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Research report

Harm reduction – ideals and paradoxes

ABSTRACT

D. Andersen & M. Järvinen: Harm reduction – ideals and paradoxes

■ AIM

The aim of the article is to critically reflect on the harm reduction approach used in Danish substance abuse treatment.

■ DATA

The article is based on qualitative interviews with staff at treatment institutions in Copenhagen.

■ THEMES AND CONCLUSIONS

Three themes are addressed. First, our data indicate that low-threshold methadone treatment is difficult to combine with a long-term goal of abstinence. In fact, many harm reduction proponents among staff are directly opposed to treatment models in which abstinence is a goal. Second, we illustrate how the development of harm reduction measures is embedded in a socio-political trend focusing on a combined "autonomization/ responsibilization" of social clients. This focus on clients as autonomous and responsible subjects clashes with another central conception among staff: the idea that heroin addicts are slaves to their substance use and hence cannot be treated as fully rational human beings. Third, the article analyses the relationship between harm reduction and social integration.

Although social integration of substance abusers is part of the rationale behind harm reduction

> "Who in their right mind could oppose the notion of reducing harm?" (Nadelmann 1993, 37)

Harm reduction is a term used to describe policies and programmes aimed at reducing the health-related, social and economic damage caused by drug use without insisting on total abstinence (cf. Riley et al. 1999). Harm reduction refers both to concrete practical measures such as setting up injection rooms, establishing "low threshold" services, giving instruction in good injection techniques, exchanging syringes and so on, and more generally to an approach and a way of thinking that focuses on reducing harm to the drug user him/herself and to the people in his/her immediate environment, rather than on abstinence.

The purpose of this article is critically to examine the phenomenon of harm reduction as practised in the Danish treatment system today. We deal with three themes, namely: harm reduction and abstinence; harm reduction, autonomy and responsibility; and finally, harm reduction and social integration. Empirically the article is based on interviews with staff at outpatient treatment centres in Copenhagen.

measures, this goal is difficult to reach with a group of clients as marginalized as the ones in focus.

■ KEYWORDS
Harm reduction, social integration, methadone treatment, heroin abuse, responsibilization

Embarking from these interviews and from the international research literature on harm reduction, we point out a number of paradoxes in harm reduction practice. Harm reduction measures are in many respects beneficial and necessary, but they also entail a number of dilemmas that in our opinion have received far too little attention in the research.

Social research and harm reduction

Alcohol and drug researchers have in general taken a very positive view of harm reduction, and in many contexts the harm reduction paradigm has been presented as a pragmatic, humane and scientific approach to the problems related to substance use: sometimes, indeed, as the *only* such approach.

The Australian sociologist Grazyna Zajdow (2005) addresses the question why researchers often take a critical and satirical view of drug policies aimed at zero tolerance and control, while they relatively "uncritically" endorse the harm reduction paradigm. Zajdow believes that, as a group, sociologists doing research on alcohol and drugs have given themselves very limited opportunities to respond to public policies because they adher to a quite rigid (negative) attitude towards social control. The practical world of drug policies and treatment is of course complicated. There is considerable ambivalence and lack of clarity regarding what goals should be chosen for policies and treatment; how these goals should be reached; which measures are effective in helping which groups of drug users, etc. Zajdow blames the harm reduction paradigm – and the proponents of this paradigm – for ignoring these uncertainties: *"Harm minimization, as a policy response to perceived problems with drug and alcohol use, is an attempt to come to terms with ambivalence by avoiding the issue altogether".* (p. 186)

Many researchers working within the harm reduction paradigm would probably be indignant at such accusations – they hardly regard their approach as unconsidered. Nevertheless, a brief survey of the research literature on harm reduction makes it clear why Zajdow has raised the issue. Harm reduction has almost universally been presented as the "self-evidently correct" approach to the problems associated with drug use, while critical reflections about the paradigm have been very rare. At least this was the case when

the idea of harm reduction was first introduced to the world in the late 1980s and in the decade that followed. In 1989, for example, the Dutch sociologist Eddy Engelsman (1989) presented the concept with the following words: "*The Dutch being sober and pragmatic people, they opt rather for a realistic and practical approach to the drug problem than for a moralistic or over-dramatized one"* (p. 212). Engelsman presents harm reduction as the opposite of a moralistic control policy based on false premises. According to him, the sensible harm reduction approach to drugs in the Netherlands is built on a recognition that drug-related problems are not a matter for the police and the judicial system, but primarily a question of health and social welfare.

Another advocate of and leading pioneer in harm reduction during the period when the paradigm was being established was Russell Newcombe, who is attached to Merseyside[1]. In a collection arising from discussions at the Liverpool conference on harm reduction in 1990, Newcombe wrote the seminal article: "The reduction of drug-related harm: A conceptual framework for theory, practice and research." Here harm reduction is (again) presented as the sensible alternative to a moralistic abstinence-oriented policy:

> "Harm reduction has its main roots in the scientific public health model, with deeper roots in humanitarianism and libertarianism. It therefore contrasts with abstentionism, which is rooted more in the punitive law enforcement model, and in medical and religious paternalism." (Newcombe 1992, 1)

The battlefronts are thus drawn up: harm reduction is based on a scientific model, whereas abstinence is founded on medical and religious paternalism. Harm reduction is linked with humanitarianism, whereas abstinence-oriented approaches are associated with repressive policies of control. It is not hard to see which drug policy Newcombe himself favours.

A somewhat later example can be taken from the American psychologist and social researcher G. Alan Marlatt. He too gives a very positive account of harm reduction, writing for example:

> "Harm reduction offers a pragmatic yet compassionate set of principles and procedures designed to reduce the harmful consequences of addictive behaviour for both drug consumers and for the society in which they live." (Marlatt 1996, 779)

Here, again, the relationship between harm reduction and other approaches is presented in either-or terms. Either one is in favour of harm reduction – in the shape in which it is presented by the authors – or one is an opponent of scientific research, common sense, humanitarianism, public health and compassion. And as Nadelmann was quoted as saying in the epigraph: "Who in their right mind could oppose the notion of reducing harm?" – if harm reduction is comprehended as a representative for all these things?

The attitude towards harm reduction among Danish researchers in the field has been almost unconditionally positive as well. One of the warmest advocates of harm reduction in Denmark is Jørgen Jepsen, who like many other social researchers combines a positive view of harm reduction with sharp criticism of the "repressive policy of control" (Jepsen 2000; 2001). Jepsen is especially critical of

the USA for its "all-out war on drug use".

> "Most peculiar is the American opposition to harm reduction measures, both in general and in relation to concrete measures such as injection rooms. Thus the USA and its followers have for many years successfully kept the term 'harm reduction' out of official UN documents, because they see 'harm reduction' as reducing the impact of the all-out war on drug use." (Jepsen 2001, 20)

Jepsen also sees the Danish policy of control as a barrier to real and practical harm reduction, and he thinks that all attempts to introduce harm-reducing measures will remain half-hearted so long as the drug field is dominated by "the illusion of an all-out condemnation of drug use and drug dealing". (Jepsen 2000, 98-99)

The above citations exemplify the way in which harm reduction has been presented in drug research. One could have chosen numerous other examples without substantially changing the picture. The early advocates of harm reduction often wrote in direct opposition to what many referred to as repressive control policies, and in this context harm reduction was presented as an unqualified good. Any critical examination of the harm reduction principle had obviously to give way to a more important cause – a fundamental showdown with the problematic policy of drug control.

Recently, however, there have been a number of contributors to the drug policy debate who take a more nuanced – and critical – view of the harm reduction paradigm. These critical interventions come both from the general social science literature on public health and harm reduction and from individual authors in the field of drug research (Miller 2001; Keane 2003; Roe 2005). We will return to these contributions later in the text.

As a precaution we should make clear that our purpose in this article is not to argue that harm reduction measures are a bad idea, or that a repressive control policy has something positive to offer. Rather, we wish to argue for a more considered and nuanced treatment of the harm reduction approach in drug research, a treatment that is open to discussing the ambivalence, paradoxes and risks that this approach entails.

In what follows we take a look at the Danish treatment system – and in particular at substitution treatment for opiate users, which is strongly influenced by the concept of harm reduction (whether explicitly formulated or implicitly assumed). In particular we consider the three themes mentioned in the introduction: harm reduction in relation to abstinence; harm reduction as a means of increasing autonomy and responsibility; and harm reduction and social integration. Under each of these headings we will relate the Danish treatment system, as it is described by practitioners at outpatient centres in Copenhagen, to the international research literature on harm reduction.

The interviewees in this study come from two types of outpatient services in Copenhagen in 2005–06: "advisory centres" (rådgivningscentre) and "ambulatory centres" (ambulatorier). The advisory centres (of which there were four in Copenhagen at the time of the interviews[2]) are the reception units for the drug treatment system, the units through which all drug users have to pass before they can be referred to various forms of treatment. Some

opiate users receive substitution treatment (primarily methadone) at the advisory centres, while others are referred to the ambulatory centres (of which there were nine in Copenhagen in 2005–06).

According to Danish National Health Service statistics a total of 13,316 people were in treatment for drug abuse in 2005. Three quarters of the clients were men, and the average age was 37. Statistics on the distribution of various forms of treatment show that 82 percent of the clients in Copenhagen were in outpatient treatment in 2005, while only six percent were admitted for inpatient treatment (the proportion of "unknowns" however was relatively high – 11 percent). Neither the Health Service nor Copenhagen Municipality has information on the percentages of opiate users given substitution and drug-free treatment respectively, but the existing treatment statistics suggest that most opiate users are receiving some form of substitution treatment (primarily methadone).

When we, in what follows, analyse the practice of harm reduction at advisory centres and ambulatory centres, we are therefore looking at an absolutely key part of the treatment system for drug users in Copenhagen. Substitution treatment on an outpatient basis, accompanied by practical support from a social worker and consultations with a contact person, is the main form of treatment for opiate users in Denmark today, while more intensive forms of psychosocial treatment aimed at abstinence (in either an inpatient or an outpatient setting) account for only a minimal proportion of client contacts. In this respect Denmark deviates from the pattern in the other Nordic countries, where in general abstinence is the overall goal for all substance users, and where the very term "treatment" tend to be reserved for activities directed towards this goal, while other activities are referred to as "care".

Harm reduction and abstinence

One question on which there has been a certain amount of controversy in the international literature concerns the relation between harm reduction and abstinence. Some authors argue that harm reduction by definition is aimed neither at abstinence nor at a reduction in intake. For others abstinence remains an ideal goal even within the harm reduction paradigm – although there are other goals (related to the minimization of harms) they regard as more immediate. A third group sees abstinence or intake reduction as a way of reducing harm, and hence as a means in the harm minimization approach but not as a goal in itself.

The Canadian sociologist Eric Single has come up with a definition that is often quoted as a typical example of the first position: i.e. an approach that excludes the goal of abstinence. He defines harm reduction as follows:

> "A policy or program directed towards decreasing adverse health, social and economic consequences of drug use even though the user continues to use psychoactive drugs at the present time […] abstinence-oriented programs […] would not be considered harm reduction measures." (Single 1995, 289)

G. Alan Marlatt, whom we quoted earlier, can be seen as an example of the second position. In Marlatt's definition of harm reduction the crucial point is that the principle recognises abstinence as the ideal goal,

but that a minimization of negative drug use consequences is seen as a valuable ambition too. Marlatt (1996; 1998) describes harm reduction in terms of a continuum, with abstinence at the positive end of the scale and high-risk drug use at the negative end. Instead of posing a dichotomy between two extremes (abstinence or a focus on harms), Marlatt recommends an approach that encourages any step in the direction of less risky and harmful behaviour.

Finally, as mentioned above, abstinence or reduced intake can be seen as means of reducing harm without being goals in themselves. The American researchers Don des Jarlais et al. (1993) express this position in their definition of harm reduction:

> "Harm reduction simply calls for reducing the harmful effects of drug use. If reducing the drug use is the only way in which harmful consequences can be reduced, then reduction is necessary. For many types of drug-related harm, however, it is possible to reduce at least a substantial part of the harm without necessarily eliminating (or even reducing) the drug use itself." (Des Jarlais et al. 1993, 424)

The relationship between harm reduction and the goals of abstinence or reduced intake has been a central theme in our interviews with representatives of the Danish treatment system. What view does the staff at the advisory centres and ambulatory centres take of the goal of abstinence and reduced intake, and is it possible to combine such goals with – or incorporate them into – a harm reduction approach? Here is an extract from an interview with a representative of one of the outpatient centres, where the interviewee is answering the question about the goals of his work:

> Answer: The focus is on the social side, on the level of functioning. How well are [the users] functioning and how are they doing? […] It's not that we're against it [abstinence]. But we believe fundamentally that it's a question of harm reduction and of supporting the drug user on the path he or she wishes to take, for his or her sake […]
>
> Question: What's your impression, do your drug users want to be drug-free?
>
> Answer: No, not all of them. Some do. Some have been trained for years to talk about abstinence. I mean, after years of going through the treatment systems they've learnt that what you have to say when you walk in the door is "I want to be drug-free" […] And we spend a lot of time, especially with new users, on teaching them that that doesn't impress us...
>
> (Interview with a practitioner at an ambulatory centre).

The interviewee in this extract evidently believes that the majority of the centre's clients do not actually want to be drug-free. If they say they do, this is because of their previous experience with treatment, i.e. because they have been socialised to say what "the systems" prefer to hear. This conception of the users being taught to say they want to be drug free is related to another widely shared opinion among the staff at the centres: the idea that abstinence is an unrealistic goal for the vast majority of opiate users, and that drug-free treatment can do them more harm than good. One practitioner made the following statement about abstinence-oriented treatment:

> "I really think that you create more

> failures for the individual user […] [Those] who are least well-functioning socially have a chance of getting through their treatment – or a risk of getting through their treatment, as I tend to call it – of about five to ten percent […] And for god's sake you shouldn't give the most down-and-out people still more defeats […] This also means that the people who make the decisions should have nerves of steel... It shouldn't be a case of drug users coming in the door at ten o'clock and out again and getting a place in outpatient treatment at two o'clock. If you do it like that, it rarely has much effect. But the dogma [of abstinence] still persists and it's kept going by the supporters of drug-free treatment."
>
> (Interview with a practitioner at an ambulatory centre).

A practitioner from another ambulatory centre says the following about abstinence:

> "It isn't our job to motivate people to become drug-free in that way. The idea is to give them a refuge here […] With these people what we're saying is that they should be left in peace to have their drugs from now on and till they die, or until they decide that they don't want to take drugs any more […] Because these people – I'd almost say they have been 'treatment abused' all of them."
>
> (Interview with a practitioner at an ambulatory centre).

Thus this interviewee too thinks that drug-free treatment is potentially injurious to opiate users (cf. the expression "treatment abused") and sees the outpatient centre as a place of freedom that the users have at long last arrived at after many years' negative experience with other forms of treatment. The interviewee compares the clients' admission to the outpatient centre to the change that takes place in the life of a person on social security when he or she is granted an early retirement pension. Just as the recipient of a pension achieves financial security and is freed from the requirement to seek work (or accept retraining and/or comply with other conditions for receiving benefit), so the outpatient clients get "security of provision with regard to their drugs" and escape "well-meaning care workers and people who have become drug-free themselves and have just discovered how it all should be done." (Interview with a practitioner at an ambulatory centre).

Thus practitioners at the outpatient centres by and large take the view that drug-free treatment is pointless for their clients. A couple of practitioners nevertheless make clear that sometimes the centres receive clients "too early", i.e. clients for whom abstinence would have been an appropriate goal:

> "Sometimes, though, you think, this is unbelievable […] because in actual fact we get people coming in the door who have never received any drug free treatment […] They are sent here from the advisory centres where care workers and social workers and you-name-it sit and make their decisions."
>
> (Interview with a practitioner at an ambulatory centre).

Once the users are sent from the advisory centres to the ambulatory centres, it is not easy to "change track" within the treatment system, according to these practitioners:

> "It's difficult, because – I mean, the whole idea of having them sent here 'on a pension' has far-reaching consequences. When the users have come here, it's very difficult for us to get them into drug-free treatment and it's also difficult to get them into stabilising treatment [residential care, where the goal is not abstinence]. The doors tend to close up once people have got here, because by then they've been dumped at the terminus."
>
> (Interview with a practitioner at an ambulatory centre).

If we relate the interviewees' statements to the international debate on harm reduction vs. abstinence discussed above, we can establish the following: the goal of abstinence is not an integral part of the harm reduction paradigm at the outpatient centres. To be sure, the practitioners say that harm reduction can in principle embrace abstinence as a goal – "the absolutely seven-star way of doing it [harm reduction] is to get the user off drugs altogether", as one of them puts it. It is merely that this goal is irrelevant for their client group. In principle they endorse the idea of Marlatt's continuum, in which abstinence is the ideal goal beyond the partial goal of harm reduction. In practice, however, they obviously work with Single's approach to harm reduction, an approach in which abstinence is not a goal, and in which harm reduction is presented as on opposite to drug-free treatment.

These findings accord with those of the Australian sociologist Glenda Koutroulis (2000) in her study of the treatment system in Melbourne. It is not easy – and it is often considered pointless by the practitioners – to include abstinence as a goal in the context of harm reduction treatment. Harm-reducing treatment is often based on the premise that drug addiction is a chronic condition and that abstinence therefore is an illusory goal. Several of the practitioners whom Koutroulis interviewed felt that they faced a dilemma if their clients said that their goal was to be drug free. The practitioners believed that the clients' desire to stop using drugs was often connected with problems in the here and now (lack of money, difficulties with personal relationships, problems with the police and so on), and that their desire to be drug free was likely to evaporate once these acute problems were solved. They therefore regarded abstinence as a difficult goal to work with. Koutroulis describes the dilemma as follows: "There is a tension concerning what the client says he or she is going to do (abstain), what the clinician anticipates the client will do (not abstain), and the provision of harm reduction prevention" (ibid., 7). Despite differences in the way harm reduction is practised in an Australian and a Danish treatment context, both Koutroulis' and our study encounter the same paradox when it comes to the relationship between harm reduction and abstinence: "In theory, harm reduction offers choices about drug use (abstinence or continued use). In practice, balancing harm-reduction messages with abstinence proved to be difficult" (ibid., 15). Many of the Danish practitioners we interviewed are so convinced that abstinence is an impossibility for opiate users – and this applies not only to the clients at the ambulatory centres but to opiate users in general (with the exception of the very youngest) – that they regard drug-free treatments as irrelevant for this group, or even as harmful.

Harm reduction, autonomy and responsibility

As several researchers have mentioned, harm reduction rests on a paradigm that assumes rational behaviour on the part of individuals who are willing and able to take responsibility for their actions. The public health researcher Tim Rhodes (2002) uses the British harm reduction programme for needle exchange as an illustration. In public-health-oriented policies, the drug user is perceived as a "health conscious" citizen capable of taking rational decisions based on public recommendations concerning risk minimization. While formerly, the disease model of drug addiction created a picture of the drug user as a slave to his/her dependence, incapable of taking rational decisions, today, the harm reduction paradigm has inaugurated a very marked shift. Rhodes speaks of an individualisation of risk behaviour and risk minimization. Individuals who are informed about different kinds of risks and about how to avoid them are also expected to act on this information (Rhodes 2002). The Australian criminologist O'Malley (1999, 198) describes the shift in thinking in these words:

> "In the new discourse, in place of the drug-slave, we have the drug-using subject who becomes a consumer choosing from a range of drugs, the risks of which are clearly outlined and known […] freedom of choice becomes a dominant theme in descriptions of drug users, who, in effect, become 'choice-makers'."

As many researchers have pointed out, social work – including social work with drug users – has tended increasingly to focus on clients' "self-management" (Villadsen & Gruber 1999; Åkerstrøm 2003; Villadsen 2004). Ever since the late 1980s social work in Denmark has consisted not merely in offering clients the help they need and are entitled to, but to a growing extent in fostering the idea of the client's duties and responsibilities (Carstens 1998). In this respect developments in Denmark reflect the international shift towards a "combined autonomization/responsibilization" of social welfare clients (Rose 2000, 1400). Treatment, and social work in general, are perceived as an animating force that is expected to help people take responsibility, monitor risks, and act rationally and with forethought (Rose 2000, 1399, cf. also Foucault 1982). In this new socio-political era it is no longer the practitioners and social workers who are supposed to define the clients' goals or to press them to find solutions to their problems, because it is believed that this approach leads to "clientization". On the contrary, it is the clients themselves – or the "users" as they are called in the new terminology – who are supposed to set the goals, suggest the means and act in accordance with the goals they have chosen.

In our interviews the discourse of autonomization/responsibilization is very prominent. Hence all interviewees pronounce that it is the clients themselves – defined as autonomous users (users of drugs; users of services) – who should take responsibility in relation to their treatment. In the following extract a practitioner at an advisory centre explains her view of the client's role in treatment. The interviewee emphasises the client's own initiative, and takes exception to the term "goal", which she obviously regards as something imposed on clients from outside – and from above:

Question: How would you describe the goals you have in relation to the people you are contact person for?

Answer: What do you mean by goals? It's one of those frightfully fine words that smell of forms with the Copenhagen Municipality logo on […] We try as far as possible to be on an equal footing with our clients; we accept that it's they who are the managing directors in their own lives […] We don't see ourselves as judges or as wiser [than they are] and we don't set out treatment plans that are just fancy words on paper […] If it doesn't come from inside, it doesn't come at all […] Compassion after all can easily be so suffocating that it takes away their own initiative.

(Interview with a practitioner at an ambulatory centre).

In the following extract a practitioner at an advisory centre explains the difference between responsible drug users and users who have been "clientized":

"I very much believe that users are much more aware of their own responsibility nowadays, that they want to be seen as equal partners in a negotiation and I really think many of them are very focused on this. And then there are others who – how should I put it – are so clientized that in principle they virtually can't wipe their own asses […] They are so socially adapted to the system that they can't actually function unless the system in one way or another provides a very high level of servicing […] And for them it's a strange thing that they are supposed to act differently now when the wind's blowing in a new direction".

(Interview with a practitioner at an advisory centre).

Although our interviewees in general regard the new focus on the clients' autonomy and responsibility as a positive thing, some of them point at potential problems in this development. A treatment system built on the assumption that all initiatives must come from the user him/herself can, according to these interviewees, easily bring about a situation where social work comes to revolve around the users who are most active and demanding. A practitioner at an advisory centre says: *"After all they have to come and tell us if they want something to change, because otherwise nothing may happen. So they had better be capable of speaking up. And of course not all of them are capable."* What this practitioner suggests, then, is that not all drug users come and ask for help, either because they are unable to formulate their wishes, or (perhaps) because they do not know what they want.

Thus the client's "goals" are not necessarily a clearly delimited and easily communicated phenomenon that the practitioner can embark from without further ado. The interviewee above also admits that she can easily end up giving priority to clients who have clear wishes – at the expense of those who are unable to formulate a goal: *"They can easily get a bit lost. At any rate they have done so recently when we've been rather busy."* On the other hand several practitioners believe – and here we come back to the emphasis on the client's own responsibility – that it is both natural and legitimate to prioritise in this way. A practitioner at an advisory centre says, for example:

"My working hours are organised in

> such a way that I attend to whoever approaches me with a request; all the others who do not approach me with a request or whatever, I do nothing about because that's the way my time has been prioritised […] Those who come to me and say they want an appointment will get an appointment, and those who come to me lots of times will get lots of appointments […] I also feel it's somewhat a matter of strategy, that when it comes to intervention, it should be in relation to people who ask for help, right? […] I do what I should do in relation to those who approach me and want help – and beyond that I can't really take responsibility."

On a busy working day the interviewee feels that he is doing what can reasonably be expected of him by attending to the requests that users approach him with. As for the users who do not formulate any goals or do not ask for his help in realising their goals, he "cannot take responsibility". The interviewee's way of reasoning is a logical outcome of the structure of the Danish treatment system and of the idea of the autonomous user that the harm-reduction approach entails. The problem that should be noted here is that this rationale poses considerable and perhaps unrealistic demands on the user. In our interviewees' understanding, a process of change can only be initiated by the users, and it is only the users who can take this process further by initiating the staff into their plans; the practitioners can only take action when the users ask them to do so. The interviewees thus operate with a strongly individualistic understanding of the user, of his/her problems and potential for change, and at the same time with a conception of the user as strong-willed and enterprising – the users are "the managing directors in their own lives", as one of the interviewees formulated it above. These conceptions, however, are at odds with the notion that opiate users are forever in thrall to their craving for drugs, and that any expressed desire on part of the clients to become drug free cannot be taken seriously. Drug users are thus defined *both* as being submitted to the power of drugs, and therefore as incapable of taking charge of their own lives, *and* as autonomous individuals who are capable of setting plans and formulating a request for help. The decisive point here seems to be whether or not the users' plans square with the harm reduction paradigm. If the users say they want stabilisation, they tend to be regarded as reasonable; if they express an interest in becoming drug-free, their plans tend to be regarded as unrealistic and ill-adviced.

Harm reduction and social integration

The final point we wish to deal with in this article concerns the various (health-related and social) objectives of the harm reduction approach as it is practiced at the outpatient centres in Copenhagen.

A review of the international literature on harm reduction reveals that the health-related goals of harm reduction are considerably more clearly described than the social objectives. Among the health-related goals are, for instance reducing the number of deaths from overdose, limiting HIV infection, and reducing injury through injection. Broadly speaking there is a prevailing consensus here that a number of harm-reduction measures – including, not least, methadone treatment – do in fact re-

duce the number of deaths from overdose, HIV infections and injection injuries, and this consensus appears to have a well-documented foundation. (e.g. Coppel 2000; Wolf et al. 2003)

By contrast the impact of harm reduction measures on the social integration of drug users is relatively unresearched. In this area too, however, ambitions are high. Once methadone prescription, needle-exchange programs, injection rooms and so on have ensured an improvement in drug users' state of health and a reduction in their stress levels, there is an expectation that the long-term social benefits of harm reduction will begin to appear, in the form of a better integration of drug users in society. And once the drug users do no longer constitute such a big law and order problem – because they reduce their criminal activities and because they no longer shoot up in the street and leave syringes in parks or on the stairways – they will be met with more acceptance and respect from their surroundings (Marlatt 1998; Springer 2000; Tammi 2004). As far as its social impact is concerned, then, harm reduction is thought to lead to a "normalisation" of the drug users' situation, increased involvement in various social arenas (work, family and so on), and a lessening of the extent to which drug abusers are stigmatised and shunned by mainstream society.

In our study the debate about the various social objectives of harm reduction leads to questions such as these: If abstinence is not the goal for (all) opiate users, what long-term goals is the staff at the outpatient centres actually working with? The term "social integration" is often used by advocates of the harm reduction approach, but what does the concept actually mean in the context of concrete treatment? Is harm reduction, for example in the form of methadone treatment, a permanent solution for the clients at the centres, or is it the first step in a long-term treatment scheme involving progressively stepped-up objectives aimed at social integration?

The answer to the last question is relatively clear. A large proportion of the methadone clients – and this applies especially to opiate users in the 35–40 age group and above – will be on substitution treatment for the rest of their lives. The objective for these drug users is not to "normalise" their situation within various social arenas (employment and family relations for instance), but to help ensure that their life is made as tolerable as possible. A practitioner at an ambulatory centre says:

> "Most of the clients we have here are not that young, and now they've reached a place in their lives where they're getting methadone, so they can have a bearable life till they're put in the grave […] But we still have to make a plan of action and a treatment plan for them, that's a legal requirement […] So we have these plans of action and they can consist of anything from putting up some curtains to making contact with mum and dad […] [but] a *treatment* plan is a bit more tricky where the older generation is concerned […] I know this is a dangerous thing to say, but that's how it is."
>
> (Interview with a practitioner at an ambulatory centre).

A practitioner at an advisory centre describes the "older" drug users as follows, and contrasts them with 25-year-old users, for whom the treatment system should have "bigger or different goals":

> "I mean people who've been on the scene […] for years and years […] and have chosen to say, I admit that I'm going to be on methadone for the rest of my life […] If they want to totter around without having someone getting at them every other minute […] I'm not the one to run after them […] In my opinion one can certainly be a happy pensioner on methadone […] But if you're 25 years old and have been through two or three years of drug use it may be that you'll get […] a couple of practitioners after you who want to set some slightly bigger or slightly different goals [than methadone maintenance]. In these cases we expect other things from them than just keeping their eyes fixed on the medicine cabinet."
>
> (Interview with a practitioner at an advisory centre).

The general attitude towards the "older" drug users is that they should be left "in peace and quiet" (this wording recurs in many interviews) both in the sense that they should have a place to live and basic economic security, and that they should be exempt from more ambitious attempts at treatment, activation or change in general. Several interviewees describe drug addiction as a form of chronic *disease*, which like other diseases requires medication (methadone), but which in other respects can easily be combined with a good quality of life. A practitioner at an advisory centre compares methadone treatment with insulin treatment for diabetics, and says she wished that drug users could relate as naturally to their illness as diabetic patients do to theirs. According to her, methadone clients should "hold their heads high" and say to the people around them: *"I have been a drug addict for many years, and now I'm getting methadone, and I don't take anything on the side. It's just great, and I feel great about it, and that's how I'm going to live the rest of my life"*. However, the same interviewee also says that this is unrealistic, because society (and drug users themselves) have a completely different attitude towards drug addiction than towards diabetes. She has never met a drug user who is proud of being in methadone treatment, she says, and moreover she doubts that there are any "clean" methadone users, i.e. clients who do not take other drugs on the side. She therefore draws the following conclusion about harm reduction:

> "On the one hand it's really, really good to help people to improve their quality of life. On the other hand I think that […] you probably make them remain in a state of dependency […] I don't personally know anyone who has succeeded in being stable without periods of drug abuse on the side."
>
> (Interview with a practitioner at an advisory centre).

Here the practitioner is articulating one of the most difficult dilemmas associated with harm reduction – the potential for improved quality of life versus the risk of persistent or increasing marginalization. This is a dilemma that demands more attention both in research and in practice.

Conclusion

We will conclude this article by returning to the criticisms that have been formulated in relation to the harm reduction paradigm. To begin with, however, let us summarise the paradoxes described above.

First, many social researchers and practitioners consider harm reduction and the goal of abstinence as fully compatible – but in practice conflicts arise between the two approaches. Abstinence as a goal is often abandoned in advance at institutions adhering to the paradigm of harm reduction, and the work at such institutions is therefore focused on other things than abstinence: stabilisation with the help of methadone treatment, and practical assistance in relation to economy and housing. In the treatment system in Copenhagen the harm reduction paradigm rests on the idea that "older" opiate users (people over 35–40 years – but in practice the category also includes younger people) neither want to become, or are capable of becoming, drug-free. Measures aiming at abstinence are therefore not an integral part of the work at the outpatient centres. Indeed, the opposite is true: many practitioners see it as their task to treat sceptically any statement on part of the clients indicating that they want to become drug-free, and to persuade them to adopt the more realistic goal of stabilisation.

Second, harm reduction is linked to the perception that all initiatives to change must come from the users themselves, otherwise any attempt at treatment is seen as fruitless. At the same time many practitioners say that clients do not always come to them and ask for the help they need. The users' lives are often so chaotic that the staff does not expect them to set out realistic plans for the future or formulate wishes that could lead to action. Thus the interviewees see their clients both as autonomous and competent to take decisions, and as helpless and in thrall to the power of drugs. Furthermore, there is a tendency for the clients to be treated as rational when their wishes accord with the harm reduction paradigm and as irrational if they express a desire to become drug free. This is natural enough, since practitioners after all regard opiate addiction as a chronic condition, and long-term/lifelong methadone prescription as the only sensible solution to the problems of addiction.

The relationship between harm reduction and the combined "autonomization/responsibilization" approach (Rose 2000, 1400) thus becomes very complex. On the one hand the harm reduction paradigm presupposes that practitioners show respect for their clients' integrity and autonomy, and this indeed seems to happen both at the advisory centres and at the ambulatory centres. Methadone treatment is administered with a minimum of control and sanctions: the clients have a great deal of say in their own treatment (methadone dosage, other medication, levels of attendance and so on) and every attempt is made to avoid "clientization". On the other hand one could maintain that, for certain groups of users, the very strong emphasis on the individual's responsibility for his/her own problems can endanger the client's dignity. Contrary to the widespread assumption that the harm reduction approach almost automatically reduces moral blame, in some cases harm reduction can have the very opposite effect: less dignity for drug users who are unable to formulate their wishes or whose wishes are brushed aside because they are not regarded as genuine or realistic, and more moral blame because in theory all drug users have access to information about the best ways of reducing harm and help in realising whatever

wishes they may have. Thus failure to act on this help and information – and failure to act in accordance with the principles defined by the treatment system – may indeed be seen as blameworthy.

Third, advocates of the harm reduction paradigm often maintain that harm reduction, for example in the form of methadone treatment, allows clients to achieve greater social integration. The question is whether this is true. Social integration as a phenomenon is not very clearly defined at the advisory and ambulatory centres, but in practice it appears to mean that methadone clients (like all other vulnerable citizens in Denmark) are entitled to receive social benefits in the form of housing and financial support. In addition they are offered varying levels of contact with practitioners, and at some of the centres opportunities to participate in social activities (visits to a summer cottage, sports, watching films, eating together etc.) All this can contribute to stabilising the client's life circumstances, but does not necessarily lead to social integration in a more ambitious – some would say traditional – sense. The interviews give the overwhelming impression that methadone clients are – and remain so over the years they are enrolled at the centres – highly marginalized citizens whose lives are marked by loneliness, untreated psychological problems, social rejection, and the tendency to "keep their eyes fixed on the medicine cabinet", as one practitioner was quoted as saying above.

The Canadian sociologist Gordon Roe (2005) is of the opinion that in practice harm reduction does not live up to the objectives originally set out by advocates of the paradigm. According to him, this approach has meant that many opiate users have entered a blind alley where they are almost automatically put on long-term methadone treatment without any thorough discussion of possible alternative treatments and of what the actual goals of methadone treatment should be in the long run. Methadone treatment has thus developed into a "lifetime" treatment even for clients who perhaps should have been offered alternatives: *" 'Mature' medical harm reduction can be seen as a move from a problematic 'curative' model, through prohibition and treatment, to an equally problematic 'palliative' model"* (Roe 2005, 248). Roe also believes that the harm reduction paradigm has not replaced the disease model in the drug field, but instead expanded it: *"It has also extended the 'disease' model of addiction, labelling drug users as permanently disabled by their dependence on drugs"* (ibid., 247). According to this argument, harm reduction has led to a medicalization of drug users' problems, including problems that are fundamentally social in nature, which in practice can mean that any attempt to find long-term solutions to such problems is blocked.

Roe subscribes to the Foucault-inspired tradition of research around "governmentality", a tradition in which one also finds other critics of the public health principles on which harm reduction is founded (cf. Mugford 1993; Miller 2001). These critics do not say that it is problematic in itself to base drug treatment and policy on public health principles – only that the new principles are not necessarily as "empowering" and free from moral judgement as is often claimed. According to Miller and Rose (1993), public-health-based policies represent part of a neo-liberal develop-

ment project that is aimed, to be sure, at ridding the system of bureaucracy and excessive mollycoddling of the individual, but at the same time entails new forms of control and moral judgement.

Petersen and Lupton (1996) describe the consequences of the public health perspective for various groups in society, not least for those who for one reason or other have problems in living up to the demands of "responsibility" and rational risk management. According to Petersen & Lupton, the public health perspective is built on a notion of "*the entrepreneurial self, that is, the self who is expected to live life in a prudent, calculating way and to be ever-vigilant of risks"*. The logical consequence of this is that an unwillingness on the part of certain citizens to live up to expectations concerning risk management, or difficulties in doing so, leads to their stigmatization for *"a failure of the self to take care of itself"* (p.16).

We agree with Petersen and Lupton in these considerations and with Roe in the arguments presented above. In Denmark as elsewhere it appears that opiate users are referred for substitution treatment without any thorough discussion of alternatives or of what the long-term objectives of such treatment should actually be. And in Denmark, too, the harm reduction approach appears to have led to a massive increase in medical treatment within the field of drug addiction: methadone prescription *is* the dominant form of treatment offered, and "guaranteed provision" of opiates appears to be the main reason for methadone clients to come to the outpatient centres in the first place. In addition, we can see from our interviews that the practitioners' understanding of their clients' problems rests on an (explicitly formulated or implicit) disease model. The clients' condition is regarded as "incurable", it is often compared to other chronic diseases (such as diabetes) and the users are expected to need their medicine for the rest of their life in order to be able to function "normally". This normality, however, does not include social integration in the traditional sense of the word (in relation to work, education and family).

The optimistic spirit in which the harm reduction approach was originally launched should be accompanied by greater attention to these aspects of concrete harm-reduction practice. In focusing on these aspects, however, we should not throw the baby out with the bathwater. There is a clear justification for harm reduction measures within the treatment system, and a critical discussion of such measures should not of course lead to a return to control, restrictions and clientization. Nevertheless, in a treatment system such as Denmark's, which has undergone radical development in the last fifteen years, it may be time to pause and reflect on whether the discrepancy between the original ideals of the harm reduction paradigm, and the reality at actual treatment centres, has become too great.

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NOTES

1) In 1992 Newcombe became the director of the "Drugs & HIV Monitoring Unit" under Mersey Regional Heath Authority in Liverpool.
2) The article describes the situation in June 2006.

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