Articulating Connections between the Harm-Reduction Paradigm and the Marginalisation of People Who Use Illicit Drugs

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Abstract

In this paper, we argue for the importance of unsettling dominant narratives in the current terrain of harm-reduction policy, practice and research. To accomplish this, we trace the historical developments regarding the Human Immunodeficiency Virus (HIV), the Hepatitis C Virus (HCV) and harm-reduction policies and practice. We argue that multiple historical junctures rather than single causes of social exclusion engender the processes of marginalisation, propelled by social movements, institutional interests, state legislation, community practices, neo-liberalism and governmentality techniques. We analyse interests (activist, lay expert, institutional and state) in the harm-reduction field, and consider conceptualisations of risk, pleasure, stigma, social control and exclusionary moral identities. Based on our review of the literature, this paper provides recommendations for social workers and others delivering health and social care interested in the fields of substance use, HIV prevention and harm reduction.

Keywords: Harm reduction, epistemology, HIV/AIDS, critical theory

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Introduction

This paper draws attention to the ethical complexities of the harm-reduction paradigm. It seeks to encourage social workers and other professionals to take a critical stance on the practices of harm reduction. Those who work with people who use illicit drugs need strategies to develop knowledge and action regarding the sociocultural, and political issues that frame how we think about and respond to illicit drug use. Such knowledge and action can translate into a renewed attention on the structural context and pragmatics of drug use and its intersection with blood-borne infections. Social workers and others delivering health and social care, many of whom often work with marginalised populations, must be prepared to address the health and social needs of people who use drugs. The unifying theme of this paper is the social exclusion and ‘othering’ of drug-using individuals through harm-reduction discourses.

Harm reduction is a pragmatic response to drug use that emerged in response to more traditional punitive and prohibitionist approaches to drug use (Hilton *et al.*, 2001). A harm-reduction approach aims to reduce drug-related harms (including negative health outcomes such as blood-borne infections) and the social and economic consequences of drug use (International Harm Reduction Association, 2010). For health and social care workers interested in the intersection of Human Immunodeficiency Virus (HIV) prevention, Hepatitis C Virus (HCV) prevention and harm reduction, epistemological issues have direct consequences on the nature and quality of work provided, as epistemological naiveté may hinder accurate and effective social work interventions, programme developments and research initiatives.

In 2004 and 2010, two important articles published in the *British Journal of Social Work* questioned whether social workers were truly prepared to address the ongoing epidemic of HCV, including the impact of increasing diagnoses on services (Paylor and Orgel, 2004; Paylor and Mack, 2010). In this paper, we build on their work by approaching the question of health and social care worker preparedness from a different vantage—one that articulates connections between the harm-reduction paradigm as understood in the UK and Canada, and the marginalisation of people who use illicit drugs.

Globally, HIV remains one of the most significant health and social care consequences associated with illicit drug use (Crisp and Barber, 1997). In 2013, throughout the UK, 81,512 individuals were receiving HIV specialist care. Among these, the number of HIV infections acquired through injection drug use was relatively low at 2.07 per cent (Public Health England, 2014a). In Canada, an estimated 71,300 individuals were living with HIV at the end of 2011, and injection drug use may have accounted for the HIV infection of an estimated 20 per cent of people living with the virus in 2011 (Public Health Agency of Canada, 2012, 2014).

The situation with HCV is just as alarming, if not more so. In 2013, throughout the UK, 13,758 HCV infections were diagnosed. Ninety per cent of these were attributed to injection drug use. As of 2013, approximately 40 per cent of people who inject illicit drugs live with HCV, and approximately half of these infections are believed to be undiagnosed ([Public Health England, 2014b](#)). In Canada, in 2009, 11,357 individuals with HCV were reported through the Canadian Notifiable Disease Surveillance System. Among individuals with newly acquired HCV, injection drug use was a known risk factor associated with 61 per cent of infections. Further, approximately 21 per cent of individuals infected with HCV in 2009 were believed to be undiagnosed ([Public Health Agency of Canada, 2011](#)). When modelling HCV prevalence from the year 2011, out of a proposed injecting drug use population of 100,000, [Trubnikov, Yan and Archibald \(2014\)](#) estimated that 66–69 per cent were thought to be infected with HCV. In addition, of 265,270 former injecting drug users (fourteen to seventy-nine years of age) an estimated 10.8–46.3 per cent were HCV positive.

As the burden of HCV and HIV persists among changing patterns of illicit drug use, in both the UK and Canada, social workers and others working in health and social care fields will find themselves with significantly increased caseloads ([Paylor and Mack, 2010](#)). This will require the expansion of training and services, and a rise in awareness of the issues pertaining to drug use and its proximity to infectious disease ([Paylor and Mack, 2010](#)).

We do not intend to dismiss the positive contributions of the harm-reduction approach (e.g. advocacy for drug use legalisation policies and laws, initiatives to address the structural conditions of marginalised drug users such as poverty, homelessness and stigma) or the pragmatics of harm reduction (reduction in mortality due to overdose, control of infectious blood-borne disease). Instead we want to draw attention to the ways in which the harm-reduction paradigm may structure professional practices to construct the drug user as a self-monitoring, pleasure-prudent and risk-adverse neo-liberal drug-using subject.

Marginalised people who use illicit drugs are often the target of widespread stigmatisation, social control and repression ([Bancroft, 2009](#); [Room, 2005](#)). In addition, policy discourses on illicit drug use often invoke the notions of fear and risk ([Moore and Fraser, 2006](#)). By attending to epistemological concerns, those who want to pursue their professional work in the field of harm reduction can advocate for approaches to health which are not pathologising and which do not further marginalise people who use illicit drugs. In this paper, we analyse the dominant narratives in the current terrain of harm reduction in order to illuminate how these narratives contribute to the contemporary framing of drug user subjectivity. Further, we address concepts which are central to knowledge production in the field of harm reduction, including risk, pleasure, governmentality and social exclusion.

On drug policies and the emergence of harm reduction: a brief history

Harm-reduction policy traces its roots to the 1920s, when the Rollerstone Committee, a group of England's prominent and well-respected physicians, suggested that it may be occasionally beneficial to maintain a person on drugs to help them lead a more productive life (Hilton *et al.*, 2001). Methadone maintenance treatment (a form of harm reduction) was introduced in Canada in the 1950s and in the UK in the 1960s (Cook *et al.*, 2010).

More recently, contemporary harm-reduction discourses can be traced back to the Acquired Immunodeficiency Syndrome (AIDS) epidemic of the mid-1980s (Moore and Fraser, 2006). Harm-reduction movements began in response to intensifying morbidity and mortality of injecting drug user (IDU) populations (from IDU-related overdose deaths and infectious disease transmission) (Dolan *et al.*, 2000). Grassroots harm-reduction movements began in Liverpool, Amsterdam and Rotterdam in response to pervasive drug-related public health problems resulting from injection drug use (Erickson *et al.*, 1997; Heather, 1993). In Liverpool, for example, the Merseyside project coordinated needle-exchange clinics, pharmacists and even the police force to maintain a harm-reduction programme that actually prescribed drugs to people instead of taking a punitive approach to drug use (Hilton *et al.*, 2001; Riley and O'Hare, 2000).

The first needle-exchange programme was started in Amsterdam in 1984, prompted by a 'Junky Union', a recognised organisation of IDUs (Heather, 1993). In 1986, parts of the UK (with Liverpool being the first city) introduced needle and syringe programmes (Cook *et al.*, 2010). These movements gradually spread to other European cities, as well as eventually influencing the policies of several nations of the Commonwealth including Canada, New Zealand and Australia (MacCoun, 1996). Federally, a number of countries and organisations have now adopted harm-reduction strategies as both policy and practice. In 1987, the Canadian government adopted harm reduction as the framework for Canada's National Drug Strategy. In Canada, needle exchanges were opened unofficially in Toronto in 1987, and officially in Vancouver in 1989 (Fischer, 1999). By 2009, thirty-one countries in Europe had needle and syringe programmes and thirty-one had opioid substitution treatment, while eighty-four countries around the world endorsed harm reduction in policy or practice (Cook *et al.*, 2010).

Conceptual tools: governmentality and bio-power

The conceptual tools of the French philosopher Michel Foucault show how to unsettle and destabilise taken-for-granted assumptions about illicit drug use. One of Foucault's (1991a, 1991b) concerns was to critique the way society

regulates populations by sanctioning particular knowledge claims and disciplines. Foucault argued that social dominance over the body is pervasive, and is promoted by the medicalisation and stigmatisation of deviance. Foucault called this domination 'bio-power' (Foucault, 1979). Foucault's notion of bio-power allows for the analysis of modern political strategies linked to the optimisation, administration and preservation of human vitality (Rabinow and Rose, 2006). This type of power regulates individuals' bodies, preventing deviation from a set norm, and in effect regulating issues relating to birth rate, longevity, the migration of populations and public health (Foucault, 1979).

Foucault's notion of 'governmentality' designates the ways in which individuals constitute themselves as subjects, endowed with the capacity to reflect and act (Foucault, 1991b). The core idea of governmentality concerns the retreat of the welfare state under current neo-liberal conditions and the emergence of government technologies that are linked directly to the management of risk. It identifies the increasing mechanisms for the subject's government of the self through the practice of becoming responsible for one's own health (Rose and Miller, 1992; Rose, 1996). Governmentality highlights how the exercise of bio-power depends on the formation of human subjects; that is, the ways in which governing practices contribute to the creation of reflexive beings with the will and capacity to attend to their own health and well-being and to take care of themselves, in accordance with societal norms of health and well-being (Foucault, 1979, 1991a, 1991b; Rose, 1996).

Scholars have identified the area of 'drug use' as a site of governmentality (O'Malley, and Valverde, 2004). The social construction of drug use and the domination of bodies (especially those of people who use illicit drugs) are relevant to an analysis of bio-power and governmentality. What we problematise in this paper is how societies produce drug-using citizens who are able to keep themselves informed about how to choose and conduct their lifestyle in accordance with various forms of knowledge. Tracing the genealogy of the harm-reduction paradigm particularly in Canada and the UK makes these epistemic beliefs clear for those interested in health and social care work with people who use illicit drugs.

Risky subjectivities: illicit drugs and threat to social order

Professionals in diverse health fields often reflect on the lenses they use to view social and cultural hegemonies and on how they examine power relations. Earlier in the *British Journal of Social Work*, three authors brought the notion of risk to the attention of social workers. Parton (1998) highlighted that risk assessments and risk management were essential elements of the *raison d'être* for social workers, as the government of risk takes place through the subjectivities of social work professionals themselves. Taylor (2008) argued that the fear of risk is instrumental to the construction of the 'otherness' of the disreputable population. Similarly, Webb (2001) argued

that social work, as a profession, will become truly reflexive when it begins to consider the manufacturing and imagining of risk in our society.

According to Mary Douglas (1966, 1992), 'risk' is a secular substitute for 'sin' in a modern Western society, which nevertheless performs the same fundamental function of imbuing social actors with the sense that they have a moral responsibility not to disturb the social order and hierarchy. The work of Douglas with regard to risk has many parallels with Foucault's work on governmentality. Governmentality entails new ways of understanding and acting upon the misfortunes of the marginalised in terms of risk and responsibility (governing people who use illicit drugs through the particular style of thinking that focuses on the notion of risk). According to Pat O'Malley (2000), truth, morality and risk are interrelated. In this view, risk becomes an instrument for government (particularly programmes that seek to govern individual consumption, lifestyle or exposure to certain hazards). One of the most formative principles underlying writings on governmentality is the rejection of the state as a centralised locus of rule, and the identification of programmes and practices of rule within micro settings, including those found within the subject itself, decomposing power into political rationalities, governmental programmes, technologies and techniques of government (O'Malley *et al.*, 1997).

By labelling groups of people as 'risky', the system is creating individuals that reproduce their own capture by internalising self-surveillance. Similarly, Pollack (2010) suggests that the labelling of action as 'risky' is fundamental to social work practice with marginalised people, as this labelling encourages self-regulatory neo-liberal strategies that capitulate to state power.

Self-regulatory subjectivities and neo-liberalism are not the only technologies of power and social control. Gordon (2006) argues that the war on drugs in Canada is bound up with a deep-seated racist fear, partly rooted in the Canadian state's dependence on cheap immigrant labour (Gordon, 2006). The fear was that drugs might provide a financial alternative to alienating market relations (Gordon, 2006). Gordon (2006) argues that critics of drug policy in Canada have failed to question its relation to the state and the production and maintenance of racialised capitalist social relations, and in doing so have not articulated in their analyses why prohibition continues despite government's inability to stop the use of drugs or create an attitudinal shift among the public.

The available discourses on risk also affect how health and social care workers think about the future and conduct their practice. Levitas (2013) calls for a sociological analysis which places at the centre of its interrogation the relationship between the accumulation of capital, the accumulation of danger and risk, and social exclusion. Levitas (2013) links the conceptions of risk to the capitalist processes of actuarial insurance, specifically insurance-based rationality as an accommodation to risk in society. According to Levitas (2013), the UK and other Western societies have experienced a shift from a class society to risk society, where pre-occupying issues with

regards to a variety of hazards become the legitimization of risk and its avoidance. Through this lens, health and social care workers might see how the common discourse on risk that surrounds the phenomenon of illicit drug use may bring the future into calculable relation to the present and become another discourse of social control.

The meaning ascribed to people who use illicit drugs before the AIDS pandemic

Before the AIDS pandemic of the early/mid-1980s, in keeping with wider Western conceptions of illicit drug use as disruptive of rationality (Keane, 2003), drug policy and practice discourses inscribed drug-using subjects as 'enslaved by pharmacology and therefore incapable of rational decision-making' (Stimson, 1995, as cited in Moore and Fraser, 2006). Describing the history of the field of addiction in Canada prior to 1980, Fischer (1999) considers how various politicians in Canada tended to conflate drug use with criminality and disorder through prohibitionist rhetoric. At that time, the term 'substance abuse' came about primarily to distinguish addiction as a disease from illicit drug use as a social problem (Fischer, 1999). Keane (2005) argues that the formulation of particular differences is crucial to discourses of addiction. The 'addict' is understood as being morally and physiologically different from the normal subject, and this difference is posited as a deviation from an unmarked, unproblematic norm (Keane, 2005). Such processes can be found mirrored in other terminology, including the phrase 'problematic substance use' (Durrant and Thakker, 2003).

Foucault (1980) showed how sciences of the human subject (in particular 'psy disciplines', such as psychiatry and psychology) are built upon the derogation and social labelling of some groups in relation to the social order. As Race (2008, p. 418) puts it, 'Far from being removed from socio-political values, these ostensibly objective sciences are bound up in the social attribution of deviance'. From this perspective, medical and human sciences clearly participate in the process of the social categorisation of 'othering' with regard to people who use illicit drugs (England, 2008).

The AIDS epidemic and the reconfiguration of drug user subjectivity

When rates of HIV (in particular due to IDU) rose rapidly in Canada, there was a need to revise drug policy. According to Fischer (1999), a general sense of public and institutional dissatisfaction regarding the effectiveness of existing drug prohibition policies began to appear in Western societies, and a number of voices began advocating for more 'rational' drug policies. In a

1986 public speech, Prime Minister Brian Mulroney declared that Canada was facing a drug epidemic which was undermining the country's social and economic fabric (Fischer, 1999). Out of this policy window, Canada's Drug Strategy programme was established. The programme proposed basing drug policy on a balanced approach between demand and supply reduction (Fischer, 1999).

The emergence of neo-liberal governments in Canada and the UK during the twentieth century coincided with political concerns about the general population, its health and well-being (Levitas, 1986; Zibbell, 2004). Approaches informed by the 'New Right', often associated in the UK with Thatcherism, provided the possibility of supplanting welfarism with a new type of government (Levitas, 1986; Zibbell, 2004). As the welfare state became more characterised by neo-liberal restructuring, the state transferred its commitment to health to a whole array of volunteer and private organisations, as well as placing obligations on the individual.

In the 1990s, as harm-reduction principles in Canada and the UK (as well as internationally) became more established in drug policy and practice, the idea of people who use illicit drugs as health-conscious citizens capable of rational decision making, self-determination, self-regulation and risk/harm management became more prominent (Moore and Fraser, 2006; Zibbell, 2004). Some scholars argue that government strategies endeavour to produce populations of healthy, self-regulated and productive citizens, and in doing so shift focus from a socio-political environment to individual responsibility—a transition which can further marginalise individuals and communities (Keane, 2003). In the context of illicit drug use, this shift has not been accompanied by socio-structural interventions that attempt to address the socio-economic and political conditions of people who use illicit drugs (e.g. legalisation of drug use). Therefore, through a poststructuralist lens, these strategies should be understood as another form of 'population governance' (Foucault, 1991b).

The notion of pleasure in harm reduction

Harm-reduction discourse has reflected different ways of linking pleasure, knowledge and subjectivity throughout history. Central to this type of inquiry is the question of how pleasure is grasped, conceptually and methodologically. The conceptualisation of pleasure is important for social workers if they are to maintain a critical awareness of stigma and pathologisation. While it is perhaps more understandable that prohibitionist approaches to drug use do not give an opinion on the subject of pleasure except when it comes to conceptions of dysfunctional pleasures (Race, 2008), the absence of consideration of the role of pleasure in harm-reduction discourses is puzzling. Some authors contend that pleasure is indeed alive and well in harm reduction, but as problematic pleasure, and as such is linked with risk, criminality and

pathology (Seddon, 2008). For instance, ‘problematic substance use’ is said to be caused not by an excess of pleasure seeking, but by such things as ‘slavery of the will’, a characteristic proposed in Valverde’s (1998) work on alcohol. According to O’Malley and Valverde (2004), while ‘the moderate middle-class wine lovers, the cocktail set and the quiet toper in the rural pub’ can all be aligned with pleasure (O’Malley and Valverde, 2004, p. 39), those who deviate from these and other similarly socially accepted scenarios risk their substance use being labelled as problematic. Thus, pleasure is mobilised governmentally as a discursive tactic: ‘... pleasure is Good and, warrantably, can only be assigned to the Good’ (O’Malley and Valverde, 2004, p. 40). By pathologising pleasure, harm reduction can further entrench discrimination through the re-stigmatisation of people who use illicit drugs as irrational and motivated by compulsive desires (Moore, 2008).

Multiple authors address the prominence of the notion of risk as a strategy for governing conduct (Douglas, 1966, 1992; Gordon, 2006; Levitas, 2013; O’Malley, 2000). These notions highlight repeated motifs which we discern in the discourses surrounding the illicit drug user: an undue emphasis on individual risk, without regard for how pleasure is embedded within socially constructed discourses of drug-related risk. We argue that, in simply focusing on the nature of risk and harm, and the means of their prevention or reduction, health and social care workers may be misunderstanding important facets of the social and cultural contexts of drug use. As such, harm-reduction interventions require a more nuanced understanding and appreciation of the ways in which both pleasure and safety may be intertwined with the harms and risks within the constructed experience of drug use.

Politics of scapegoating, stigma and social exclusion

Stigma and discrimination as well as the fact that illegal drug use is criminalised, rather than seen primarily as a health issue, all create many barriers to the involvement of drug users in public health responses (Baral *et al.*, 2014). According to Link and Phelan (2014), stigma also has a rarely recognised potent function. It justifies those with an interest in keeping others away from power resources. The process of stigmatisation is therefore connected to the process of social exclusion (Allman, 2005, 2013). Social exclusion (as experienced, for example, through family breakdown, poor housing, ill health, limited education, unemployment and/or criminal activity) may exacerbate the social context in which individuals consume illicit drugs (Neale, 2008). At the same time, drug use itself can lead to further social exclusion, as the stigma, discrimination and prejudice associated with drug use can further exclude individuals from mainstream society (e.g. being shunned by health services, negatively portrayed in the media and blamed by the criminal justice system) (Neale, 2008).

Politically, scapegoating and stigma distract from the socio-structural conditions and policies that aggravate the problems marginalised people who use illicit drugs may face and may emphasise certain solutions that are in tune with market-oriented, neo-liberal, fundamentalist worldviews (Friedman, 1998). Stigma and discrimination are forms of social exclusion—a process linked to power and domination. Allman (2013) exposes how the concept of social exclusion embodies the functionality of ‘outsiderness’, with a particular aim to control, limit or facilitate the movement and interaction of people through hierarchies of integration (or architectures of inclusion). Following on this line of thought with regard to the functionality of stigma and social exclusion (Allman, 2013; Levitas, 2000; Link and Phelan, 2014), casting people who use illicit drugs in the role of excluded and marginalised actors within contemporary society serves specific socio-political and economic functions. Within such a frame, the arrangements by which members of an excluded and marginalised community become responsible for their own well-being and the management of their own risk contribute to the production of an economy characterised by uncertainty, plurality and anxiety, thus an economy that is continually open to the construction of new problems and the marketing of new solutions (Rose, 1996). In other words, the creation of new fields of problematisation engenders new economies where problems are commodified and solutions become markets upon which society can capitalise. Under the logic of competition, market segmentation relative to stigmatisation and social exclusion can herald the potential profitability of problematisation on the one hand and the state responses that seek to govern such problems on the other.

Drug users’ organisations have worked to resist stigmatisation and the repression of people who use drugs while preventing the spread of HIV, HCV and other infections in many countries, and have done this through the involvement of people who use drugs in decision making and advisory structures using a *Nothing About Us Without Us* principle. History shows that in the context of the AIDS pandemic, public health authorities and medical establishments often have been forced to seek lay expertise (Pisani, 2008). By the late 1970s, communities of drug users in North America recognised early on that there was a new fatal disease among them, before science had decreed the existence of AIDS, and took steps to protect themselves well before public health agencies took action (Friedman *et al.*, 2011). This example shows that, given the opportunity, in the absence of social equity, marginalised communities can organise to protect themselves against disease and harm (Friedman *et al.*, 2011). However, since drug user groups are often unpopular and socially and politically demonised, the ability of civil society to sympathise with those at risk of harm is essentially already poisoned by the dominant norms (e.g. punitive control) and moral judgements of that society (Zibbell, 2012).

Additionally, health and social care workers should be aware that national policies differ in terms of the extent to which the politics of scapegoating is

institutionalised, and the degree to which some groups are scapegoated. For instance, policies that link drug use and unsafe practices may be based on assumptions and beliefs that no individual would intentionally engage in unsafe practices. This can be exacerbated by policy makers who occupy an outsider perspective—one in which practices are interpreted exclusively on the basis of what funders and policy makers in dominant domains consider rational or fundable.

Implications for health and social care

In this paper, we have argued that, in harm-reduction discourses, health and social care clients are frequently perceived as inherently health-conscious citizens capable of self-regulation with regard to pleasure and risk management with regard to harm, and hence able to minimise drug-related damage. Making sense of such epistemological issues within harm-reduction paradigms provides the background to help us understand discourses surrounding illicit drug use and the meanings that are ascribed to people who use illicit drugs. We believe this theoretical perspective is essential to counter-balance other dominant approaches to the study of the harm-reduction paradigm. Further, the approach provided in this paper has implications for individual, meso-level and structural intervention strategies for social workers who work with people who use illicit drugs.

Limitations

In this paper, we have argued for the importance of unsettling dominant discourses in the field of harm reduction; however, in doing this, we have had to contend with several limitations. First, given the paper's orientation towards critical theory, other theoretical orientations are not represented. Our decision to apply critical theory has stemmed from the ethical implications of some of the elements of the harm-reduction paradigm, which concern the construction of the 'illicit drug user' and 'illicit drug-using communities' as risks in need of regulation, and the emerging discursive creation of people who use illicit drugs as a particular type of citizen group, with an ascribed relationship to the care of the self.

Second, our argument is framed within a Western scholarship tradition and, as such, other perspectives are not represented. The context of illicit drug use and the experiences of people who use drugs may differ in distinct regional settings like the Middle East, Africa or Asia, where the number of illicit drug users is on the rise, but where harm-reduction movements are not proliferating to the same degree.

Individual-level recommendations

Reflexivity, as a tool, should be put forward to encourage social workers and professionals in diverse health fields to stand in a self-critical position and reflect on how knowledge is produced, and how relations of power are exercised through the process of knowledge production. Those who work as harm-reduction practitioners may benefit from querying how their clients are subjected to sets of intricate values like those proposed by governmental and biopolitic perspectives. Health and social care workers who are able to uncover the epistemological and historical roots of the fields they work in can make the various competing discourses on harm reduction more apparent. Specifically, we can argue that, rather than replacing the existing punitive control of drug-using subjects, the new presumably progressive practices of harm reduction in Canada and the UK co-exist (and at times become co-opted) alongside more traditional forms of repression (criminalisation and law enforcement), potentially masking the punitive values embedded within these more liberal approaches to drug use. For example, in the context of drug criminalisation, the inner workings of supervised injection sites for IDU populations can be framed and understood as surveillance and discipline sites, given the extent to which they are regulated and controlled.

Professionals also may wish to understand the construction of the harm-reduction paradigm in light of the ethical challenges raised by burgeoning neo-liberal forms of governance. To do so will require awareness of the importance of countering psychological-reductionist and socially pathologising frameworks that blame victims for their self-destructive behaviours. Health and social care workers may instead consider the role of systemic inequities and oppressions like homelessness, poverty, racism, stigmatisation, ableism, classism, hetero-sexism and neo-liberalism in the context of harm reduction, as well as HIV and HCV prevention for people who use illicit drugs.

Meso-level recommendations

On a meso level, community interventions which critically address the stereotypical media representations of people who use illicit drugs and are aimed at addressing the stigma of drug use and the ‘othering’ of people who use illicit drugs within broader society in both Canada and the UK may be helpful. Typically, media representations of people who use illicit drugs have tended to be exceedingly problematic, which may contribute to the social exclusion of drug-using individuals as well as to symbolic violence against them.

Further, on a community level, those working in health and social care can advocate for the cessation of aggressive neo-liberal regimes of control of space enforced by private and public institutions, which may aim, for

example, to reshape inner cities from the sites of destitution to entities of competitiveness and economic attractiveness. Such policing focuses primarily on disturbing elements of social order, such as people who use illicit drugs (as well as homeless people or sex workers).

Advocacy and structural-level recommendations

On a structural level, laws and policies that afford people who use illicit drugs the same opportunities as those who do not use illicit drugs and that offer protections against discrimination can reduce stigmatisation, social exclusion and potentially alleviate health problems at their source for large segments of this population. Additionally, advocacy for anti-discrimination policies and laws could be accompanied by other interventions that include continuing funding for health and social programmes specifically designed for people who use illicit drugs, as well as continuing funding support for organisations and programmes that aim to dismantle the social oppression that impacts this population.

Arguably, social workers have a responsibility imposed by our code of ethics to be involved in social justice and change. We are well placed to work with and advocate for people who use illicit drugs (Neale, 1999). Social workers frequently advocate for change on behalf of, and in the best interests of, our clients and for the benefit of society. We are in a position to change the model of pathologisation and social control of people who use illicit drugs and to start responding to the realities of drug-related harms in more pragmatic ways.

Recommendations for social work research

Our recommendations for health and social care researchers centre on the need to be more reflexive and forthcoming in our assumptions and opinions about the topics that we investigate. Failures of reflexivity compounded by epistemological naiveté may not only hinder accurate and effective social work interventions and programme developments, but also limit research initiatives. The reflexivity principle debunks the myth of the researcher and policy maker as a passive observer, and makes us rethink certain disciplinary norms towards ‘standpoint epistemology and strong objectivity’ (Harding, 2004), in order to evolve and grow in practice and ‘create spaces within the culture of domination’ (Hooks, 2004). Doing so will facilitate research that gives voice to marginalised populations, while acquainting mainstream cultures with lifestyles which are situated outside the boundaries of mainstream society.

Professionals can achieve reflexivity by utilising the emancipatory frameworks of social work. For instance, we can use ethnographic methods to

attend to the power distribution between the researchers and the researched. Using such emancipatory methods like critical discourse analysis can enable researchers to reveal latent power structures of cultures, institutions and societies and, in doing so, to provide opportunities to question and challenge taken-for-granted beliefs on the topics of illicit drug use and harm reduction.

All too often, policy discourse delineates a specific regime of truths within which the lives, needs and interests of disadvantaged, marginalised, socially excluded individuals, families and communities are masked or neglected. Our task is to remain alert and vigilant in our need to question dominant rhetorical structuring paradigms like harm reduction. The truths dominant discourses establish often seem to be normal, the best practice, yet alternative truths continue to provide articulating connections.

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