Different Paths and Potentials to Harm Reduction in Different Welfare States: Drug Consumption Rooms in the United Kingdom, Denmark, and France

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We discuss the role of drug consumption rooms (DCRs) as a harm reduction strategy to prevent drug overdose and show that "welfare states" collectivize the management of risk and in so doing cushion the socially vulnerable from harm (Houborg and Jauffret-Roustide, "Drug Consumption Rooms: Welfare State and Diversity in Social Acceptance in Denmark and in France," p. S159). We argue that providing harm reduction services can also be viewed as a process of negotiating relationships between the state and those receiving welfare. By "state," we mean the institutions that are established by law and controlled by the government. We note that health and harm, as well as intervention and policy, are always situated effects of their risk and enabling environments.[1–3] A harm reduction response to overdose crises, as with other public health emergencies, necessitates a systematic, adaptive, and structural response.[4]

DCRs are one form of structural intervention among many that have proven effective in reducing overdose, thereby protecting the welfare of vulnerable people who use drugs.[5–7] DCRs seek to adapt the drug use and social environment to make these safer in the face of multiple risks and constraints.[8] Yet, the introduction of DCRs has become a matter of controversy, including in policy environments that historically enable harm reduction approaches, such as the United Kingdom.[9] This tells us that harm reduction interventions like DCRs can be blocked in policy environments that potentially support harm reduction as well as in environments of comparatively repressive drug policies.[10] Moreover, some progressive harm reduction tools can be implemented in the absence of extensive welfare state policies that seek to collectivize or cushion risk, as is done in Denmark and France. Indeed, crises such as the AIDS epidemic and the COVID-19 pandemic have driven change that would not be considered in normal times.

Harm reduction has emerged as a "generous constraint" of shifting policy environments that can vary in time and space as well as in relation to how policies recalibrate concerns about health, crime, and welfare. Emilie Gomart coined the term "generous constraint" in her work on harm reduction in France that she conducted at the end of the 1990s.[11] The term suggests that harm reduction interventions and environments[1,2] can enable and constrain action. Harm reduction practices regulate social behavior and empower people to choose their own consumption practices.

We caution against overly linear assumptions in the idea of welfare states enabling more progressive harm reduction interventions. We emphasize that the activism and organization of activist groups, especially people who use drugs, are critical in creating the conditions in which harm reduction interventions become possible, including in the face of restrictive policy.[12,13] In many communities, prosecution, job loss because of stigma, and punitive treatments aiming at total abstinence have cultivated a deep

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distrust of the law, officials, and state representatives. Harm reduction can be seen as a matter of adaptive potential in relation to its policy and social environment—an environment in which the welfare state actor is but one element among many that are open to adaptation. We illustrate this point by examining how harm reduction emerged in the welfare states of the United Kingdom, Denmark, and France.

UNITED KINGDOM

In the United Kingdom, harm reduction services were first developed through local action in the Merseyside area of northwest England.[14,15] The Mersey model spread, first nationally and then to receptive parts of the world. The harm reduction approach entered British national policy after the Thatcher government—which was no friend of the welfare state—accepted the 1988 recommendation of the Advisory Council on the Misuse of Drugs, which asserted that preventing HIV transmission was more important than insisting that people stop using heroin.[16] Rates of HIV and hepatitis C among people who inject drugs are still much lower in the United Kingdom than in the United States.

Since the 1990s, support for harm reduction in UK policy and funding has waxed and waned. In the 2000s, concern for limiting HIV was largely replaced by expanding opioid agonist treatment (OAT) to reduce the criminal offending of people who use heroin and crack. When the Conservative Party reentered power in 2010, it brought a new focus on abstinent recovery.[17] Harm reduction interventions, such as OAT, have become refashioned as addiction recovery interventions in a post-AIDS crisis era and relabeled "recovery-oriented treatment."[18] Maintaining harm reduction services requires health workers to work with the generous constraints of recovery-oriented interventions.[19] In this context, harm reduction is delivered as an interim strategy to those in "active addiction" to keep them alive until they achieve the primary goal of abstinence. Cuts to treatment budgets, recommissioning of treatment services, and a push for people to leave treatment drug-free were followed by annual increases in drug-related deaths starting in 2013 and a decrease in the number of people in treatment.[20]

The most recent UK government drug strategy (published in December 2021) makes little direct mention of harm reduction but does include it in the wide range of services in which GBP780 million of new funding is to be invested from 2022 to 2025 in England.[21]

The UK government is also reviving punitive rhetoric alongside its new investment in treatment services, blaming drug users rather than blanket prohibition for the harms of organized crime and ruling out DCRs on spurious legal grounds.[22] It was left to an activist with a lived experience of problematic drug use to set up the first overdose prevention service in the United Kingdom, which they did in a secondhand vehicle on the streets of Glasgow in 2020–2021. An overdose prevention service is a less formal version of a DCR that offers a narrower range of services.[23] Efforts to set up an officially sanctioned and funded DCR have so far been thwarted by government resistance, although there are signs of progress, in Scotland at least.[24] Much of the opposition to DCRs in the United Kingdom and elsewhere focuses on whether they can appropriately control the actions of their users. Once again, enabling and sustaining harm reduction in practice becomes a matter of working in the generous constraints of policy.[25] The UK approach shows how political support for drug policy approaches can change rapidly in a way that is against evidence and professional advice. Meanwhile, Scotland's desire to adopt DCRs is backed by Scottish nationalist politicians but blocked by the Westminster Conservative government.

Peer-to-peer needle and syringe programs played a significant role in the 1980s and 1990s in ensuring access to sterile injecting equipment, especially outside big cities. Internal strife compounded by national policymakers' active undermining of the funding and legitimacy of the drug user rights movement reduced the influence of self-organizations of peers in policy and practice.[26] The absence of an active drug user rights network in the United Kingdom has undermined the defense of harm reduction and the promotion of community mobilization.[27] There are now some signs, especially in Scotland, of a revived role for drug user activism.

DENMARK

Harm reduction emerged in Denmark from different roots in 1984 when "graduated goals" was introduced as the basis for Danish drug treatment. Graduated goals meant that treatment "should not only aim to 'heal' addiction, but to provide rehabilitating measures while drug abuse continues"[28(p132)] and should include basic improvement of physical health and improvement of the situation of those who use drugs, including through abstinence. The introduction of graduated goals was based on a conception of problematic drug use as a symptom of social inequality and social deprivation. Anticipating a focus on social exclusion in Danish social welfare policy that was introduced in

the late 1980s, the central idea of introducing graduated goals was to include people who could not or would not abstain from drug use in social welfare and health care systems. Harm reduction thus arose from Danish drug policy as a social welfare measure against social exclusion rather than primarily as a public health intervention. Public health became an important element of Danish harm reduction policy some years later, coinciding with the onset of the HIV/AIDS crisis.

Danish drug policy as it was developed during the 1960s and 1970s was based on the ideas that criminal sanctions should reduce the supply of drugs and that social welfare measures should reduce the demand for drugs.[29] This meant that possession of illicit drugs for personal use was depenalized from 1969 to 2004. In 2004, this policy was repealed when a zero tolerance measure was passed stipulating that all possession be sanctioned.[30] Parallel to this repressive policy, other measures aiming to improve social rights (e.g., a treatment guarantee) and new harm reduction measures have been implemented. In 2008, it became possible to use heroin as an OAT. In 2012 municipalities were permitted to open DCRs, and there has been a general trend toward establishing low-threshold social support and health services. The Danish Drug Users Union and lately also the Users Academy have actively voiced their concerns in policy deliberations.[31] Denmark is currently in the paradoxical situation of advancing progressive harm reduction interventions in the generous constraints of repressive policies on drug use.

FRANCE

Interventions enabling access to sterile syringes and OAT were implemented in 1987 and 1995, respectively, in response to the HIV/AIDS emergency but without a robust legal basis for disseminating strong harm reduction policies.[32] Not until 2004 to 2006 and 2016 did France's Ministry of Health institute a series of laws that included harm reduction in the public health code, thereby recognizing the role of the state as an instrument of harm reduction. DCRs were introduced in 2016, 30 years after Switzerland, and have been highly contested, despite strong consensus among health professionals, including through political debate and through local community resistance in gentrified areas where DCRs were planned.[10]

The difficulties in implementing harm reduction in France can be traced to the persistence of the 1970 law that punishes any drug use, thus framing repression as a dominant response. This prohibitionist law treats drug use as a moral vice.[33] In France, initial debates on harm reduction implementation (such as enabling access to syringes and OAT) through the 1980s and 1990s were tense: opponents (mainly psychoanalysts) saw harm reduction, including OAT, as a form of promoting drug use and social negligence that left patients as slave to their addictions, whereas harm reduction activists claimed that HIV/AIDS was a sanitary and humanitarian emergency that required urgent population-level risk reduction.[34] Through the 1990s, experimentation in generous constraint between dependence and freedom materialized in the OAT clinics, where the rules and practices of treatment (e.g., dose and delivery regimens) were adapted and tweaked to enable simultaneous treatment engagement and rehabilitation.[11]

Harm reduction was thus made possible by alliances between the activist networks of people who use drugs (especially ASUD [Auto-Support des usagers de drogues/Self-Support for Drug Users]), people living with HIV/AIDS (especially ACT-UP [the AIDS Coalition to Unleash Power] and AIDES [a French community-based nonprofit organization]), and humanitarian activists (especially Médecins du Monde) alongside addiction professionals. Together, they created a social movement called "Limiting the Break," which—by highlighting harm reduction's success in other countries, such as the United Kingdom in the 1990s—pushed the Ministry of Health to implement and strengthen harm reduction.[34]

In France, harm reduction has been enabled in a national policy framing of "addiction as a chronic disease," which is symbolized by abundant access to OAT. Indeed, high coverage of this medication (85% of people who inject drugs attend harm reduction facilities under OAT)[32] has been made possible by a strong welfare state model. This model allows free access to health care and sustainable financial support to harm reduction facilities and drug addiction centers that are mainly publicly funded. Nevertheless, national drug policy maintains a strong emphasis on the criminalization and biomedicalization of drug use that still neglects other areas of harm reduction (e.g., social and racial justice and inclusion).[10] The French sanitary model of harm reduction is sustainable because of public funding, but it does not enable a general environment of social freedom, inclusion, and personal choice of empowered recovery.

CONCLUSIONS

We have traced the development of harm reduction in three welfare states. Each country exemplifies one of Esping-Andersen's three "worlds of welfare

capitalism": the liberal one for the United Kingdom, the social democratic one for Denmark, and the conservative one for France.[35] In each country, harm reduction is made possible, not only because of policies—policies that are oriented to welfare, social control, or public health—but also despite policies—policies that narrow welfare opportunity, exacerbate or extend inequality, or emphasize criminalization in relation to drug use. In each country, harm reduction has emerged as a generous constraint of that country's shifting policy and social situation and has been calibrated comparatively and historically in each country's way in relation to health, crime, and welfare.

These examples suggest caution against overly simplistic assumptions related to harm reduction's emergence as an effect of state collectivization of risk or shared welfare responsibility in relation to a country's citizens. A key element in the emergence of harm reduction, and in the adaptation of conditions that enable such generous constraint, is activism, including by people who use drugs. Discourses of harm reduction have moved away from just providing people the means to make healthy choices about drugs to emphasizing social justice and antiracism.[36] It is essential to listen to the voices of people who use drugs when defining drug policies.[12,13,26,27]

It is also important to recognize different roads to harm reduction. There are some key differences between harm reduction as a civil society service and as a state service. If harm reduction exists as a civil society service based on local collective action, there is a risk of disparities in access to harm reduction. If harm reduction services become a state responsibility, it may become possible to make rights-based claims on the state. In reality, the situation may sometimes be more complicated, as in the state of DCRs in Denmark and France (Houborg and Jauffret-Roustide). In both countries, it is official policy to include DCRs in the national harm reduction policy, but it is left to local governments to decide whether to implement DCRs.[10,30] There remains a difference in principle between access to harm reduction services as a social citizen and access to harm reduction as part of a local community or—as in the case of the United Kingdom so far—being denied access to DCRs except in the legal gray zone of an unsanctioned overdose prevention service.

Drug policy plays an important role in shaping the risks that marginalized people face and their access to resources that enable them to manage these risks. Because of similarities and differences between the United Kingdom, Denmark, and France in areas of social welfare and health care policy, and differences in their drug policy, these three countries provide interesting sociological case studies for examining drug policy effects and the role of different welfare states in harm reduction implementation and sustainability. AJPH

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CONFLICTS OF INTEREST

The authors have no conflicts of interest to declare.

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