policy-makers responding to HIV/AIDS began looking at alternatives to enforcement (Giffen, Endicott, & Lambert, 1991). Health authorities in North America began to work around the laws, and, through activists or members of the affected communities, to prevent HIV/AIDS moving from intravenous drug users and sex workers to the general population. Criminal subcultures were now presented as 'communities' with specific medical needs that could not be isolated or ignored. Health authorities were now more willing to defy the *letter* of drug laws, and to risk the penalties for possession of criminal 'paraphernalia', including syringes and condoms (Blackwell, 1988; Pascal, 1988). Community activists provided them with an arms-length means to evade the law while developing new techniques to address the spread of HIV/AIDS. This unlikely coalition of public health authorities and activists challenged the enforcement of drug laws.

Initial experiments in intervention supported granting health programmes specific exemptions from drug laws for the public good (Blatherwick, 1989; Grund et al., 1992; Newmeyer, 1988). The reforms were presented as substantially beneficial to society as well as to the newly minted drug-using 'community' but the resulting harm-reduction approach was not indicative of any revolutionary change or the appearance of a radically new paradigm. Just as in the Netherlands, they were adjustments to and reforms of social and legal policies whose enforcement has grown too unpopular, expensive or difficult. In this harm-reduction advocates were following a route well travelled by reformers of other unpopular laws 'when evasion or avoidance of the existing regulations has become so widespread that the reform largely ratifies the *de facto* situation' (Leitzel, 2003, p. 75). The 'new' harm reduction worked with existing institutions and moved away from direct challenges to existing policy and laws.

'Mature' and apolitical harm reduction

We have a tendency to take what we now see as harm reduction back in time, to retroactively unify historic critiques of drug prohibition under its banner. But within this new harm-reduction 'movement' there remains a historic tension between those who see harm reduction primarily as a medical means of promoting health and mitigating the harm to individual, and a more activist group who see it as a platform for broader and more structural social change. The latter accuse the former of propping up the flawed 'prohibitionist' laws of the past, while the former accuse the latter of advocating an unrealistic 'legalizationist' position.

Community-based organizations, user groups and other grassroots and politically active groups tend to be more committed to a political analysis of 'risk' and 'harm' as by-products of social, economic, racial or political inequality. They see harm reduction as a political and moral commitment to altering the material and social conditions of drug users. Only a small portion of this agenda for social change is the legalization or de-criminalization of drugs. The primary focus is on the deeper social, economic and racial inequality that the 'drug problem' masks. From this point of view, harm reduction is ideological and oppositional (Herkt, 1993; Crofts & Herkt, 1995; Jose et al., 1996; Balian & White, 1998; Livingston, 1999; Wieloch, 2002). On the other hand, most public and preventive health bodies see 'risk' and 'harm' as having an objective, factual existence that affects identifiable individuals, groups or populations in definable ways. Their mandate within established political and medical systems is (at least explicitly) non-ideological. Cooperation and collaboration rather than confrontation are their preferred means to bring about change, even though the health problems they address are substantially created by the ideology of systems in which they work (Clatts & Mutchler, 1989; Freeman, 1992; Savitz, Poole, & Miller, 1999; Bourgois & Bruneau, 2000).

In the decades before harm reduction became a 'brand', marginal social and political groups were loosely organized around opposition to drug prohibition (Lindesmith, 1947; Morgan, 1981). They formed a coalition with public health as well other 'mainstream' groups to address the crises engendered by HIV/AIDS. The vagueness of harm reduction in the early days had advantages in winning general acceptance and deflecting criticism, but became a liability once mainstream support was gained. In the policy and funding process, medical professionals were the acknowledged experts, and they advanced medical not social arguments for harm reduction. This 'official' harm reduction saw itself as having matured beyond the sort of activism that engaged in embarrassingly direct and counter-productive attacks on drug prohibition. It was now as much or more a career than a cause, and the political and community voices of harm reduction again became marginalized (Alexander & Van De Wijngaart, 1997; Lenton & Single, 1998; Marlatt, 1998a; Weingardt & Marlatt, 1998; Tsui, 2000; MacCoun & Reuter, 2001).

What began as a 'bottom-up' movement became 'top-down' policy. Harm reduction as a 'mature and coherent paradigm' (Cheung, 2000, p. 1699) stayed away from larger political issues (what Cheung calls the 'wrong message') and adopted a more saleable emphasis on medical benefits. This harm reduction sought to 'accept that drug-taking cannot be prevented, and instead to concentrate on reducing its consequences for health and crime' (Reporter, 2003). The focus on individual consequences and societal costs rather than their social causes separated medical harm reduction from the more activist advocates of harm reduction.

Miller (2001) argues that harm reduction actually enables society to continue causing harm to individuals without accepting responsibility for or acknowledging the social, legal and economic source of those harms. He links harm reduction with the modern trend to decentralizing power from the state to the local and the individual level. He describes the practice of harm reduction as 'a safety net, not a strategy, representing a convergence of economic rationalism and social policy' (p. 177). Similarly, Mugford (1993) warns that the creation of specific interventions and policies based on scientific definitions of harm reduction are the latest strategies in the historic efforts to minimize risk from, and maximize control over, marginal populations. The 'paradigm' of harm reduction is actually only part of an overall shift away from social control through overt or coercive power, to more productive or even seductive techniques to elicit compliance through self-regulation (Moffat, 1999).

> [T]hese technologies of agency often come into play when certain individuals, groups and communities become what I have called target populations, i.e. populations that manifest high risk or are composed of individuals deemed at risk . . . the object being to transform their status, to make them active citizens capable, as individuals and communities, of managing their own risk. (Dean 1999a, p. 168)

Foucault's writing on 'governmentality' (Foucault, 1979, 1991, 1994[1976]) has resonated with a number of authors who see them as the analytical key to understanding how postmodern or late modern states exercise power (Gordon, 1991; Dean, 1992, 1999b; Beck, 2000; Wickham & Pavlich, 2001). Neoliberal or neoconservative states of the latter twentieth century drew back from direct intervention and devolved many of their powers to an array of not-for-profit and for-profit service providers. Power was located more generally in society and in the social rather than in overtly governmental institutions (Crook, Pakulski, & Waters, 1992; Barry, Osborne, & Rose, 1996; Dean, 1999b). 'Modern politics is being bypassed for a postmodern politics that exists more as an ethos than a set of institutions and a programmatic agenda' (Gabardi, 2001, p. 98). It follows that all institutions are *governmental* institutions and all citizens have a role to play in the governance of self and other. Government action on a particular issue or area is negotiated and mediated through consultations with the stakeholders who were created in turn by the states' need for bounded populations to act on and sub-governmental bodies to act through. These 'new regimes of government' are based on what Dean described as a 'new prudentialism' (Dean, 1999a, p. 166).

Epidemiology, community and the governance of drug users

'Prudentialism' refers to the increased reliance on the scientific calculation of risk based on large data sets, and the minimization of these risks based on the self-regulation of those affected by and therefore now responsible for them (Castel, 1991; Pratt, 1999). Every citizen is expected to be aware of his or her culpability for the risks identified by statistical analysis, and to take the appropriate measures recommended by studies of their 'population' to reduce their own risk. Harm reduction is an excellent illustration of a technology of agency, through which 'populations that manifest high risk or are composed of individuals deemed at risk' become the target of programmes 'to transform their status, to make them active citizens capable, as individuals and communities, of managing their own risk' (Dean, 1999a, p. 168).

The goal is to take a group created out of risk classification and create a 'community' whose identity and purpose is to regulate itself according to that classification. This new infrastructure of institutionalization and supervision extends the control of drug users to those unwilling or unable to respond to other options—the 'service resistant'. Harm reduction provides a refined set of 'interventionist technologies which . . . make it possible to *guide* and *assign* individuals without having to assume their custody' (Castel, 1991, p. 295). Safe injection facilities and heroin prescription trials to 'reach the unreachable' and to stabilize them *medically* save money on general healthcare and HIV treatment. But they also save money on law enforcement and insurance premiums for theft and damage by controlling the previously uncontrollable and stabilizing them as *social* problems.

One of the central tenets of harm reduction is that it was a 'bottom-up' approach, 'empowering' communities to address their own problems by providing them with the knowledge and the means to do so. 'Empowerment by invitation' (Handler, 1996, p. 210) is available to those who can organize themselves into appropriately 'healthy' endeavours that support better connected institutional partners (Herkt, 1993; Smith & Lipsky, 1993; Crofts & Herkt, 1995; Gusfield, 1996; Cruikshank, 1999). 'These targeted populations

are enjoined to recognize the seemingly natural bonds of affinity and identity that link them with others and to engage them in their own self-management and political mobilization' (Dean, 1999b, p. 149). Drug user groups have to accept the authority of medical and social service professionals in order to be deemed 'functional' and healthy organizations. Groups that assert more political goals are denied these partnerships and resources. They are not deemed to be legitimate communities of interest, and their members are simply categorized as 'hard to reach' and 'service resistant' individuals who still need to be 'brought into service'.

Conclusion

HIV made drug users, sex workers and street populations more worthy of attention—and therefore regulation. Harm reduction achieved a stature as an idea whose time had come because it provided such regulatory mechanisms. As the numbers of proponents of harm reduction grew, it attracted more people who were not part of the original activism. It also attracted to the system people who were not outsiders but unapologetic insiders—reformers rather than revolutionaries, technologists rather than activists. As a broadly based *social movement*, harm reduction contained many outsider groups and radical ideas. But in the policies and practices of institutions (both governmental and non-governmental), harm reduction is deployed much more selectively. To win the support of mainstream political bodies, the winners in the harm-reduction movement willingly restricted themselves to a reform agenda.

The pro-harm reduction literature generally assumes that it represents a theoretically and ideologically new approach separable from other means of addressing the social and medical costs of drug use, and that the adoption of a complete 'harm-reduction approach' would provide a complete solution to these costs and problems (Des Jarlais, 1995; Alexander et al., 1997; Weingardt et al., 1998). But by ameliorating their worst effects, harm reduction simply relieves the institutions of prohibition and abstinence-based treatment of responsibility for those harms. It reduces their incentive to fundamentally change those damaging policies. It has also extended the 'disease' model of addiction, labelling drug users as permanently disabled by their dependence on drugs (Health Canada, 1998) and supports ongoing dependence on new harm reduction as well as older addictions services. Harm reduction's supposed 'radical' reforms were accepted because they reduce the medical and political burden on the state and divert certain segments of the drug-using population out of the legal system. Proponents of 'late modern' harm reduction explicitly promise to reduce the actual and political costs of drug laws, while implicitly leaving the historic rationale for those laws intact. The reward for this is employment opportunities for the medical and social service supervisors of extra-legal administration of drug users' lives. For evidence of this, one need only review current medical literature selling increased funding for harm-reduction programmes based on their potential to save the state a bundle for each prevented seroconversion, expensive treatment and lingering death (Anderson, 1996; Hanvelt et al., 1994; Hurley et al., 1996; Millar, 1998; Palepu et al., 2001). Certainly arguments of social justice and political responsibility are made, but they are offered as much weaker arguments than those based on the savings of money, material resources and public order. Similarly, harm-reduction researchers strongly support expanding services as the immediate and viable solution, while only wringing their hands about the injustice and inequality that necessitate them.

Harm reduction is in danger of becoming just another means of producing human service professions and new professional programmes. These exist to address the pressing needs

of marginalized groups, and they do represent a necessary new wave of service provision in both the services they provide and their philosophy in providing them. They are, however, a continuation of a tradition of service provision that is dependent on the persistence of needs—and the creation of new ones—even as they are charged with eliminating them (Gusfield, 1996). 'Mature' medical harm reduction can be seen as a move from a problematic 'curative' model, through prohibition and treatment, to an equally problematic 'palliative care' model. The non-judgemental and apparently amoral approach of the harm reduction works within social margins and actually reinforces them by replacing explicit moral judgements with implicit ones based on scientific assessments of 'good' and 'bad' behaviour. It accommodates prevalent approaches to drug use and users and simply updates them with neoliberal policies, practices, institutions and rhetoric. It is non-judgemental of drug use and users, but equally non-judgemental of the system that creates them. Official harm reduction is characterized by a dangerous acceptance of the present situation of drug users, fatalism towards the prospect of larger change, failure to challenge the contradictions of licit and illicit drug use, and a continuation of the assumptions of addiction and morality that underlie abstinence and enforcement.

The productive power of harm reduction is now gaining acceptance in other areas: in smoking reduction (Baer & Murch, 1998) and alcohol use (Hass, 2001), certainly, but also in school programmes for gay and lesbian youth (Van Wormer & McKinney, 2003), treating sexual deviance (Ward, Laws, & Hudson, 2003), youth gambling (Lia Nower & Alex Blaszczynski, 2004), psychotherapy (Denning, 2000) and even as a new approach to female circumcision (Shell-Duncan, 2001). But the portrayal of harm reduction as a *paradigm*, self-contained and removed from earlier approaches, is unsustainable. What we see developing as the official harm-reduction programmes and policies certainly offers needed comfort for the immediate problems of individuals trapped in addiction. There is no question of its practical and needed effectiveness at the levels of individual and population health. But without a return to the more socially and politically active analysis it began with, harm reduction offers little prospect for real, long-term solutions to the increasing difficulty posed to society by drug use. Harm reduction has 'matured' into a conservative movement, an apology for the past and an effective means to carry that historic dysfunction into the future.

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