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The biopolitics of needle exchange in the United States

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Abstract

Needle exchange began in the United States as a fragmented and illegal practice initiated by actors at the grassroots level; since the late 1980s, needle exchange has achieved increasing yet variable levels of institutional support across the country, receiving official sanction and funding from state and municipal governments. In turn, the practice(s) and discourse(s) of needle exchange have shifted significantly in many locales, becoming the purview of professional administration that advocates needle exchange as a necessary public health measure. This article is interested in the ways in which needle exchange has become implicated in and appropriated by networks of power seeking to discipline and regulate injection drug use. Drawing theoretically on Michel Foucault's writings concerning biopower and governmentality, it will examine the proliferation of discourses, knowledges, and rules surrounding needle exchange in the United States. At the same time, this article will avoid a characterization of needle exchange that envisions the unilateral control of drug users by governmental power, illuminating instead both its negative and productive effects for drug users. Namely, it will explore how needle exchange creates both subjects of interest and subjects of resistance among drug users – that is to say, the governmentalization of needle exchange and its 'clients'.

Keywords

drugs; governance; population

Introduction

The distribution of sterile needles to injection drug users (IDUs) began in the early 1980s in the United States as a highly fragmented and ostensibly illegal practice initiated by drug user advocates and community organizations. In its earliest manifestations, needle distribution was framed by turns as an act of last resort or outright civil disobedience, caught within a legislative and political climate that actively stigmatized drug users and criminalized outreach efforts that purported to circulate drug use paraphernalia (i.e., clean needles). Since the late 1980s, needle exchange has achieved increasing yet variable levels of institutional support across the United States, receiving the official sanction of local public health and police departments, deriving funds from state and municipal governments, and becoming enshrined in public health law in certain contexts. In turn, the practice(s) and discourse(s) of needle exchange have shifted significantly in many locales, becoming the purview of public and professionalized administration that advocates needle exchange as a necessary public health measure protecting both IDUs and the populations they put at risk for disease transmission.

This article will show how needle exchange has become implicated in and appropriated by networks of power that seek to discipline and regulate injection drug use. Drawing theoretically on Michel Foucault's writings concerning the biopower and governmentality, it will attempt to trace the proliferation of discourses, knowledge, and rules surrounding needle exchange in the United States. In particular, this article will seek to describe the encroachment of biomedicine upon the theory and practice of needle exchange, and further, how such encroachment has been rhetorically justified.

At the same time, this article will seek to avoid a characterization of needle exchange that envisions the unilateral control of drug users by governmental power, illuminating instead both its negative and productive effects for drug users. Namely, it will try to explore how needle exchange creates both subjects of interest (oriented toward risk reduction and eventual abstinence) and subjects of resistance (oriented toward continued drug use and an identity founded therein) among drug users – that is to say, the governmentalization of needle exchange and its 'clients.' An ambiguous term within Foucauldian theory, governmentality refers to the external 'arrangement' and manipulation of individuals' practices, while also noting important implications for selfcultivation and the elaboration of identity (Foucault 2004). The complex rituals emerging from needle exchange and the instruction of 'safe shooting' may be understood as 'technologies of the self' that may positively influence drug user subjectivities.

While the status of needle exchange as an ambiguous technology of biopower may prevent its overwhelming indictment, this article will conclude with an exploration of the 'necropolitics' of needle exchange (Mbembe 2003). As the flip side of the biopolitical coin, a necropolitical perspective might view needle exchange as a genocidal or racist policy (in the Foucauldian sense) that seeks to subtly deprive certain populations of the right to life by encouraging a deadly habit. Alternately, the long-term ban on the federal funding of needle exchange in the United States, resulting in its patchy and precarious implementation, may be cited as an evidence of a necropolitical stance toward drug users, who are left to die without sincere attempts at intervention. While differentiating political regimes that condone harm reduction techniques from those that explicitly seek the extermination of drug users, this article will question the role of needle exchange as a technique of integration or isolation in the era of HIV/AIDS. Ultimately, the relevance of a distinction between bio- and necropolitics may be diminished, as all considerations of needle exchange reveal the intimate entanglement of drug users' lives and deaths with the prerogatives of the state.

While representing a primarily theoretical endeavor, this article will draw on the history of needle exchange practice and legislation in the United States, citing specific programs and policies where relevant; this work should ultimately be supplemented by an ethnography of the concrete practices that occur within needle exchange programs (NEPs), and an analysis of the site-specific discourses that shape them. In rendering the 'common sense' assumptions of harm reduction problematic, this article seeks to stimulate further discussion on the diverse rationalities underlying needle exchange, with view to improving its acceptability to users and encouraging reflexivity among advocates.

From politics to public health: the ideological cleansing of needle exchange?

In 1983, Jon Stuen-Parker, Yale student and former heroin user, began publicly distributing sterile needles to intravenous drug users in New Haven, CT. Perhaps, the first American practitioner of harm reduction, Stuen-Parker claimed inspiration in the comments of a guest speaker to the medical school, where he was enrolled; the speaker advised Stuen-Parker not to waste his time trying to educate drug addicts, assuring him that such individuals would

‘never change their behavior’ (Curtis 2001). While ejected from medical school the same year, Stuen-Parker ultimately persisted in his efforts to implement needle exchange in the United States, founding the National AIDS Brigade in 1985, a volunteer-based outfit which would eventually offer exchange services further along the Northeast Corridor, in Philadelphia, Boston, and New York (Drucker 2009). Stuen-Parker’s illegal endeavors in the 1980s and early 1990s ultimately led to 27 separate arrests in seven states – an experience common to the first cohort of needle exchange practitioners in the United States (Rubin and McCampbell 2000).

In March of 1991, Stuen-Parker was among the eight activists from the AIDS Coalition to Unleash Power (ACT-UP) arrested for their informal exchange efforts on the Lower East Side of Manhattan in New York City (Lambert 1989). Where needle exchange in New York City existed then in a space of legislative limbo, the activists’ actions clearly lacked official sanction and bureaucratic oversight from the New York City Police Department and Department of Health (NYCDOH); earlier attempts to install a NYCDOH-sponsored needle exchange pilot program had been squelched in the wake of fierce political opposition and low turnout by drug users themselves (Anderson 1991, Sullivan 1991). By the end of 1991, needle exchange was offered in a small handful of cities across the US (in Portland, Tacoma, San Francisco, and occasionally, New York, New Haven, Philadelphia, and Boston). Only Portland’s privately financed exchange had achieved clear, albeit limited, legality. The size of such operations ranged from one man to several volunteers, often with little more at their disposal than a curbside table, cache of sterile needles, and bucket for the disposal of used works. Citing an ethics based in pragmatism and social justice, many of the first needle exchange practitioners actively sought to contest a politics that excluded and abandoned drug users, publicizing their cause through acts of civil disobedience. Yet, in order to establish permanent and legal sites of needle exchange, these early practitioners relied upon sympathetic partners in local health departments and medical institutions, a strategy that risked the governmental appropriation of needle exchange.

Although a 1988 ruling by Congress continues to bar the use of federal funds for needle exchange, the Centers for Disease Control (CDC) enumerated the existence of 185 NEPs, distributed across 36 states (as well as the District of Columbia and Puerto Rico), as of November 2007. Over 50% of such programs are administered by non-governmental organizations, but all operate with the oversight from local and state health departments, and assume legality under an assortment of structures that vary from state to state; many function via the periodic renewal of a public health ‘state of emergency’ that justifies their continued necessity (CDC 2007). Such ‘security-oriented’ provisions are indicative of the shifts in needle exchange advocacy and sponsorship that led to their progressive legal implementation across much of the United States. Seeking to render irrelevant discourses that challenged the morality of needle exchange, Alvin Novick, chair of the (New Haven) Mayor’s Task Force on AIDS, stated in 1990: ‘This is not a political agenda. It’s a public health agenda’ (Anderson 1991). Needle exchange is offered here as a value-free, technical solution to an essentially biomedical problem; merely addressing the proximate, individual causes of disease transmission, needle exchange by itself remains conveniently mute as to the larger social, political, and economic context that drives drug use and HIV infection.

While the level of institutionalization enjoyed by NEPs has certainly increased over time, it is necessary to ask whether significant discursive shifts might also be mapped alongside changes in funding and authoritative support. 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 like Stuen-Parker were more broadly interested in advancing a program attuned to the larger social welfare of drug users, and the communities

in which they lived. Acts of illegal exchange have also been framed as a method of last resort, aimed at saving lives *despite* the political consequences and media attention entailed therein. In recent years, it has been argued that harm reduction has increasingly lost interest in addressing the broader social, political, and economic context that make drug use (more) dangerous. A new body of social science literature critical of harm reduction as a 'mature and coherent paradigm' has emerged, arguing that 'what began as a 'bottom up'' movement became 'top down'' policy' (Cheung 2000, Roe 2005). Several analyses within this literature have also applied the idea of governmentality to describe the decentralized and depoliticized regulation of IDUs epitomized by needle exchange, thought to be the resonant of the 'new prudentialism' of Western late modernity (Dean 1999, Bourgois 2000).

Where subsequent sections of this article will attempt to further mine the concept of governmentality to discern the positive, or at least productive, effects of needle exchange, it is here necessary to both concede and question a history of needle exchange that envisions its progressive ideological cleansing by the neoliberal state. In the United States, early advocates of needle exchange undoubtedly disputed the stigmatization of IDUs within a political climate that focused intensely upon their criminalization, a stance that further decried the social, political, and economic climate that promoted drug use within certain communities. Further, it is valid to assert that the codification of needle exchange within public health law has led to its increasing relegation to a domain of biomedical expertise, which concentrates upon the creation of regular protocols and the production of statistics seeking to portray the public health benefits of needle exchange in relatively limited terms. In its exhortation of needle exchange's efficacy, the CDC (and most evaluatory studies of NEPs) focus upon the intervention's (purported) ability to reduce disease and save money. A CDC fact sheet on syringe exchange programs boasts that 'an impressive body of evidence suggests powerful effects from needle exchange programs ... Studies show reduction in risk behavior as high as 80%, with estimates of a 30% or greater reduction of HIV in IDUs.' Cost-benefit analysis is further employed in demonstrating the unlikely virtues of needle exchange, which saves an estimated 178,000 to 186,000 US dollars per HIV infection thus averted (CDC 2005).

It appears obvious that contemporary proponents of needle exchange invoke new logics hardly envisioned by its early supporters. Yet, it cannot be said that individuals and organizations such as Stuen-Parker, ACT-UP, or the National AIDS Brigade acted 'outside power' or sought to mobilize an oppositional identity among drug users. From its grassroots origins to institutional investment, the major concern addressed by needle exchange may be the preservation of the biological integrity of IDUs, and by extension, the general population. Needle exchange attempts to establish injecting drug users as legitimate members of the national body, and further allows this group to demonstrate their qualifications through the uptake of risk-conscious health practices. Whether disseminated by street-level activists or public health 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.

Here it is necessary to qualify the relationship between needle exchange and biopolitics, a paradigm of power that some scholars have already relegated to the past (Rose 2006). In the first volume of his tripartite *History of Sexuality*, Michel Foucault coined the term 'biopower' to describe a new modality of power, emergent in the eighteenth century, which took life itself as its target. Biopower is here further broken down into two forms, or poles, which often work in concert: where anatomo-political, or disciplinary power, generally seeks to maximize the energies and capabilities of individual bodies, biopolitical power endeavors toward the optimization of a population's vitality, focusing on 'the species body, the body imbued with the mechanisms of life and serving as the basis of biological

processes: propagation, births and mortality, the level of health, life expectancy, and longevity, with all the conditions that can cause these to vary' (Foucault 1990, p. 139). Public hygiene is highlighted as a major field of biopolitical intervention, wherein increasingly rationalized mechanisms are employed toward the medicalization of bounded populations.

According to Foucault, the biopolitical mode of power culminated under the twentieth - century providential, and at times eugenic state – a state that has dissolved in the wake of neoliberalism, giving rise to more diffuse forms of governance that operate through techniques of the subjectivation. Rose (2006) asserts that the modern neoliberal state has abandoned the biopolitical concern in population, while individuals have increasingly intensified the management of their health and bodies as identity projects. As the next portion of this article will elaborate, needle exchange, and other strategies of harm reduction have undoubtedly spawned unique practices and understandings that may be termed technologies of the self. Nevertheless, it seems rather premature to proclaim the end of biopolitics in a period so attuned to the circulation and in many cases, mutation, of infectious disease within and between populations. While the real and imagined epidemics of SARS and avian influenza may have garnered more media attention in recent years, HIV/AIDS has historically been framed as not only a matter of individual pathology, but also one of the national security and economic growth. Strategies such as needle exchange are arguably undertaken with the vitality of both the IDU and general populations in mind, whose health and productivity remain a crucial concern to government at all levels. Needle exchange hosts an interaction between disciplinary and regulatory power, wherein the fitness of the larger population is willfully engineered through the instruction, manipulation, and surveillance of individual bodies.

It should further be noted that the biopoliticization of needle exchange does not begin with its legalization or institutionalization in the public sphere. The grassroots advocates of needle exchange described above ground their claims in the 'right to life,' thereby citing the state's accountability toward the biological welfare of its citizens, including IDUs. Invoking a definition of biological citizenship that includes state sanction and funding for needle exchange, these 'indigenous' actors reveal themselves to be thoroughly immersed within the discursive regime of biopolitics. Needle exchange here might be understood as both a mobilization of and resistance to existent strains of biopower, which functions to invest the life of certain segments of the population with political meaning. Exemplifying a movement of governmentality, early needle exchangers appealed to the *biological* rights of IDUs, as individuals and population, while further asserting their status as rational subjects and thus full citizens, capable of making informed and responsible decisions about their health. The early politics of needle exchange focused not on difference, but rather on essential similarities, in which rights were supposed to accrue to bodies, qualified by membership in the national corpus.

The other side of governmentality: unsanctioned ends of needle exchange

In considering how NEPs may be deployed toward the greater surveillance and regulation of IDUs, the previous section may be seen to reveal one manifestation of governmentality in the context of needle exchange. A term first proposed during Foucault's 1990 lecture series at the Collège de France, governmentality describes the ways in which power conspires to regulate the quality of populations through the conduct of individuals. Yet, the mechanisms of security envisioned by governmentality operate in a more diffuse manner than previous power modalities, seeking to *manage* populations rather than control them (Foucault 2004, p. 353). By providing IDUs with instructions and equipment intended to facilitate 'safe

injection', needle exchange endeavors to, at best, prevent, and at worst, monitor, the circulation of infectious diseases such as HIV and hepatitis within this pervasive population.

NEPs manage dangerous drug use not only through the manipulation of the material conditions in which injection occurs, but further through the shaping of drug users' subjectivities. The discourse of risk that underpins needle exchange posits IDUs as rational subjects who are inevitably interested in preserving their health status through strategies of HIV prevention; it further encourages them to take responsibility for the welfare of others by declining to share injection equipment. The language of needle exchange also highlights its attempt to attract rational 'consumers' of health, labeling participating IDUs as 'clients' who exercise self-interest in accessing NEP services. As a governmental strategy, needle exchange seeks to produce the desired behavior among its targets by effectively aligning the interests of individual users with a larger institutional logic emphasizing disease prevention.

The rhetoric of consumer choice may be thought wholly disingenuous in the context of needle exchange as a service that, on some level, seeks to disarm a dangerous group of a potentially deadly infection. Yet, as a technology that must ultimately rely upon motivated individuals to carry out its mandate, NEPs must effectively mold self-interested subjects in order to succeed at the goal of harm reduction. Writing about governmental programs of risk management, Dean (2000) has observed a similar tension between interventions aimed at 'active citizens,' presumed capable of their own care, and 'targeted populations,' thought to require external assistance. Needle exchange might be conceived as a technique which creates both categories of risk subject, as a program that seeks to identify and monitor 'at risk' individuals, yet does so in part by inculcating an ethos of self-care and individual empowerment (Dean 2000, p. 147).

The analysis of needle exchange and the real practices of participating IDUs may also generate a more authentically agential rendering of governmentality. Needle exchange is undoubtedly a site where Foucault's 'technologies of domination' and 'technologies of the self' intersect and unique social and biological identities are forged. As observed at one New York program offering needle exchange, some of the 'risk identities' that arise in NEPs and other harm reduction programs are certainly in line with the governmental projects pursued therein. Many participants develop and pursue identities as responsible drug users, who are knowledgeable about their risk and devoted to techniques of safe injection. Such users may also strive to serve as formal or informal peer educators, seeking to motivate and educate less enthusiastic NEP participants. The cultivation of responsible risk identities may be facilitated by the organizations' promotion of membership within client-led 'community advisory boards.' An elected body that allows for the administrative input of clients, the community advisory board in fact reflects an explicit directive of the state's AIDS Institute; all sanctioned NEP in the state of New York are required to 'give voice' to the needs of their clients, an endeavor that undoubtedly shapes the needs it purports to represent (New York State Department of Health AIDS Institute 2007).

In this way, needle exchange may serve as a site for the 'bottom-up' generation of governmentality, as users learn to advocate for their inclusion and access to services using the language of vulnerability and risk reduction. While some users may demonstrate a wariness of the governmental power implied by needle exchange, in refusing to provide personal information and disputing program rules as a means of contesting authority, others may seek empowerment through total immersion in its governmental logic. In this vein, the refusal to provide NEPs and other harm reduction services may begin to be perceived in necropolitical terms, as a policy that effectively denies IDUs access to life-saving technologies. Campaigns for the legalization and expansion of harm reduction services have

been tied to the formation of drug-user groups and the solidification of drug user identities in many locales, as use becomes a source of positive identification.

NEPs may also give rise to the so-called ‘oppositional identities,’ as users learn to use organizational interests and bureaucratic irrationalities for their own purposes. Drawing on the contributions of Petersen (2003), it is also valid to interpret individuals’ attempts to subvert or manipulate the programmatic goals of needle exchange as constitutive of governmentality, as acts of resistance that continue to acknowledge and adapt to this regime of power. IDUs may enroll within NEPs for a variety of reasons, not all of which relate to the institutional goals of HIV prevention. Offering a variety of services broadly aimed at risk reduction, NEPs may provide a hospitable and warm environment, television, coffee and snacks, and social connections that may be exploited toward a number of ends, including drug procurement. Individuals who do not inject drugs or do so infrequently may nonetheless exploit the opportunity to obtain free, sterile needles on a regular basis, for the purpose of street sales, or to distribute to friends or family members in need. Participation in needle exchange and ancillary HIV prevention programs may also be employed as an alibi for individuals who wish to improve their image with diverse authorities, such as doctors, case workers, family members, or even parole officers. As infuriated critics often argue, NEPs may sometimes serve as sites facilitating criminal activity, while the risk discourses that are perpetrated therein are regarded as irrelevant or laughable.

Conclusion: needle exchange as a politics of life or death (?)

In the late 1980s, segments of the African-American community in New York City decried needle exchange as a potentially genocidal policy – at best, a surface-level treatment of the deeper problems that afflicted black neighborhoods, and at worst, one that sought to exacerbate the destructive habits that had taken root therein (Watters 1996). However, as needle exchange has assumed its position within the dominant discourse, as a public health ‘best practice,’ its thanatopolitical framing has likewise entered new territory. Needle exchange has become framed as a right of biological citizenship, claimed by and for IDUs who accept a designation of ‘at-risk’ or embrace an identity based upon drug use. Consequently, state and other actors’ refusals to sanction or fund NEPs (and other harm reduction programs aimed at HIV prevention) have been construed in some advocacy circles as acts akin to sanctioned massacres.

In many ways, such pronouncements echo Foucault’s own understanding of state racism, as manifested in biopolitical strategies that ‘let die’ – depriving certain populations of life not merely through blatant acts of violence, but also through policies of neglect (Foucault 2002). Agamben’s (1998) elaboration of Foucauldian biopower is perhaps most poignant here, in its evocation of the state’s fundamental power to devalue and abandon certain populations, who are thus reduced to ‘bare life.’ Agamben’s rendering of biopower as pervasive, total, and finally inescapable within sovereign formations renders the distinction between needle exchange irrelevantly as bio- or necropolitical technology. From this perspective, IDUs represent politically disqualified bodies, only of interest to state power in the infectious threat they pose. In turn, measures that attempt to empower and ‘save’ drug users through diverse forms of biomedical triage only perpetuate users’ status as bare life.

Yet, as harm reduction technologies proliferate to include safe consumption rooms, harm reduction activists and service providers might consider the possibility of going beyond an advocacy campaign grounded solely in the logic of public health. An investment in the health of IUDs – and drug users at large – is not incompatible with a broader concern for social justice, the macro-level determinants of drug use and addiction, and the larger context of risk. Where the language of biological citizenship may be expedient within a nation that

retains a strictly pathological view of drug use, needle exchange and harm reduction proponents at large should be wary of the ways in which it contributes to the devaluation of users' social and political existence.

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