Harm reduction policy: biopower, race & stigma at the heart of the 'opioid crisis'

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HARM REDUCTION POLICY:
BIOPower, RACE & STIGMA AT THE HEART OF THE ‘OPIOID CRISIS’

by

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ABSTRACT

Across the U.S., concerns regarding substance abuse, addiction, and treatment are coming to the forefront of public discourse, due to increased media coverage of the popularly dubbed ‘opiod crisis.’ As overdose rates increase, particularly in rural and suburban white communities, so have debates about the ethics and efficacy of harm reduction services. Through a review of existing literature and reflections on interviews from key informants at New York State Department of Health, grassroots harm reduction organizations, and a ‘mainstream’ addiction clinic, this thesis will critically examine the history of drug user stigmatization in the U.S. and how it has influenced the modern-day opioid epidemic. I argue that Foucault’s framework of biopower and Agamben’s theory of ‘bare life’ can shed light on the stigmatization and marginalization of minority communities and individuals, particularly in relation to the punitive measures of the “War on Drugs.” The long-standing stigmatization of drug users, particularly along racial and ethnic lines, and resulting drug policies have resulted in the inability of modern U.S. policy to reconcile existing drug laws with the modern ‘opioid crisis’ now that it is impacting white communities, as well as a failure to develop a mainstream harm reduction apparatus. I recommend various sociocultural and legislative changes needed to shift perception and policy to effectively address the ‘opioid crisis,’ including the necessity of incorporating hard reduction programs into the mainstream healthcare system, as well as the incorporation of racial impact assessments into the development of new drug policies.

Keywords: harm reduction, drug policy, addiction services, stigmatization, neoliberalism
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Introduction

As I walked in the rain through the South End neighborhood of Albany, New York, on my way to a community event, “Opioid Overdose Prevention Training,” my mind was filled with images of what I might see when I entered the building. It was an exceptionally dreary day in the fall of 2018, in an exceptionally dreary area of Albany. South End is a historically low-income neighborhood, with the typical indicators of socioeconomic contrast between more affluent areas that one might find to expect in many modern American cities. Its proximity to a major highway and the bustling Port of Albany make it an undesirable place to develop residential communities or businesses for those with more attractive options; several large government housing buildings are situated in this area. Being the capital city of the New York State, much of Albany’s economic and cultural vitality comes from the state governmental organizations, many of which are located in the beautiful and historic downtown. From down in South End, one can look up the hill and see the capitol buildings only blocks away, but the divide between the inhabitants of the respective neighborhoods could not be more clearly visible. After entering the Albany County Department of Mental Health building for the overdose prevention training, I was instructed to take the elevator downstairs and wait in the classroom for the instructor. Although I was about 10 minutes early, I was the last to arrive for the training; in total, there were about 15 participants in the windowless, basement room. As one might expect, it was not a pleasant or cheerful atmosphere. Some people sat alone, others looked as if they had come with family or friends, but nearly everyone looked tired and full of worry.

I tried to imagine various circumstances in which someone would wish to attend an overdose prevention training at 11:00 A.M. on a Tuesday; I knew I had to get my supervisor’s permission to leave work to come to the training, and I wondered how others made this work
around their schedule. I doubted that others in the class were interested in the training from an academic perspective, although it is reasonable to assume that some participants were attending because of their professional involvement in health and/or substance abuse. I suspected that the majority of participants were most likely in attendance because either they or someone close to them was struggling with opioid addiction, and they were preparing themselves for the worst possible outcome. By learning the risk factors, causes, and symptoms of an opioid overdose, as well as the procedure for delivering Naloxone (often referred to as Narcan), they were taking the responsibility for potentially saving their own life, or the lives of someone close to them. As I listened to the instructor deliver his presentation, giving clear instructions and sharing his story of substance abuse, ongoing recovery, and the need for second (and third and fourth) chances, I found myself considering various questions. Why isn’t this training taking place in a hospital or a clinic with medical professionals? Is the state involved in funding these trainings? If so, did they participate in similar community-engaged events during previous drug epidemics?

Over the past several years, concerns regarding substance use, addiction, and treatment have come to the forefront of public discourse across the U.S., due in large part to increased awareness and media coverage of the popularly dubbed ‘opioid crisis.’ As overdose rates continue to increase at previously unseen levels, particularly in rural and suburban white communities, so have debates regarding the ethics and efficacy of harm reduction services (Centers for Disease Control and Prevention 2019; The Henry J. Kaiser Family Foundation 2019). Through the review of existing literature and reflections on interviews with key informants from the New York State Department of Health (NYS-DOH), grassroots harm reduction organizations, and a ‘mainstream’ addiction services clinic in Albany, this thesis situates the current ‘opioid crisis’ in the historical, political, and social context of the United
States, describing the mechanisms of sociopolitical power that have resulted in a medical system which is unable to manage this crisis.

This exploration will first involve an examination of theoretical underpinnings of mechanisms of governmental power over the lives and health of citizens, using Michel Foucault’s concepts of biopower and biopolitics. I then describe how the stigmatization of drug users, particularly People Who Inject Drugs (PWID), has been employed to marginalize communities along racial and ethnic lines, utilizing Giorgio Agamben’s concepts of ‘bare life’ and the ‘state of exception’ to explore how and why certain populations have been intentionally excluded from mainstream healthcare. I highlight the grassroots, anarchistic origins of the harm reduction movement as a reaction to this institutional marginalization, and how this grassroots resistance developed into a culture of harm reduction that is uniquely suited to provide the range of services necessary for PWID to mitigate various socioeconomic barriers to their recovery. I will then explore the rise of neoliberal policies of decentralization, the proliferation of private organizations in health maintenance, and dominant ideas of personal responsibility, particularly relating to health. Throughout, I demonstrate how the stigmatization of PWID has worked in concert with these mechanisms of power and policy, pushing PWID out of mainstream healthcare and leading to a failure of the U.S. government to develop an apparatus to provide harm reduction services to PWID. I conclude by recommending various social, political, and legislative changes that are necessary to address the long-standing stigmatization of PWID, and how changes in perception must be accompanied by legislative reforms in order for the U.S. to take meaningful steps to deescalating the current ‘opioid crisis’ and prepare a better future for those who are working toward recovery from opioid addiction. First, a brief overview of the modern ‘opioid crisis’ and introduce harm reduction as a set of principles and services.
The Modern ‘Opioid Crisis’

By any metric, the statistics involving drug overdose rates in recent years are alarming, to say the least. According to the Centers for Disease Control and Prevention (CDC), the 63,632 drug overdose deaths in the United States in 2016 represented a 21.4% increase from 2015; two thirds of these deaths involved an opioid (CDC 2019). Overdose deaths have occurred overwhelmingly in white communities. In 2017, 78% of all opioid overdose deaths occurred among non-Hispanic Whites, while 12% occurred among non-Hispanic Blacks, and 8% among Hispanics (Kaiser Family Foundation 2019b).

![Figure 1](image)

**Figure 1**

In the 7-year span from 2006-2013, rates of overdose death as a result of opioid usage per 100,000 increased by 2%; from 2013-2017 (nearly half the time), these numbers more than tripled, with the same metric showing a 7% increase in deaths per 100,000 (The Henry J. Kaiser Family Foundation 2019a) (Figure 1). It is important to note that much of this increase is due to the illicit manufacture of synthetic opioids, such as fentanyl, which are characterized by their
potency and resulting likelihood to induce overdose. While overdose deaths increased in all categories of drugs from 2015-2016, the largest increase in overdose deaths involved synthetic opioids; since 2013, the current wave of the opioid overdose deaths has been driven, in large part, by illicitly manufactured fentanyl (CDC 2019). While the phenomenon of illicitly manufactured fentanyl is a worthy topic of inquiry in relation to the ‘opioid crisis,’ it is out of the scope of my research and will not be discussed further.

In recent years, the term ‘opioid crisis’ has become something of a buzz word in popular culture and media throughout the United States. Much of this focus is due to the fact that previously unaffected groups, namely rural and suburban white communities, have been dramatically impacted by the increase in overdose rates (Kaiser Family Foundation 2019b). Although I will discuss issues of race in detail further on in the paper, I should address why I have thus far referred to the ‘opioid crisis’ with quotations. After exploring the history of U.S. drug policy and talking with professionals in harm reduction and addiction services, I do not feel that it is appropriate to reference the ‘opioid crisis’ without including such a qualification. There have been drastic differences in the media portrayal of the ‘opioid crisis’ compared to other drug epidemics, specifically those within communities of color, such as the crack cocaine epidemic of the 1980s and 90s (Netherland and Hansen 2016). While phenomena such as the crack epidemic drew heavy attention in the media, the focus of this reporting was the demonization of low-income, ‘urban’, and racialized communities, sparking well-known phrases such as the “crack baby,” a largely disproven theory recognized today as another method of stigmatizing drug users (Gershon 2018; Netherland and Hansen 2016; Reinarman and Levine 2004). Phrases like “crack crisis” were rarely, if ever, employed in popular media. In contrast, media coverage of opioid overdoses among white communities are marked by sympathetic descriptions of individuals
struggling with addiction (Netherland and Hansen 2016). In this context, it is crucial to analyze different connotations between the words ‘crisis’ and ‘epidemic.’ ‘Epidemic’ refers to a widespread infection or contagion, whereas ‘crisis’ drums up imagery of a situation that is out of individual control and implies the need for sympathy and intervention. I argue that the implication of the opioid epidemic as a ‘crisis’ among white communities contributes to inequalities of perception along racial lines. However, the startling increase of overdose rates due to opioid usage certainly represent a significant phenomenon with health implications impacting a large number of Americans. With this in mind, I will hereafter refer to the issue as the ‘opioid epidemic’ (sans quotations), in line with the widely referenced ‘crack epidemic’ of the 1980s and 90s.

Methods and Limitations

I conducted research for this project during the spring of 2019 in Upstate New York. Methods included reviewing existing literature, observing public opioid overdose trainings, and conducting semi-structured, key informant interviews with five individuals, four of which are currently high-level professionals in harm reduction and addiction services at the governmental, non-governmental, and clinical levels. I obtained connections with these individuals through personal networks, some of which were generated through my work with the State University of New York - University at Albany’s Center for the Elimination of Minority Health Disparities. With IRB approval, interviews were audio-recorded with the consent of interviewees, each of whom agreed to allow me to use their names and quotes. As I will reference interviewees’ relevant views on topics covered throughout various sections of the paper, some introductions are in order.
My first interview was with Allan Clear, a pioneer of syringe exchange in the late-1980s in New York City and current Director of New York State Department of Health (NYS-DOH) Office of Drug User Health in New York City. Clear was on the ground floor of harm reduction activism, founding the first underground (unsanctioned) syringe exchange program in the Lower East Side of Manhattan. Clear also served as Director of the Harm Reduction Coalition for 21 years. Second was Keith Brown, Director of the Katal Center for Health Equity and Justice, a community-engaged harm reduction organization located in Albany, NY. Brown started working in harm reduction in the late-1990s, focusing primarily on HIV/AIDS programs, has worked extensively in syringe exchange programs throughout the State of New York for nearly two decades. My third interview was with Barry Walston, AIDS Program Manager at the NYS-DOH Division of Prevention, managing various contracts overseeing funding for programs designed to address LGBTQ+ health and wellness, as well as drug user health. Fourth was Carol Greco, Director of the Addiction Services Clinic of St. Mary’s - Ascension Healthcare Network in Amsterdam, NY. Greco has over 30 years of experience in the clinical setting, more than 25 of which spent in addiction services. Last was Kevin Flatley, an MD student at Albany Medical School in Albany, NY. Kevin frequently volunteers on a mobile syringe exchange unit which offers various harm reduction services, primary syringe exchange, from a van parked at various locations in Albany, Rensselaer, and Troy, NY multiple times a week.

Admittedly, there were various limitations that made gathering data for this research challenging. First, it seems necessary to address why I have refrained from interviewing any PWID who are currently accessing harm reduction services. The perspectives from PWID have historically been ignored during research on drug policy, and acknowledging this disparity is important. However, this project focuses primarily on structural and institutional factors that
have inhibited the development of harm reduction services. While these voices and perspectives would undoubtedly have contributed to the exploration of drug user stigma, given the brief time frame and scope of the project, I decided to focus on interviews with administrators and management working at high levels within harm reduction and drug user health organizations in order to develop a clearer picture of the large-scale forces that impact these organizations. Additionally, I found that harm reduction organizations are justifiably wary of exposing their employees and clients to outside research, due to the sensitive nature of the services they provide from a legal perspective. For all these reasons, I chose to focus on interviews with a smaller number of key informants, with significant expertise and years of collective experience in drug user health and/or harm reduction. If feasible, I would hope to continue this research at a later time; with the proper funding and time allotment, I would intentionally gather a larger number of participants from a wider range of perspectives on drug user health and harm reduction services.

**What is Harm Reduction?**

Given that much of this thesis revolves around large-scale forces that have impeded the development of a mainstream harm reduction apparatus in the U.S., it is important to provide a useful definition of harm reduction and the services associated with its implementation. I will refer to the various descriptions provided by the Harm Reduction Coalition (HRC), a national advocacy and capacity-building organization that promotes the health and dignity of individuals and communities impacted by drug use. According to the HRC, harm reduction represents “a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use (HRC, n.d.). Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs. Harm reduction incorporates a spectrum of
strategies from safer use, to managed use to abstinence to meet drug users ‘where they’re at,’ addressing conditions of use along with the use itself” (HRC, n.d.). The webpage description goes on to explain that because harm reduction requires various strategies for implementation depending on community and individual needs, there is no concrete formula for its implementation. However, HRC outlines several principles that are central to harm reduction. I do not include all the principles here, but highlight one that is crucial to understanding the logic of harm reduction: “[harm reduction] accepts, for better or worse, that licit and illicit drug use is part of our world, and chooses to work to minimize its harmful effects rather than simply ignore or condemn them” (HRC, n.d.). Harm reduction accepts the fact that individuals use drugs, and argues that it is more helpful to reduce the harm involved in drug use than to stigmatize users. This principle is central to my research, given my focus on how the stigmatization of drug users has worked with political factors to push PWID out of the mainstream healthcare system.

A few examples of harm reduction services are: 1) Syringe Access Programs, or Syringe Exchange Programs that allow PWID to access clean syringes in order to fight the spread of blood-borne disease, such as HIV and Hepatitis C; 2) Medication Assisted Treatment (MAT) is the prescription of medication, such as methadone or buprenorphine, during detoxification treatment to lessen withdrawal symptoms, allowing PWID to stay clean long enough to give them a better chance at a full recovery; 3) Law Enforcement Assisted Diversion (LEAD) programs grant police officers discretionary authority at the point of contact with those suffering from drug addiction, allowing them to be diverted to a case manager rather than being moved directly into the criminal justice system; 4) Naloxone (Narcan) is a simple, life-saving treatment for those who overdose on opioids. Naloxone can immediately reverse the effects of an overdose,
if delivered in a timely manner; and 5) Safe Injection Facilities (SIF) provide PWID and other individuals a safe space to use drugs under trained medical supervision.

Since the 1980s, significant evidence has developed regarding the efficacy of syringe exchange programs and other harm reduction strategies in combatting the outbreak of blood borne diseases such as HIV/AIDS and Hepatitis C among PWID. Ongoing political battles over the issue have raged since the 1988 congressional ban on the use of federal funds for syringe exchange programs (Green et al. 2012), after North Carolina Senator Jesse Helms equated syringe exchange programs with a federal endorsement of drug abuse (World Health Organization 2004). Proponents of the ban claimed that federal funding of syringe exchange would contradict law enforcement efforts in the “War on Drugs” by signaling tacit governmental approval of illegal drug use, and claim that the resulting availability of sterile syringes could cause a rise in drug abuse and negatively impact the overall health of the public (Dempsey 1997). As such, the United States still has a long way to go in accepting and promoting the use of syringe exchange as a helpful tool in reducing harm for PWID. Lack of funding has been reported as being the most common problem for syringe exchange programs (Des Jarlais et al. 2009). As of 2016, there were still 29 states with no laws in place to authorize the use of syringe exchange programs at the state level (Center for Disease Control and Prevention 2017), although many programs operate without state authorization. Moreover, public acceptance and legislative support for safe injection facilities, in the United States is even more contentious. The U.S. still has no legal safe injection facilities, despite clear evidence of their effectiveness in Canada and around the world (Elliot 2014; Jozaghi and Andreson 2013; Strike et al. 2014). In the current culture of stigma surrounding drug use, this harm reduction measure is unlikely to be sanctioned by the United States government in the near future, especially considering the fact that
communities across the U.S. are still deeply divided over less controversial syringe exchange programs.

A useful example of social and political resistance to such harm reduction programs is that of a proposed syringe exchange program in Springfield, Massachusetts in the early 2000s. The proposal incited massive opposition from the community, revealing complex sociocultural dynamics which led groups of suburban white and inner-city black and Latino voters to jointly oppose the syringe exchange program on the basis of neoliberal frameworks, but for clearly diverging reasons (Shaw 2006, 34). For many white suburban residents, the very notion of harm reduction and public health intervention contravened their ideals of individual autonomy, personal responsibility, and small government. Through their attempts to hold the government accountable to the neoliberal ideas of limited government, white suburban syringe exchange opponents demonstrate a vision of direct citizen control of government practices. African-American needle exchange opponents in Springfield also conceived of drug addiction as an obstacle to individual self-sufficiency and personal responsibility, but their interpretations were embedded within a social context of marginalization, racism, and oppression. This minority community essentially felt that if the government was unable or unwilling to address the degradation of their community (partially due to drug use itself) and the disparities in health, education, and employment opportunities, why should they support a program that is perceived to encourage drug use? “Conservative, white suburban residents are motivated by a firm belief in small government and the postwelfare state, while the politically marginalized residents of Springfield’s inner city are motivated by their daily struggle with poverty, racism, and the withdrawal of public resources from their neighborhood” (Shaw 2006, 33).
Allan Clear described his experiences with similar circumstances in New York City in the 1980s and 90s, in which both black and white communities opposed syringe exchange programs for similar reasons. Clear specifically cited the high costs associated with healthcare, which initiated a compelling discussion about the state of U.S. healthcare.

Clear referenced a meme, which circulated widely around the internet in early 2019, in our discussion about community resistance to harm reduction programs, in this case referring to the provision of Narcan to prevent opioid overdoses. The image was a public sign, which stated “Why is Narcan free to a dope addict, but my insulin is $750 a month?” In the meme, the words “Narcan free to a dope addict, but” were scratched out, so that the sign merely reads, “Why is my insulin $750 a month?” Clear discussed how resistance toward harm reduction are often projections of frustration regarding other social problems impacting the community. Here, we can observe multiple different attitudes at play. First, a resentment toward PWID, implying that “dope addicts” should not receive an opioid reversal without having to participate in the high costs of healthcare services. Also, the image implies that the perceived immorality of drug use makes PWID undeserving of free Narcan, while simultaneously suggesting that those with diabetes have not neglected their health in the same way and are deserving of free insulin. The ‘corrected’ version of the image puts the responsibility on the government and pharmaceutical companies, insinuating that the high cost of insulin and lack of governmental regulation of drug costs are to blame. This image ultimately argues that issues of drug overdose and high insulin costs are not mutually exclusive, and Clear argued that this issue represents one of the most significant social barriers to the acceptance of harm reduction among communities in the United States suggesting that communities and individuals must question the capitalist structures of U.S. healthcare, rather than pitting themselves against PWID. The complex ideologies underlying
Springfield citizens’ perceptions of syringe exchange, as well as social conceptions of harm reduction interventions within the U.S. healthcare system described by Allan Clear and the internet meme both provide useful introductions to the issues to be addressed through the paper. In the following section, I turn to a more theoretical discussion of underlying concepts surrounding the role of the government in the health of populations examining the ways in which the stigmatization of marginalized groups, particularly in the historical context of the U.S., reflects larger power structures and institutional control. To investigate the theoretical foundations of such power mechanisms, I will turn to seminal works from Michel Foucault and Giorgio Agamben.

**Biopolitics, Sovereign Power, and Bare Life**

If one were to pose a basic question such as, “What is the role of the United States government?” to a mixed group of contemporary Americans, undoubtedly the inquiry would elicit a wide range of responses. Progressive liberals might submit a broad range of responsibilities that they conceive to be incumbent on the government to uphold, while traditional conservatives might limit these responsibilities to a few key issues such as defense or law and order. While many Americans are well-educated about their rights as citizens and acutely aware of the key points of contention between the binary conceptions of liberal vs. conservative, the history surrounding the development of styles of governance and political power is simply too complex to consider holistically, particularly in everyday decision-making.

In order to situate the current opioid epidemic in the modern social and political contexts of the U.S., it is crucial to situate this within theories of governmental involvement in the health of the population, particularly the relationship between power and knowledge as a means of
institutional control. Michel Foucault, a French social theorist and philosopher, attended to such issues in much of his work.

On January 11th, 1978, Foucault began a series of lectures at the College de France entitled *Security, Territory, Population* (although at the end of the course, Foucault states that if possible, he would rename the lecture series to *A History of Governmentality*) (Foucault 2004, 380). At the beginning of the very first lecture, Foucault begins,

This year I would like to begin studying something that I have called, somewhat vaguely, biopower. By this I mean a number of phenomena that seem to me to be quite significant, namely, the set of mechanisms through which the basic biological features of the human species became the object of a political strategy, of a general strategy of power … [how] modern Western societies took on board the fundamental biological fact that human beings are a species. [Foucault 2004, 1]

Foucault is interested in the ways in which structures of power and governance weaponized the concept of *man as species* as a means of control over vast populations, which Foucault claims occurred in the early 18th century. In Volume 1 of *The History of Sexuality*, written concurrently with the lectures at the College de France, Foucault describes a shift from sovereign power to biopower. He describes one of the primary characteristics of sovereign power was the right to decide life and death, directly or indirectly, via punishment or war, respectively. The sovereign’s “power of life and death” was exercised through the ability to “take life, or let live.” By contrast, Foucault describes the turn to biopower as a more nuanced form of state control, designed to “monitor, optimize, and organize” the forces under it, characterized by “a power bent on generating forces, making them grow, and ordering them, rather than one dedicated to impeding them, making them submit, or destroying them…[one] might say that the [sovereign] right to *take life or let live* was replaced by a power to *foster* life or *disallow* it to the point of death” (Foucault 1990, 135-138). As opposed to medieval concepts of domination or early forms of the
state, in which “government” was an inclusive term encompassing all realms of social, cultural, religious, and philosophical life, Foucault claims that the origins of biopolitics were closely linked to the emergence of liberal forms of government (Lemke 2011, 45). Rather than seeking to maximize governmental power, liberal governments were designed with the intention of optimizing the population. This is not to say that liberal governments were unconcerned with power; understanding the “nature” of society may be used to illuminate previously unrecognized possibilities for intervention. Throughout his description of biopower, Foucault continually returns to some of his other work regarding the “technologies of security,” describing mechanisms of institutional control. Foucault regards these security mechanisms as “counterparts to liberal freedom and as the condition for its existence” (Lemke 2011, 47). In contrast to previous forms of sovereign power, in which governments attempted to “adjust reality to a “should-be” value, the technologies of security [in liberal government] take reality as the norm: as a statistical distribution of events, as average rates of diseases, births and deaths…[they] do not draw an absolute borderline between the permitted and the prohibited; rather, they specify an optimal middle within a spectrum of variations” (Lemke 2011, 47). I would argue that Foucault sees the adoption of liberal styles of government as a means to design power structures that work with the population, thus allowing for more efficient powers of intervention and enhanced technologies of security. We can see this concept reflected in liberal reforms of the mid-20th century in the U.S. (i.e. welfare state, “New Deal,” social security etc). While less concerned with personal freedom from a classic 18th century liberal perspective, these reforms sought to enhance and optimize the population through forms of “social security.”

With the theoretical framework of biopolitics in mind, some useful concepts that explore the mechanisms of power which ‘disallow’ life to the point of death are developed by Giorgio
Agamben, an Italian philosopher who explored concepts of sovereign power, ‘bare life’ and the ‘state of exception,’ among others in his series of publications entitled *Homo Sacer.* “Homo Sacer” refers to an obscure figure in the laws of ancient Rome, in which “homo sacer” (or “sacred man”) is someone who could be killed without any punishment or charges of homicide, but is not able to be sacrificed. This figure represents Agamben’s conception of a bare life, stripped of all personhood. Foucault’s theories of biopolitics heavily inform Agamben’s work. Whereas Foucault conceives of biopower as a mechanism of control in which human lives become the target of state organization, Agamben takes a different perspective, asserting that biopolitics and sovereign power are linked through the ‘state of exception,’ a concept Agamben draws from German political theorist Carl Schmitt. The state of exception refers to the suspension of judicial law due to an emergency or existential threat to society. Agamben argues that sovereign power may use the state of exception to establish itself by producing a political order based on the exclusion of a human life, in which the human being is stripped of all status and becomes transformed into, and ultimately defined by, its relationship to the sovereign power as a ‘bare life,’ devoid of rights. This exception gives rise to a new judicial order, “[the] rule, suspending itself, gives rise to the exception and, maintaining itself in relation to the exception, first constitutes itself as a rule” (Agamben 1998, 16-18). In other words, the juridical order suspends its own validity and produces the exception of bare life; in order to maintain relative power over the bare life, judicial rule constitutes itself as a sovereign rule. Furthermore, Agamben argues that the entire ‘Western State’ is predicated on the production of sovereign power through the exclusion of bare life (Peters 2014, 330), (in)famously claiming that the Nazi concentration camp is the dominant paradigm in all biopolitics of the West, with detained Jews representing the bare life excluded for purposes of establishing the sovereign power of Germany.
Admittedly, the historical context surrounding the stigmatization and marginalization of PWID may not be overtly attributed to an emergency threatening the U.S. However, I maintain that the theoretical framework behind the state of exception is crucial in understanding the purposes for, and the manner in which individuals and communities are reduced to “bare life” in the view of certain power structures. I will argue in subsequent sections that these mechanisms, working within the historical context of distinct racial hierarchies, have ultimately contributed to the stigmatization of PWID and the failure of U.S. policymakers to develop an accessible, mainstream apparatus of harm reduction. But first, a brief thought experiment to contextualize the argument, with a specific attention to racial hierarchies.

First, consider whether any of the descriptions in Agamben’s concept of bare life apply to the historical treatment of, say, African-Americans in the United States. Foucault claims that the development of biopower accompanied the rise of liberal governments of the mid-18th century, and Agamben, using biopolitics as a framework, claims that the foundations of Western politics is grounded in the production of sovereign power through the distinction of the “fundamental categorical pair…[of] bare life/political existence” (Agamben 1998, 12). Consider, then, that during the mid-18th century the Thirteen Colonies were in the midst of the most significant period of political enlightenment in our country’s history. A virtual paradise of Lockean ideologies of liberalism, “not only was John Locke one of three most-cited political philosophers during the Founding Era…he was by far the single most frequently-cited source in the years from 1760-1776” (Lutz 1988, 143). And finally, consider that at the time of independence, the
U.S. was roughly 150 years into an extremely lucrative trade involving the enslavement and ownership of black bodies, with nearly 100 more years to come, followed by an additional 100 years of Jim Crow. With this context in mind, I would argue that the government of the United States had an interest in enhancing and monitoring the health of its African-American subjects as a means of control. Given the strong influence of Lockean principles of life, liberty, and property, it is reasonable to claim that slavery represented the suspension of judicial rule, excluding black bodies from any political agency or personhood and therefore aiding in the production and maintenance of sovereign power.

Agamben’s concepts of bare life and state of exception and Foucault’s framework of biopolitics suggest a theoretical foundation capable of describing the fundamental mechanisms of early U.S. biopower, particularly in the subjection and ordering of black bodies. It was an accepted legal policy for slaveowners to promote and enhance the health of slaves that were deemed ‘productive,’ and equally acceptable to cast slaves aside when they were unable to perform tasks, or simply at the whim of the slaveowner. The exclusion of African-Americans from ‘political existence’ and its usefulness in the maintenance of power structures are embedded in the fabric of U.S. politics, and continues to reverberate among minority communities as they continue to suffer from a broad range of structural inequalities. As biopolitical mechanisms of control developed throughout the 19th and 20th centuries, particularly in post-Abolition Jim Crow contexts, African-Americans continued to be robbed of the right of ‘political existence,’ constituting a prime example of bare life. In other words, creating the “Other” was an invaluable strategy for the maintenance of political power throughout this time period, leading to widespread discrimination, segregation, and vast disparities in all realms of social existence for people of color. While the process of “Othering” is a more commonly-used,
colloquial concept, Agamben and Foucault illuminate the usefulness of these strategies from a different perspective; rather than simply describing the racism of the time, these concepts highlight the ways in which liberal governments without monarchical or sovereign claims to power may use biopolitics to enhance, and simultaneously exclude or disregard, members of the population. In the mid-to-late 20th century, drug policy and the stigmatization of drug users was yet another mechanism used to maintain existing power structures.

With these concepts in place, the discussion will now turn to issues of structural racism and stigma in relation to the development of U.S. drug policy, particularly how the stigmatization of drug users was heavily racialized, acting as a mechanism of maintaining white supremacy and political control through the marginalization of minority communities. Drug user stigmatization along racial lines has contributed to the inability of modern drug policy to reconcile the opioid epidemic, now that it is impacting white communities at such alarming rates.

**Racism and Stigma: Structural Inequalities in U.S. Drug Policy**

Drug policy in the United States has been a subject of contentious political debate for decades, particularly in regards to the War on Drugs and the harsh punitive measures taken against (some) offenders. For many progressives, it constitutes one of the most tangible, widely referenced and colloquially accessible icons of structural inequality among American public discourse. Typical American progressives hold a more sympathetic view toward the plight of minority communities, and remain intensely aware of the impacts that the War on Drugs has had on marginalized groups. For conservatives, many consider drug use to be indicative of a moral failure or lack of traditional values and consider harsh policing as a necessary mechanism in the maintenance of law and order. “[The U.S.] has a long tradition of moralistic condemnation of
intoxication with psychoactive drugs (including licit drugs like alcohol). The Puritans are often blamed for this tradition, even though they consumed alcohol. They did, however, condemn inebriation and also set precedents for extensively incorporating religious codes into civil laws” (Des Jarlais 2017, 52). These traditional views condemning psychoactive drugs and stigmatizing intoxication are commonly shared among those who wish to incorporate religious, moralistic standards into rule of law, a majority of whom are conservatives. It may also be said that the typical conservative favors capitalist and neoliberal concepts of personal responsibility and self-governance, such as the suburban white community in the Springfield, Massachusetts syringe exchange case discussed above; this framework would not necessarily elicit a particularly sympathetic response to the plight of those struggling with drug addiction.

In addition, there has been a long history of demonization regarding psychoactive drugs associated with stigmatized racial/ethnic minority groups. This includes the use of opium by Chinese immigrants, the use of cocaine by African-Americans, and the use of marijuana by Mexican-Americans (Des Jarlais 2017; Felner 2009; Netherland and Hansen 2016). As Netherland and Hansen argue,

The U.S. popular media association of illicit drugs with non-white ethnic groups stretches back at least one century, to images of the threat of Chinese immigrant opium dens, of ‘cocaine crazed Negros,’ and Mexican reefer madness that led to the passage of early narcotics control laws, including the 1914 Harrison Act and the 1934 Marijuana Tax Act. [Netherland and Hansen 2016, 666]

The combination of moralistic intolerance and the stigmatization of minority groups often led to the demonization of many of the psychoactive drugs in question. This vilification of specific drugs did not prevent the use of the drugs, but it created a context of fear surrounding the drugs, which lead to fear and anger towards minority communities (which supposedly constituted the
users) which encouraged a culture of abstinence as the only form of dealing with drug use (Des Jarlais 2017, 53). Public opinion and media discourse regarding drug use was characterized by stereotypes of both the drugs and the users, and criminal law became the most acceptable way to address these demonized drugs and communities (Des Jarlais 2017). For example, here, I argue that conceptions of black and brown individuals as constituting ‘bare life,’ which was deeply rooted in the biopolitics of liberal governments since the mid-18th century, continued to be used as a means of marginalization of these communities in 20th century U.S. drug laws. This marginalization on the basis of race becomes even more clear when considering the contrasting punitive legal measures of white drug use against portrayals of drug use among minority communities.

The primary example of disparities in punitive drug laws comes from an examination of drug laws surrounding crack cocaine and powder cocaine in the 1980s and 90s. During this period, policy largely denigrated black and Latino crack users, while essentially ignoring white powder cocaine users (Felner 2009; Netherland and Hansen 2016). Specifically, policy was instated that required harsh minimum sentencing for crack possession, with the amount of crack cocaine and powder cocaine needed to trigger certain U.S. federal criminal penalties being set at a disparity of 100:1, even though these substances have essentially the same chemical composition (Felner 2009). Furthermore, the intensified policing of minority neighborhoods, contrasting that of white suburbia, led to minority men more likely to be detained, although statistically these individuals were no more likely to be using drugs than young men in white suburban communities (Singer 2007). These legal disparities “led the United States to the highest incarceration rates in the world, with black and Hispanic men six and three times, respectively, as likely as white men to serve time” (Hansen and Netherland 2016, 2128). These disparities in
sentencing reflect a glaring disparity among black and Latino individuals, which I argue is inherently connected to the ongoing maintenance of existing power structures on the basis of the exclusion of ‘bare life.’ The mechanism that reproduces this inequality in the social realm is that of stigma, which acts to “Other” drug users, particularly by portraying drug use within minority communities.

In his seminal work on stigma, Erving Goffman (1963) discusses many different ways that stigma can serve to dehumanize individuals. Of the stigmatized, Goffman says, “He is thus reduced in our minds from a whole and usual person to a tainted, discounted one. Such an attribute is stigma […] it is also called a failing, a shortcoming, a handicap” (Goffman 1963, 3). Several of my key informant interviewees paid close attention to the impacts of stigma on public discourse surrounding drug users, as well as U.S. drug policy. Allan Clear of NYS-DOH Office of Drug User Health discussed the ways in which PWID continue to be pushed out of mainstream healthcare systems seeking to treat their addiction. Clear discussed how the stigmatization of PWID on the basis of their ‘moral failure’ and lack of personal responsibility in popular discourse has led to mainstream clinics “marginalizing” and “infantilizing” PWID in the course of their treatment, also noting that the discourse in these treatment programs focus on “individual failure,” rather than failure of the treatment program itself. Furthermore, Clear shared that his extensive experiences with PWID have taught him that stigma is not only institutionalized, but internalized by the PWID themselves, making recovery even more challenging in a clinical environment not designed to “meet them where they’re at.” Goffman also attends to this concept of internalized stigma, “[shame] becomes a central possibility, arising from the individual’s perception of one of his own attributes as being a defiling thing to possess” (Goffman 1963, 7). Kevin Flatley, a volunteer for a mobile syringe exchange unit, explained that
in his experience, many individuals that stigmatize drug users simply do not believe that PWID care about reducing harm; if they are injecting substances into their arms, why would they care about the harmful consequences? Flatley discussed how in his opinion, this is a result of the vilification of drug users, which in turn dehumanizes PWID by portraying them as being somehow outside of the realm of society, devoid of rights and privileges afforded to others, resonating strongly with Agamben’s ‘bare life.’ Director Keith Brown of the Katal Center in Albany, NY discussed how the perception and stigmatization of drug users is grounded in power and control at a structural level. Brown maintains that the criminalization of drugs has served a larger purpose in maintaining existing power structures of marginalization over communities impacted by drug use. Moreover, Brown stated that grassroots, community-focused harm reduction organizations are the only mechanism capable of battling the stigmatization of drug users and the structural inequalities in U.S. drug policy, and that we can’t expect mainstream health systems to do so. This idea will be explored in more detail below.

Another crucial determinant in the widespread stigmatization of drug users along racial and ethnic lines is the vastly different media portrayals of white drug use as opposed to those of use among minority populations. These contrasting media images illuminate the social and cultural stigmatization of drug users among the general population of the U.S., leading to greater political support for ongoing criminalization and further impeding the ability of policymakers to implement a mainstream healthcare apparatus for PWID. As stated at the outset of this thesis, recent media coverage of the opioid epidemic has led to increased public awareness of this issue, sparking debates about the ethical implications and usefulness of harm reduction strategies. Much of the focus in popular media has been aimed towards sympathetic accounts within white communities (Shihipar 2019; Netherland & Hansen 2016). This is in contrast to the past, as print
and televised media has a long history of portraying ‘addicts’ as ethnic minorities (Taylor 2008). As such, it is crucial to investigate how this media discourse has portrayed the opioid epidemic in white communities, particularly in regards to the stark contrast in the manner in which previous drug epidemics have been portrayed in the media. This section will examine media portrayals from two key perspectives, drawing almost exclusively from two articles from Helena B. Hansen and Julie Netherland (Hansen and Netherland 2016; Netherland and Hansen 2016), both of which explore the opioid epidemic through the lens of race. First, media portrayals of white opioid usage tend to focus primarily on what initially led white users to become addicted to opioids in the first place. This is largely related the proliferation of prescription opioid use and abuse, in which the initial prescription of such drugs strongly correlates to the race of the patient. Second, media portrayal of white individuals struggling with addiction either focus on sympathetic descriptions of the lives of the individuals and how addiction has impacted their lives, contrasted with portrayals that focus largely on criminality and ignore personal or sympathetic descriptions among stories of drug use among minority populations.

One of the often-ignored aspects of the racialized nature of the modern opioid epidemic is the structural inequalities of the American healthcare system, particularly in terms of rates of prescription, access to primary care physicians, and insurance coverage. Regarding rates of prescription, a racial disparity worthy of note is prescription opioid regulation and marketing, “which gave U.S. white patients the ‘privilege’ of unparalleled access to prescription opioids” (Hansen and Netherland 2016). Furthermore, racially stratified insurance coverage and access to physicians led to “opioid prescriptions disproportionately [going] to white patients, whereas non-White patients, even those with access to a physician, were less likely to be prescribed opioids, which increased racial differences in opioid use” (Hansen and Netherland 2016, 2128). In
Netherland and Hansen’s (2016) work on media portrayal of opioid use, a content analysis of 100 media articles revealed a focus on prescription opioid use among white communities, while focusing heavily on heroin injection among black and Latino communities.

In stories about suburban or rural white drug use, the etiology of the person’s drug use was often explored, while in accounts of drug use among blacks and Latinos such explanations about why someone started using drugs were simply missing… In stories about black and Latino people who use drugs, the criminality of their actions is the story. [Netherland and Hansen 2016, 673]

By highlighting the etiology of white drug use, media portrayals display a sympathy and understanding of white addiction that is not afforded to minority communities. This accompanied the consistent contrast between sympathetic portrayals of suburban white opioid users and descriptions of criminalized urban black and Latino heroin injectors. Highlighting these contrasting images is a key factor in recognizing the history of racialized differences in U.S. drug policy. These media accounts also highlight the critical role of racialized imagery and narratives in the development of a political culture that supports drug policies that disproportionately impact minority communities. “The extent of unmarked, naturalized discourses of white deservedness and humanity in the face of opioid addiction indicates the degree to which racially disparate drug laws require extensive cultural work to justify and maintain against political challenges” (Netherland and Hansen 2016, 681). In addition, the authors found that media portrayals also revealed important distinctions about where drug use is assumed to occur, and by whom.

One of our strongest findings was that drug use in black and Latino urban communities is not considered newsworthy. In contrast, drug use in suburban, predominantly white communities is portrayed as surprising and novel. Story after story describes drug use in suburban, white communities as a new and dangerous phenomenon, even though decades of the epidemiological evidence shows that blacks and whites have long used illicit drugs in relatively similar proportions (SAMHSA 2014). The assumption in the media accounts
is that white communities have heretofore been free from drugs; these neighborhoods are not the expected place to find drug use. [Netherland and Hansen 2016, 671]

These findings highlight racialized images of drug use that have developed in the culture of the U.S., specifically noting that although white communities have long used drugs in similar rates to minority communities, drug use has been indexed as a non-white issue. “Race is seldom mentioned explicitly in stories about drug use by white people. Indeed, being unmarked is a hallmark of whiteness” (Netherland and Hansen 2016, 667).

Examples of media portrayal are important for understanding how public discourse surrounding drug use has shaped policy responses to the opioid epidemic, particularly in contrast to the policies enacted for crack and powder cocaine sentencing. Policy responses among U.S. legislators in reaction to the opioid epidemic highlight the increased concern and sense of urgency with which “white problems” are addressed. As white communities have turned to heroin, policymakers are now advocating for reduced sentencing for nonviolent drug offenses, along with the expansion of drug treatment programs.

When nonmedical opioid use increased in white communities, regulators mandated physicians to use Prescription Drug Monitoring Programs, distributed the opioid overdose reversal medication Narcan, while passing Good Samaritan laws to protect those calling for emergency assistance during an overdose from drug charges (Hansen and Netherland 2016, 2128). In addition, US Congress legalized office-based opioid maintenance with buprenorphine after an expert testified that methadone was inappropriate for the “suburban spread of narcotic addiction;” this essentially means that middle-class opioid-dependent people were thought to be more often employed and deserved not to have to visit methadone clinics, due to stigma. (Hansen and Netherland 2016, 2128). These policy responses to the opioid epidemic illuminate the ways
in which racial and ethnic inequalities are reproduced as institutional structures, with large-scale changes in treatment policies being made in response to health issues in white communities after decades of enhanced punitive measures for minority communities suffering similar issues. Unfortunately, these unequal responses may have contributed to the opioid epidemic of today, as harsh punitive measures taken against minority communities may have kept harm reduction strategies from being implemented at an earlier time. As Kassandra Fredrique, Director of the New York State Drug Policy Alliance writes, referring to the harsh penalties and criminalization of earlier drug epidemics, “[if] we had invested in harm reduction programs and increased the availability and quality of addiction treatment then, we would have been better positioned to reduce the toll of the current opioid crisis” (Frederique 2016). The stigmatization of drug users along racial lines has encouraged a culture of racism surrounding drug policy, which has deeply impacted the development of the harm reduction movement. This culture of stigma, and more specifically, its broad influence on drug policy, encouraged a grassroots, anarchist movement of harm reduction aimed at resisting mainstream institutions. However, given the opioid epidemic of today, a review of existing literature and my interviews with key informants in harm reduction organizations indicated that the harm reduction movement has long experienced an ongoing identity crisis, which I will explore in the following section.

Harm Reduction Then & Now: Anarchism, Biopolitics, and Entering the ‘Mainstream’

Thus far, I have highlighted some of the key factors that have led to the stark inequalities in public discourse and policy responses to drug epidemics in minority communities in the United States. Indeed, the tendency to marginalize minority communities is woven into the very fabric of American history and extends far beyond drug policy. These structural inequalities
resulted in numerous social justice movements, such as the Civil Rights or Feminist movements, intended to illuminate inequality and lobby for change. Similarly, the harm reduction movement began in response to the marginalization of PWID, specifically in the context of the HIV/AIDS epidemic of the 1980s and 90s. Much like many social justice movements of the mid-to-late 20th century, the pioneers of harm reduction involved a significant amount of personal risk, originally practiced as an illegal activity in which activists and politicized grassroots workers accepted the possibility of arrest by distributing clean syringes (Roe 2005; Smith 2012; Stoller 1998). More than political activists, however, Nancy Stoller (1998) describes the origins of San Francisco’s syringe program as an underground “act of civil disobedience by a group of pagan, hippie anarchists” (101). However, there is significant evidence to suggest that relatively early on in the movement, harm reduction strayed from its politically engaged foundations (McLean 2011; Smith 2012; Roe 2005). Since the late-1980s, harm reduction initiatives have received increased, but widely variable, support from state and municipal governments (McLean 2011; Roe 2005). During this time, participating states and municipalities adopted harm reduction as public health policy, taking certain pieces of harm reduction that were deemed morally acceptable in ‘a la carte’ fashion. Thus, the evolution of harm reduction is characterized by compromise and cooptation, as well as a strained relationship, with institutional forces (Smith 2012). As McLean argues, “The civil disobedience of early exchangers has been described as encompassing acts intended to stimulate political and public debate around the marginalized status of drug users; in advocating for the implementation of harm reduction strategies, [individuals] were more broadly interested in advancing a program attuned to the larger social welfare of drug users, and the communities in which they lived” (2011, 74). However, there is a growing body of literature that claims the adoption of harm reduction as a public health policy has “confined the anarchist
spirit” of harm reduction’s origins (McLean 2011; Smith 2012; Roe 2005). Smith astutely describes this phenomenon in his analysis of Roe (2005),

Suggesting institutionalization has effectively sanitized harm reduction’s oppositional political origins, Roe articulates a historic tension between those who see the movement as a ‘medical means of promoting health and mitigating harm’, and a more activist faction positing harm reduction as ‘a platform for broader and more structural social change.’ Institutional harm reduction advocates, Roe asserts, engage in cooperation with state bodies ignorant to the fact that ‘the health problems they address are substantially created by the ideology of the systems in which they work’. (245) [...] Harm-reduction-as-public-health-policy thus ‘avoids confronting the very things that produce the most harm for drug users: drug laws, dominant discourses of drug use and the stigmatization of users. [Smith 2012, 211]

Here, the earlier discussion of biopower comes into play. Roe, and subsequently Smith, are concerned about institutional structures of power utilizing harm reduction as yet another means of controlling, regulating, and further marginalizing PWID. In her discussion of the biopolitics of needle exchange, McLean (2011) echoes these sentiments, positing that the major concern of needle exchange may be the “preservation of the biological integrity of [PWID], and by extension, the general population” (75). McLean claims that harm reduction services such as needle exchange attempt to establish injecting drug users as subjects within the national body, “Whether disseminated by street-level activists or public heath bureaucrats, all discourses of needle exchange, and perhaps harm reduction at large, illuminate the entrenchment of such programs within a still-existent biopolitical regime of power” (McLean 2011, 75). Here, McLean is arguing that although the grassroots nature of harm reduction was meant to fight institutional power, the adoption of harm reduction in the mainstream healthcare system has inherently depoliticized harm reduction, effectively rendering it as another mechanism of biopower.

Although these politicized concerns regarding the institutionalization of harm reduction as public health policy are certainly supported by a breadth of literature, it was in this subject that
I encountered perhaps the most compelling contrasts in opinions within key informant interviews. In my discussions with Keith Brown, long-time harm reduction activist and director of Katal Center for Health Equity & Justice in Albany, NY, he embodied the anarchist spirit which characterized the origins of harm reduction. Giving passionate and energetic, yet concise and well-researched descriptions of oppressive governmental structures and their relation to drug policy, Brown was adamant that mainstream addiction clinics and treatment programs are inadequate to provide harm reduction services. Brown stated that these mainstream services do not embody the social justice movement that is harm reduction, and are subsequently not designed to provide the broad range of services needed to PWID, merely “diluting” the work that harm reduction organizations are engaged in. With this statement, Brown is highlighting the concern of many grassroots harm reduction advocates that the institutional health policies of mainstream addiction clinics have historically contributed to the rejection of PWID, and as such, they do not maintain a broad enough range of services to mitigate the various socioeconomic barriers that PWID face day-to-day. Much to my surprise, when I discussed this issue with Carol Greco, Director of Addiction Services at St. Mary’s Hospital, her response confirmed Brown’s sentiments in no uncertain terms. My assumptions led me to believe that Greco would refute this claim and discuss the ways in which the clinic performed harm reduction services in their own setting. However, Greco stated that the “progressive harm reduction” (referring to harm reduction’s political nature) does not fit the structure of their clinical setting. For example, Greco was very clear that the clinic would “never” become a Safe Injection Facility (Safe Consumption Space). Furthermore, Greco described incremental changes, such as the clinic’s relatively new service of Medication Assisted Treatment (MAT) via Suboxone, as creating a major disruption in the clinic’s focus on abstinence as the main way to recover from addiction, with her employees
struggling to provide such services from a moral perspective. Brown and Greco, respectively, represent professionals at the polar opposite ends of the treatment spectrum, from grassroots harm reduction activism to veteran clinical addiction services. Both agree that harm reduction programs and mainstream addiction clinics are incompatible, but while Brown argues that only harm reduction organizations can provide acceptable harm reduction services from a systems perspective, Greco sees harm reduction as highly politicized, and seemed dismissive of the idea that its progressive ideologies would ever be enacted in the clinical setting.

These opinions are both at odds with those of my interviewees at New York State Department of Health (NYS-DOH). In my discussions with Allan Clear, current Director of NYS-DOH Office of Drug User Health, he was unambiguously in support of the “mainstreaming” of harm reduction into health policy. Although Clear was on the ground-floor of syringe exchange, founding the underground (then-illegal) syringe exchange program in the Lower East-Side of Manhattan in the early 1990s, Clear continually referred to the need of mainstream healthcare agencies to develop adequate services for PWID. Clear stated that if mainstream healthcare services served their intended function (improving the health of citizens), grassroots, community-based harm reduction programs would not be necessary in the maintenance of drug user health. However, it is important to note that Clear is a staunch supporter of any and all harm reduction programs. In fact, he discussed the importance of recognizing that PWID themselves are the ones responsible for the initial design and implementation of harm reduction services, such as syringe exchange and Naloxone distribution. And although Clear acknowledged early harm reduction as being a “movement of outsiders” with a distinct “element of resistance,” it nonetheless needs to become a part of the mainstream healthcare apparatus in order to gain access to the extensive funding streams within the federal
government and other private entities, as well as addressing long-held stigma toward PWID. In my interview with AIDS Program Manager Barry Walston, a colleague of Allan Clear’s at NYS-DOH in the Division of Prevention, Walston echoed Clear’s sentiments. Walston stated that drug epidemics such as the opioid epidemic are a direct result of systemic inequality in the U.S., a system created by the U.S. government and its policymakers. As such, it is incumbent on the U.S. government and its mainstream health systems to solve the problem. Walston also stated that as with any societal change, ‘growing pains’ may occur in the mainstreaming of a controversial issue, but these growing pains are necessary in order to shift the culture away from the stigmatization of drug users.

Neoliberalism in Harm Reduction

In discussing the role of mainstream health systems in the expansion of harm reduction services, it is crucial to examine the impact of the rise of neoliberal forms of governance. The development of harm reduction and its varying scales of incorporation into public health policy is closely tied to the rise of neoliberalism, both temporally and in terms of policy. The impact of neoliberal ideologies on the development of harm reduction are vast; here, I will explore a few key issues. I examine the quintessential neoliberal focus on decentralization, particularly how the proliferation of state-funded programs, private entities, and NGO’s have influenced the fractured development of harm reduction. This fracturing occurred through inconsistencies in neoliberal tropes of “partnership” and “community,” specifically how these ideas have ever-shifting meanings and are more useful in discourse than in practice, leading to private “partners” often being left out of decision-making processes in policy development, as well as a lack in dedicated funding streams. I also discuss the inclination of neoliberals to focus on aspects of personal
responsibility, particularly among religious fundamentalists and right-wing conservatives, and how these factors serve to further the stigmatization of drug users.

According to Des Jarlais (2017), a major barrier to the adoption of harm reduction has been the diminished role that the federal government played in healthcare, placing more responsibility on the role of states. This allowed individual states to implement harm reduction programs which ignored attitudes of the federal government. “The federal government, however, had much greater financial resources for both implementing HIV prevention for PWID and for funding research. Thus, the initial opposition to harm reduction by the US federal government delayed widespread implementation of harm reduction programs for many years” (Des Jarlais 2017, 53). As a result, there are widely varying levels of harm reduction implementation among states and municipalities in the U.S. In addition, the rise in neoliberal forms of government has also led to the proliferation of private entities and NGO’s working in collaboration with state entities. In their exploration of neoliberal discourses within Australian drug policy, Thomas et al. (2016), argue that these discourses have largely focused on governing ‘through community.’ The authors describe how the shifting language of partnerships under neoliberalism have led to a diminished responsibility of state actors to uphold their end as a contributing partner. “Increasingly under neo-liberalism, social problems and their solutions are represented as the responsibility of individuals, families, and communities” (Thomas et al 2016, 40). Here, I argue that although harm reduction, with its origins as a grassroots, community-based movement, seems to fit the paradigm of ‘governing through community,’ the reason for this community focus came out of necessity rather than strategy. Harm reduction activists were concerned about social injustice and structural inequality at the heart of U.S. drug policy and were forced to create a movement of resistance. While I recognize the insistence among harm reduction activists that
harm reduction is incompatible with mainstream health and is best conducted at the grassroots level, I maintain that structural inequality in drug policy and coordinated stigmatization of marginalized groups has created a political and social environment in which harm reduction is forced into its role as a community-based endeavor.

In combination with the decentralization of healthcare systems into private entities and communities, public discourse surrounding U.S. drug policy in the latter-20th century has reflected neoliberal discourses of enhanced focus on the role of personal responsibility and self-determination; a useful example of this may be shown in the Reagan Administration’s iconic phrase regarding drug use: “Just say NO!” Championed widely by conservatives and religious fundamentalists, this conception of individual choice in drug use, along with racialized media portrayals demonizing drug users, was reminiscent of the traditional, Puritan moralistic condemnation of intoxication (Des Jarlais 2017). Baru and Mohan (2018) describe some of the ways in which the resurgence of religious fundamentalism has accompanied neoliberal discourses, “[the] rise or resurgence of religious fundamentalisms is a political project of neoliberalism that is influenced by the discontents of liberalization and globalization” (97). The increasing emphasis on the ‘private’ over the ‘public,’ as well as the ‘personal’ over the ‘political,’ is one of the defining traits of the neoliberal discourse. Exclusion of minority communities from civic participation is a characteristic which contributes to marginalizing their rights in the personal and political spheres (Baru and Mohan 2018).

Throughout the interviews with Keith Brown (Katal Center) and Allan Clear, (NYS-DOH Office of Drug User Health), both interviewees stressed the challenges of securing funding. As New York State is a state government that invests in harm reduction through partnerships with private entities, the possibility for funding does exist. However, Clear
described the process of securing as a complex series of “hoops” to jump through. One of the challenges in applications for funding described by both Clear and Brown is the difficulty in demonstrating the impact that harm reduction services have on PWID in quantifiable terms. Brown stated that he often hears anecdotes from PWID to the effect of, “this is the only place where I don’t feel terrible, where I’m accepted.” Quantifying this type of impact in a traditional grant request seems to be a challenge for those attempting to access state funds. Barry Walston, from NYS-DOH Office of Prevention, highlighted “legislative days,” where representatives from private entities and NGOs are able to connect with legislators and lobby for funding. Walston described these legislative days as an important point of connection for these entities to let legislators know what they need. However, Brown indicated that it can be difficult to make an impact at such legislative days without a significant show of support and a large number of individuals present on a consistent basis, which can be challenging to assemble. Additionally, Brown stated that departments such as NYS OASAS (New York State Office of Alcoholism and Substance Abuse Services) have a tendency to funnel monies into clinical treatment services, rather than harm reduction. That clinical addiction services are not required to generate activists and rally public support in such a way in order to receive funding constitutes an inequality in legislative support. Brown also noted that the structure of election cycles do not encourage political representatives to invest in progressive harm reduction programs, stating that representatives allocate funding for uncontroversial treatment programs, “take a victory lap” and “kick the can down the road.” This strategy essentially represents a ‘win-win’ scenario for representatives; they do not alienate conservative voters who remain staunchly opposed to progressive harm reduction initiatives, but also remain in good standing with progressives by being able to claim that they allocated funding for drug treatment and services. In contrast, Carol
Greco from St. Mary’s Addiction Services described the clinic’s funding as primarily revenue-driven, with various “small” start-up grants from offices such as OASAS. The tone of my conversation with Greco indicated to me that the clinic does not struggle with funding, due to being revenue-driven and reimbursements from Medicare.

These challenges in securing funding for private entities and NGOs providing harm reduction services illustrates inconsistencies in “partnership and collaboration” with state governments. Rather than operating on an equal playing field with other health services, private harm reduction organizations are forced to continually generate public support and put pressure on legislators to allocate sufficient funds, although ostensibly these programs have already been accepted by the state as valid (in cases such as New York State, not all states have such ‘support’). This issue is especially relevant when considering the lack of issues in funding among mainstream clinical addiction services. If harm reduction practices were incorporated into the mainstream health system in previous decades, organizations providing these services may have benefitted from consistent funding sources, allowing for a mainstream harm reduction apparatus more capable of address the current opioid epidemic.

**Conclusions**

In this thesis, I have critically examined various large-scale forces that have shaped the history of drug policy in the U.S., contributing to the current state of addiction services that are ill equipped to manage the rapid increase of opioid related overdoses in recent years. Understanding the theoretical frameworks behind the Foucault’s theory of biopower/biopolitics, as well as Agamben’s concepts of ‘bare life’ and the state of exception, are crucial to understanding the purposes for, and the manner in which individuals and communities are
reduced to an existence of bare life in the view of certain power structures seeking to maintain control over the biological lives of political subjects (or politically ‘bare’ subjects). Through the application of these concepts, I first established a theoretical foundation capable of critically examining mechanisms of early U.S. governmental biopower, particularly in reference to the subjection and ordering of black bodies. These mechanisms, working within the historical context of distinct racial hierarchies, have ultimately contributed to the stigmatization of PWID, the failure of U.S. policymakers to develop an accessible, mainstream apparatus of harm reduction, and have thus led to the inability of legislators and political leaders to reconcile U.S. drug policy now that the opioid epidemic is affecting white communities.

The more recent historical context surrounding the stigmatization of drug users showed that conceptions of drug users were heavily racialized, acting as a mechanism of maintaining white supremacy and political control through the demonization and marginalization of minority communities. This marginalization on the basis of race becomes even more clear when considering the contrasting punitive legal measures of drug use among minority communities against modern sympathetic media portrayals of drug use among white communities. These media accounts also highlight the critical role of racialized imagery and narratives in the development of a political culture that has supported drug policies that disproportionately impact minority communities.

Policy responses to the opioid epidemic illuminate the ways in which racial and ethnic inequalities are reproduced as institutional structures. These reactions to health issues in white communities after decades of enhanced punitive measures for black and brown communities suffering similar issues provides further evidence of the inherent structural inequality in the domain of drug policy. These unequal responses have resulted in a lack of infrastructure to
manage the opioid epidemic of today, as harsh punitive measures taken against minority communities may have kept harm reduction strategies from being implemented at an earlier time.

Structural and institutional inequalities in the maintenance of drug user health ultimately resulted in resistance among concerned communities of drug user allies, which instigated the grassroots, anarchistic origins of harm reduction. However, within the community of harm reduction activists, providers, and administrators, there are starkly contrasting views on harm reduction’s integration into mainstream public health policy. Some view the mainstreaming of harm reduction services as incompatible with institutional health systems, citing a belief that the design of these clinics and hospitals is unable to provide the range of harm reduction services necessary to mitigate the socioeconomic challenges that PWID face on a day-to-day basis. Others believe that the mainstreaming of harm reduction is crucial in the destigmatization of drug use and PWID themselves, as well as the ability to secure adequate funds to provide these services in a more consistent basis across the country.

Finally, the development of the harm reduction movement is linked with the rise of neoliberal conceptions of governance, with a neoliberal focus on decentralization and private partnerships influencing the fractured development of harm reduction. This fracturing occurred through inconsistencies in neoliberal tropes of ‘partnership,’ ‘collaboration,’ and “governing through community,” leading to private ‘partners’ often being left out of decision-making processes in policy development, as well as a lack in dedicated funding streams. In addition, I discussed the proclivity of neoliberal politics to focus on aspects of personal responsibility, particularly among religious fundamentalists and right-wing conservatives, and how these factors serve to further the stigmatization of drug users. The challenges in securing funding for private entities and NGOs providing harm reduction services illustrates inconsistencies in “partnership
and collaboration” with state and municipal governments. This is especially relevant when considering the lack of issues in funding among mainstream clinical addiction services.

**Recommendations**

I have argued that historically rooted governmental structures of power and control are intimately linked with the stigmatization of drug users, based largely along racial and ethnic lines. Such stigmatization, which was historically used as a mechanism of maintaining the political status quo, has led to inadequate policies and healthcare systems in the face of the modern opioid epidemic. Legislators are scrambling to address the alarming rates of opioid overdoses through new drug policies. I suggest that if harm reduction practices were incorporated into the mainstream health system in previous decades, rather than punitive legal measures and intensified policing, organizations providing these services would have benefitted from consistent funding sources, allowing for a mainstream harm reduction apparatus more capable of addressing the current opioid epidemic. I maintain that addressing these structures and reconciling the inequalities therein is a crucial step toward making meaningful changes to the culture surrounding drug use and U.S. drug policy.

Despite compelling, contrasting arguments from distinguished harm reduction professionals regarding the institutionalization of harm reduction, I recommend first and foremost that harm reduction be incorporated broadly into mainstream healthcare systems. I center my argument on the basic principle of reducing harm for the most people. This is not to say that dedicated and experienced harm reduction activists who disagree do not want the same thing; I believe that changing the culture surrounding PWID on a broad level will do more for PWID in the long run, especially considering the inconsistencies in funding and policies from
state-to-state. I disagree with the claim that mainstream health systems are simply incapable of providing these services. I consider the harm reduction movement to be another pivotal issue in the struggle toward social justice in contemporary U.S., and I argue that we should face the task of changing the culture of stigma, and in turn, mainstream health systems.

To accomplish this, U.S. politicians and legislators must be willing to stake their political capital on raising awareness of harm reduction logics and programs in order to address the rise in opioid overdoses. It is important to note that often, public health interventions can create inequalities by disproportionately impacting less disadvantaged groups (Lorenc et al. 2013). To combat this trend, it is important to support interventions that address the potential unequal outcomes and actively work to support health equity among all populations. To this end, I will borrow from Hansen and Netherland (2016) in recommending racial/ethnic impact assessments in the development of new drug policies as way to consider the impacts of health policies and clinical practices on racial and ethnic communities. According to the authors, “[racial/ethnic impact assessments] require policymakers to conduct a formal assessment of how a specific policy proposal is likely to ameliorate or exacerbate racial disparities, particularly in the criminal justice system” (Hansen and Netherland 2016, 2128). I acknowledge that these broad changes represent a lofty goal, but through these various steps, I believe that we can make the necessary changes that will ultimately result in a culture that is primarily concerned with the wellness of all its citizens, and drug policies that reflect such a concern.
References


