REDUCING RISK, PRODUCING SELVES:
DRUG USE AND IDENTITY IN NEEDLE EXCHANGE

by

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Abstract

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"Harm reduction" refers to a drug policy paradigm that promotes measures intended to reduce the negative consequences of illicit substance use within the context of legal prohibition. Citing values such as pragmatism, flexibility, and humanism, harm reduction "technologies" include needle exchange, methadone maintenance, and supervised injection – programs that defer the long-term goal of abstinence in favor of short-term measures aiming at the amelioration of risk. Discourses of risk pervade harm reduction programming, and indeed, the dangers of overdose, infection, and arrest faced by injection drug users are real, and further, exacerbated by a national drug strategy that emphasizes criminalization. However, this dissertation is less interested in the objective nature of the risk(s) surrounding injection drug use, and instead focuses on the construction of risk and risk subjects within harm reduction practice. By documenting the "techniques of subjectivation" employed at one community-based needle exchange, Bronx Harm Reduction, this project ultimately seeks to characterize harm reduction as both a technology of domination, and a technology of the self, while describing the identities forged therein (Foucault 1988). Drawing upon one year of participant observation and in-depth interviews with program participants and staff, this study contributes to an emerging body of critical social science research into harm reduction. Where previous study have focused upon

more “spectacular” methods of harm reduction, like methadone maintenance, this research aims to explore a less controversial structural intervention, needle exchange, which works upon users’ bodies by first molding their sense of self. It further endeavors to move beyond a binary of empowerment and control, in problematizing the forms of agency that are generated within needle exchange. Where harm reduction theory rests upon a construction of “clients” as autonomous and rational subjects, Bronx Harm Reduction’s rules, staff actions, and client experiences betrayed a more complex reality. Ultimately, this dissertation asks: how empowering is an identity that posits the individual as potentially dangerous to him or herself and others?

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I would like to thank the members of my committee for their invaluable contributions in shaping this project and the resulting dissertation.

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Chapter I
Introduction: The Surprisingly Sanitary World of Bronx Harm Reduction

When asked their first impressions of Bronx Harm Reduction, a syringe exchange program in the Mott Haven neighborhood of New York City, many newcomers expressed their surprise at how clean it was, like a clinic. Others used the words "orderly" and "peaceful" to describe the drop-in center with astonished approval. On one level, such remarks revealed common preconceptions of what a space populated by illicit drug users might look like – dirty, chaotic, and disorganized, like the lives of users themselves. Yet, these unlikely adjectives also praised Bronx Harm Reduction's ongoing efforts to remake itself, in a multi-year project that sought to transform both its physical space and organizational culture.

In 2010, the facility enjoyed a complete aesthetic overhaul. Walls were repainted in soothing shades of blue and green, and flat-screen televisions were installed in the main space. While the administration joked that the makeover was inspired by New York's famous "W" Hotel, a new bathroom for program participants was explicitly modeled after those found at a luxury gym and spa. Imposing an atmosphere of calm, if sterile, competence, the renovation presaged the installation of an actual medical center set to begin the following year. Employees often quipped that their chosen field was as "raw" or as "grimy as it gets," yet their work environment itself increasingly betrayed this description. A two-man maintenance team was constantly on-hand, mopping floors and emptying garbage bins, while program participants were often seen to pick up a broom and dustpan, to address a spill or simply pass the time.

Cleanliness was a major point of pride for Bronx Harm Reduction's relatively young leadership, who took the reins in the year before this study began. Contrasting the "new Bronx Harm Reduction" with the old, administrative staff emphasized that the improved facilities were

more respectful to clients, and further reflected the organization's consolidation of order and stability after several volatile years. The arrival of the new regime saw a proliferation of rules and official procedures at Bronx Harm Reduction, intended to increase professionalism and accountability on the part of both staff and participants. "Community Rules" streamed continuously on a television in the drop-in center, while monthly "Participant Advisory Board" meetings encouraged clients to "actively voice" their interests or complaints. Having achieved a palpable shift in the agency's atmosphere, Bronx Harm Reduction set its sights upon the transformation of harm reduction at large, positioning itself as a model program for the state, country, and world. Of course, some observers might note that the "revolution" exemplified by the freshly scrubbed Bronx Harm Reduction had long been in motion, for better or for worse.

What is harm reduction?

As the previous statement implies, "harm reduction" is a moving target, a social construct whose content varies by time, place, and social position. While a short history and theorization of harm reduction will be undertaken in the chapter ahead, this term must be briefly defined in introducing the major objectives of this study. In its contemporary, institutionalized and perhaps hegemonic form, harm reduction refers to a set of strategies that seek to ameliorate the individual and social harms associated with illicit injection drug use: primarily, infectious disease and public disorder. While such harms may be understood as pathologies of drug prohibition, harm reduction largely focuses on changing individuals' drug-use behaviors. "High risk" practices such as syringe sharing and public injection are specifically discouraged through harm reduction programs like needle exchange and supervised injection facilities. Historically, harm reduction has distinguished itself from other (treatment and law enforcement) approaches to illicit drug use

through a non-judgmental and fundamentally pragmatic service ethic. Framing drug user clients as rational, self-interested and responsible agents, the language of non-coercion and choice is paramount to harm reduction's social identity: harm reduction programs give people the *freedom* to continue using drugs, while *empowering* them with the information and tools necessary to reducing their risk (O'Malley 1999).

At Bronx Harm Reduction, such tools included syringes, condoms, and assorted injection equipment, arrayed in neat displays throughout the main drop-in space. The building was similarly saturated with information on HIV and Hepatitis prevention and care; bilingual bulletin boards illustrated routes of disease transmission, and racks of pamphlets adorned several walls. While the director boasted that the organization's work was ultimately "reducing the community's viral load for HIV," Bronx Harm Reduction harbored a grander vision for its participants. Framing harm reduction as a technology of total health promotion, the organization endeavored to develop its "transformational aspect" – proposing that clients might improve their lives through improving their health. To this end, the new leadership sought to integrate harm reduction with the "medical model," advancing a scientific approach to drug use that demanded more assertive education, and despite protests to the contrary, the imposition of more expectations upon clients. To some degree, the organization projected its own ambitions of transformation onto its client body, setting itself as an example of positive change through the imposition of goals, strategies, and discipline. Transformation was undoubtedly an end desired by many program participants, some of who managed to "transcend their situation" with the assistance of Bronx Harm Reduction, by getting an apartment or being hired for a part-time "stipend" position at the agency. Yet for many, basic survival remained the primary, seemingly

insurmountable goal, threatened by not only infectious disease, but also hunger, homelessness, and incarceration.

Harm reduction and/as survival

To some degree, this dissertation is about survival – organizational and individual – in a barren economic landscape, in a highly policed neighborhood, and in a culture and institution consumed by risk. Drawing on one year of ethnographic observation and interviews at Bronx Harm Reduction (BHR), this study documents the ways in which an organization and its clients used each other to manage the precariousness of their mutual existence in an era defined by budget cuts. In this context, survival took on a distinct air of competition, due to the limited resources available for and at Bronx Harm Reduction. While the agency fought to maintain its funding from a dwindling number of public contracts, clients struggled over finite food, jobs, and space at the drop-in center.

As described above, Bronx Harm Reduction faced the crisis through reinvention. Located in a stretch of the South Bronx dense with social service providers, including three other harm reduction programs, the agency sought to differentiate itself from its scrappier peers. Where harm reduction was once a fringe movement, adversarial toward the state, Bronx Harm Reduction increasingly staked its claim as a public health guarantor and soon-to-be medical provider. BHR's activist ancestors had initially challenged a political and scientific establishment reluctant to invest in injection drug users; yet, as gradual acceptance begat a thriving harm reduction industry in the city's poorest neighborhood, the organization found it necessary to

better emulate the institutional culture it had once critiqued. Refurbished facilities and an overall re-branding of the agency comprised one tactic of distinction, but, simply put, Bronx Harm Reduction needed bodies. Harm reduction itself had been re-packaged as an "evidence-based" program, and clients were necessary to generate the evidence that justified funding. Overall, the collection of data depicting the agency's effectiveness became an activity of increased importance.

Bronx Harm Reduction's new entrepreneurial spirit was not lost on clients, who were surrounded by explicit and implicit messages to regard the self as enterprise. The organization rarely lacked for participant volunteers, who swept the front sidewalk or packed bags of condoms, in hopes of receiving a coveted stipend ("peer") position. Even when the chance of peer work was remote, some participants gamely completed grant-funded training programs in HIV education or risk reduction, attempting to gain some kind of formal credentials. Yet there were other ways to eke out a living at Bronx Harm Reduction - selling cigarettes or hustling carfare, for example. Many clients recognized data as the contextual currency it was, taking part in regular focus groups or research projects that offered incentives. Of course, many others simply came for food, a shower, and a safe place to nap. The diverse ways in which participants used the agency to survive spoke to the many types of risks they faced, few of which were the official targets of harm reduction.

Defining, contesting, and performing risk reduction

This dissertation is interested in what types of risk *were* constructed as the formal targets of harm reduction. As noted above, Bronx Harm Reduction was rife with discourses of risk, which circulated in many forms and multiple directions. Signs, pamphlets, and personal risk

assessments communicating the negative health effects of injection drug use were found throughout the facility, while the amelioration of risk was a topic of nearly every educational group. Explicit pronouncements of risk largely flowed from the top, down, from staff members, to participants - which is not to say that the definitional power assumed by the agency went uncontested, nor that messages of risk did not occasionally flow through alternate channels.[1] On one level, this dissertation will consider the clients of Bronx Harm Reduction as a "targeted population," to use a term borrowed from Mitchell Dean (1999). Representing persons not fully trusted to take care of themselves, targeted populations are the subjects of specific, intensive, and sometimes intrusive interventions by the state and its agents. Drawing on the work of Dean and his theoretical forefather, Michel Foucault, I will consider harm reduction to be, at times, a disciplinary approach to drug use, which seeks to the lower population's burden of disease through the taming of certain "risky" individuals. Some might dispute harm reduction's designation as such, highlighting instead its "new public health" emphasis upon voluntary self-care and consumer incentivization (Petersen and Lupton 1996). This dissertation will indeed consider the neoliberal threads of harm reduction, while noting its retention of disciplinary technologies that aspire toward the creation of more docile, and less infectious, bodies. By working to shape the consumption of certain drugs in certain ways, harm reduction normalizes injection drug users as patients, a trend that may only be amplified by Bronx Harm Reduction's move toward the medical.

To discuss the disciplinary effects of harm reduction is not to dismiss its overwhelming productivity – of particular client practices, performances, and subjectivities. Exploring the intersection between Foucault's "techniques of domination" and "techniques of the self," this

[1] The importance of participant "peer" workers in disseminating official risk reduction messages will be discussed in chapters ahead.

dissertation will also describe the framing of risk reduction as an opportunity for reinvention (Foucault 1988). As stated, Bronx Harm Reduction stressed client transformation within its own revitalized mission, while many clients sincerely desired to transform their lives after many years of living in sustained crisis. For the agency, transformation was predicated upon a shift in subjectivity, or "readiness to change," itself achievable through education, planning, and incentives. This study will both describe the techniques of subjectivization deployed by Bronx Harm Reduction to produce responsible and "recovering" drug users, and portray the subjectivities ultimately performed by clients. Here, the place of harm reduction within a neoliberal governmentality, or rationality of governance, will be recognized and critiqued (Dean 1999). In qualifying harm reduction as a neoliberal approach to drug use, I discuss how the burden of change is placed on the individual, who is plied with information, encouragement, and discourses of agency, yet little in the way of financial assistance.

By depicting the ways in which harm reduction selectively, and reservedly, fosters the lives of its clients, this dissertation seeks to contribute to a developing literature on neoliberal biopower (see, for example, Willse 2010). Michel Foucault (1990) coined the term "biopower" to describe a modality of power emergent in the eighteenth century, which took life itself as its target. Working through the entwined poles of anatomo-politics and biopolitics, which target the individual and species body respectively, biopower ultimately endeavors toward the optimization of a population's vitality, through the surveillance and control of biological processes like mortality and morbidity. Some theorists have already relegated biopower to the past, noting its culmination in the twentieth-century providential state – a state that has dissolved in the wake of neoliberalism. Nikolas Rose (2006), for example, asserts that the contemporary state has abandoned its biopolitical concern with population, in favor of strategies that contain costs by

devolving responsibility for health onto individuals. This dissertation will suggest that it is precisely this interest in minimizing the economic burden of certain individuals' risky behavior that defines neoliberal biopower and its technologies, like harm reduction. Attempting to prevent such costly conditions as HIV, hepatitis, and overdose, harm reduction provides clients with "low-threshold" emergency assistance and the exhortation to change; at the same time, the neoliberal emphasis upon "freedom" – of both behavior and markets -- precludes harm reduction from mandating said change, or implicating the larger structural conditions that effectively frustrate it. Echoing such theorists as João Biehl (2005), this dissertation will characterize neoliberal biopower as providing for only the barest survival of those excessed from late capitalism.

Research Site and Population

While the next chapter will offer a brief history of my research site alongside that of harm reduction more generally in the United States, I here provide a basic sketch of Bronx Harm Reduction, its staff, and clients. One of three local needle exchange programs, Bronx Harm Reduction occupied several floors of a converted warehouse in the South Bronx, minutes away from a bustling stretch of the Grand Concourse, the borough's major artery. While staff members often referred to needle exchange as the "heart" of the organization, Bronx Harm Reduction offered an extensive, and expanding, roster of services related to drug use and HIV/AIDS. All participants were invited to attend educational and support groups, obtain sterile injecting equipment, and receive free HIV testing and medical/social service referrals; HIV-positive clients were additionally able to access case management, mental health care, medical escort services, and housing placement assistance. A small onsite primary care clinic, offering limited

medical services to all clients, was also poised to open in the near future. Yet Bronx Harm Reduction's most distinctive feature was perhaps its multi-floor drop-in, which might be framed as a service in itself, rather than a mere staging area.

The only space continuously open to all participants, the ground-level drop-in was typically the busiest, and noisiest, area in the building, adjacent to the needle exchange and a large group meeting room. It was also the first room one entered at Bronx Harm Reduction, and as a result, the drop-in often had the feel of a hospital emergency room. A participant bathroom was situated on the first floor, boasting three stalls, a double sink, and a large shower for sign-up. During regular business hours, a second-floor drop-in space was additionally accessible by participants, and offered a somewhat more relaxing, or less frenetic environment. Three vinyl couches were open to individuals who wanted to sleep, or establish a more elaborate camp, while another flat-panel television pegged to the "History Channel" was turned to an audible volume for most parts of the day. The second floor public space also contained a smaller group meeting room, and a tiny kitchen, from which lunch was served each day at noon.

As of 2010, Bronx Harm Reduction estimated its current participant population at around 3,000 individuals, including over 750 people living with HIV/AIDS. On average, around 200 participants signed in to the drop-in daily. Across all participants, approximately 60 percent reported past or present drug use, while 75 percent were homeless or unstably housed at intake; nearly all participants were currently unemployed, and receiving less than $10,000 in official annual income. Located in an area of intense migration from Puerto Rico and Latin America, Bronx Harm Reduction further claimed a client population that was two-thirds Latino/a, nearly half of whom were monolingual Spanish; the remaining 33 percent of participants were mostly African-American. As in most local needle exchange programs, participants were majority male,

at 72 percent, with a mean age of 45. While showing a more balanced gender breakdown, Bronx Harm Reduction's 33 staff members closely mirrored the ethnic composition of its clientele.

A Note on Terminology

In my first days at Bronx Harm Reduction, I made the mistake of referring to individuals accessing services as "clients," a term used by some similar agencies. I was quickly corrected by the Administrative Director, who noted that Bronx Harm Reduction rejected the label of "clients," in favor of "participants," which was believed to be a more accurate and empowering characterization. Instead of being passive recipients of pre-packaged services, individuals at Bronx Harm Reduction were expected to actively "participate" in their own change, by using the organization in a way specific to their needs. While respecting the semantic preferences of my research site, I will use the terms "participants" and "clients" interchangeably, in order to avoid both confusion (with research participants more generally), and linguistic monotony.

Methodology

This study is based upon twelve months of participant observation at Bronx Harm Reduction, from July 2010 through June 2011; it also draws on semi-structured interviews with 30 participants and staff members. Positioning myself as a "researcher-volunteer," I spent an average of 20 hours each week observing, assisting, and interacting with staff and participants at Bronx Harm Reduction, in a variety of spaces and situations: the main drop-in center, support and educational groups, meals and parties, staff meetings and trainings, and the administrative offices. In this particular organization, two unisex bathrooms also served as venues for (brief)

sociality. In my capacity as volunteer, I helped staff with relatively mundane tasks such as food service, cleaning, reception, and photocopying.

At the beginning of my tenure, volunteer work was a not merely a means of fitting in, but, to some degree, a requirement of access. Like many community-based organizations, Bronx Harm Reduction employed few full-time staff outside the realm of direct service provision (e.g., case workers and counselors), leaving few people responsible for everyday tasks of maintenance and administration. As a consequence, the organization's "hierarchy of needs" drove my immersion at the research site. Initially charged with simple clerical tasks, like developing a mailing list for the agency, I was told by the Administrative Director to "go do (my) thing" in the main drop-in space after several weeks of mediated entrée. From that point, I awaited less formal invitations from participants and staff members to observe support groups, staff meetings, and other "closed door" events at the agency, while continuing to help out around the building as needed.[2] By the time I began conducting interviews several months into my research period, I was a fairly familiar presence at the organization.

To say that I became a staple feature of the drop-in is not to imply that I blended; indeed, as a relatively young, white woman, I was often the most conspicuous individual within a building largely populated by middle-aged Latino and African-American men. While my anomalous status was never patently disruptive, it was often remarked upon, and caused people to label me in ways that implicated my gender, race and presumed class. Upon first approach, most clients asked if I was a social worker, or perhaps a social work intern from a nearby

[2] The only activity I did not assist in during my research period was syringe exchange itself. A self-imposed restriction stipulated within my IRB application, I refrained from syringe exchange fearing that it might undermine clients' informed consent to participate in my research, by effectively forcing some individuals to interact with me. In general, I did not approach participants at the agency unless already acquainted with them, while pursuing an extremely passive method of subject recruitment for interviewing.

university. Others guessed me to be a visiting representative of the New York City Department of Health, or the Centers for Disease Control, taking account of my initial tours through the facility with senior staff members. Such labels stuck even after multiple corrections, while my self-identification as "researcher" was often questioned or amicably mocked by participants and staff alike. Several clients teased me about being an undercover journalist seeking to capture the "real story" of drug addiction; pretending to hold a microphone, one man frequently approached me with "insider" information he thought might be helpful to my project. Another client joked that I was little more than a "spy" or "busybody" – terms that I myself sometimes used in describing my research method.

Over the course of my research, it became clear that many clients at Bronx Harm Reduction were accustomed to the objectifying gaze of outsiders, whether researchers, writers, case workers, or doctors. While I constantly denied any interest in individuals' past or present drug use, I found myself a frequent recipient of spontaneous "confessions" from clients, a phenomenon that belied the power asymmetry characterizing even our most casual interactions. Thus, in describing the performances elicited by harm reduction, it is necessary to recognize myself as part of the disciplinary apparatus, an approach discussed by other addiction researchers (Campbell and Shaw 2008). Power also suffused my relationship with staff members, though in different ways. When I attended groups, staff members would sometimes look to me to confirm information, or solicit guidance when stuck on a particular topic. As harm reduction becomes an increasingly professionalized field requiring formal credentials, my status as an individual with

advanced degrees appeared to unnerve some employees with much experience but less education.[3]

Disclaimers of inadequate expertise also occurred in interviews with several frontline employees. Interviews followed a similar instrument for both clients and staff, focusing on subjects' perception of the risks of drug use, and the construction of risk in harm reduction. Interviewees were also asked to define the purpose of harm reduction, in their own words and opinion, while further commenting on what participants "got out of" coming to the agency. Where all subjects were asked to describe how they arrived at Bronx Harm Reduction, as employees and/or clients, interviews did not actively solicit information on participants' drug use, or medical, history. In fact, past or present drug use was not a required criterion of interview enrollment for clients.[4]

All current employees, volunteers, and participants who were able to converse in English were eligible for inclusion as interview subjects.[5] Interviewees were recruited via flyers posted throughout the agency, and a brief announcement at one staff meeting, and one Participant

[3] Indeed, such staff members faced escalating pressures to go back to school, as emerging funding contracts demanded workers with a B.A. or better.

[4] While needle exchange formed the founding rationale for Bronx Harm Reduction, only 60 percent of its current clients reported past or present drug use. This figure largely represents the enrollment of HIV-positive clients who sought housing case management services at the organization, without reporting any history of illicit drug use. Bronx Harm Reduction also made efforts to enroll individuals who identified as transgender (some of whom reported hormone injection.) Yet it should also be noted that the organization hosted other individuals who simply sought safe space, hot meals, and friendly company – a population more fully addressed within Chapter Four.

[5] As recruitment efforts were conducted entirely in English, almost all participants requesting participation had a working knowledge of this language; however, one individual was turned away, being unable to converse without translation. It must be noted that this linguistic requirement, reflecting my own lack of Spanish language skills, excluded a unique demographic from this study. Having spent less time in New York City, clients who spoke only Spanish were more likely to be homeless, and more likely to access syringe exchange, as compared to the English-speaking population at Bronx Harm Reduction.

Advisory Board Meeting. In exchange for their participation, clients were offered a 2-ride mass transit ticket or "Metrocard" (worth $4.50), while employees were not offered any incentive.[6] The final interview sample consisted of 19 staff and 11 clients, including six peer workers, who were dispersed between both groups. Given their unique status as part-time employees and program participants, peers were invited to interview as either staff or clients, according to their preference. All interviews were digitally-recorded, and ranged in duration from 8 minutes to 2.5 hours. As interviews took place during normal business hours, their duration was invariably correlated with the subjects' schedules on any given day.

Data analysis was guided by a set of established research questions that sought to capture the discourses and practices around risk and risk reduction at Bronx Harm Reduction. Drawing on the work of Elizabeth Wheatley (2006), my analysis also attempted to characterize a range of "harm reduction subjectivities," as distilled from different clients' interpretations and performances of risk reduction at the agency. Analysis also accounted for emergent themes in the data that reflected unanticipated, site specific features, such as the medicalization of harm reduction, and the organization's "off-label" usage by clients, toward ends unrelated to health or disease prevention. Interview transcripts and field notes were coded iteratively using TAMS Analyzer, an open-share qualitative analysis package, while printed program materials (e.g., pamphlets, annual reports) were read and coded for relevant content by hand.

Outline of chapters

Chapter Two will trace the evolution of Bronx Harm Reduction alongside that of harm reduction at large in New York and the United States. Once a fragmented and illegal practice,

[6] As clients were able to obtain two $2.25 Metrocards each day by attending two hour-long support groups, this incentive was believed to be appropriate and non-coercive.

harm reduction has received increasing levels of institutional support in the past two decades, and in turn, become implicated in and appropriated by networks of power that seek to discipline and regulate injection drug use (Roe 2005; McLean 2011). Drawing upon both first-hand accounts and documentary evidence, this chapter will portray Bronx Harm Reduction's move toward both professionalization and medicalization – aspirations in part driven by the recent recognition of harm reduction as an evidence-based practice. At the same time, this chapter will locate harm reduction within a body of critical social theory that considers its fundamental resonance with neoliberal strategies of governance.

Chapter Two will set the theoretical stage for its successor, which will describe the disciplinary practices deployed by Bronx Harm Reduction. Using staff interviews and observations, Chapter Three will tie such techniques of bodily discipline to the organization's focus upon the biomedical risks of drug use. This framing is in turn related to staff's understanding of harm reduction as a public health technique, first and foremost, aiming toward the prevention of HIV/AIDS. This chapter will also explore the agency's emerging emphasis upon accountability and judgment, exploring senior staff's distinction between harm reduction and "harm maintenance."

Chapter Four will consider client discourses of risk that go beyond matters of health. Citing both interviews and group observations, this chapter will show how clients contested a unilateral understanding of risk, by asserting the ways in which health behaviors were mediated by their larger social environment. The diverse risks faced by clients were made further apparent in the "off-label" ways they used Bronx Harm Reduction to fulfill their basic needs for food, sleep, and simple human contact. In characterizing the unofficial uses of Bronx Harm Reduction,

this chapter will locate the agency within many users (and non-users) "geographies of survival" – the assortment of public and private spaces tapped to stay alive. (Mitchell and Heynen 2009).

While Chapter Four discusses Bronx Harm Reduction's status as a site of triage, Chapter Five will look at the organization's increasing interest in "transformation." This chapter will explore the framing and adoption of harm reduction as a "technique of the self," productive of not only distinct discourses and practices, but also harm reduction subjectivities. Looking at the organization's new CDC-funded intervention, Safety Counts, this chapter will the depict the intense performativity engendered at Bronx Harm Reduction, while describing how harm reduction creates both subjects of interest and subjects of resistance in its efforts to change behavior by targeting identity.

The concluding chapter will revisit the designation of harm reduction as a site of biopower, while further expanding upon the meaning of neoliberal biopolitics. As HIV/AIDS remains an object of not only public health, but national security and economic concern, Chapter Six will posit that the state has retained its interest in managing population health, albeit under new logics, and through different means. While disease containment is increasingly driven by the imperative of cost containment, neoliberal biopower has shed the socioeconomic assistance characteristic of welfare state interventions. This chapter will also depict harm reduction as a site of biopower from below, as an institution that frames its users' rights in terms of health, as members of a national corpus. Having defined harm reduction as a technology intended to foster life, this dissertation will conclude by asking what kinds of lives can be fostered at such little expense.

Chapter II
Banking on AIDS: A Local History of Harm Reduction

In 2010, Bronx Harm Reduction rechristened its first-floor drop-in after the agency's founder, Kevin Jones, a photographer and syringe exchange pioneer in New York City.[7] Beneath a large sign bearing his name and image, several of Jones' original photographs were displayed as a professionally-framed triad, depicting protesters at an unidentified ACT-UP demonstration in which Jones himself had taken part.[8] Stark, grainy, and visually arresting, the pictures infused the otherwise nondescript waiting room with an air of activism and defiance – traits often attributed to the man himself. One afternoon, Bronx Harm Reduction's Administrative Director paused before the photographs, describing their significance to a pair of visitors from the Department of Health. He explained that the pictures were taken during an ACT-UP protest against a pharmaceutical company – Pfizer, perhaps -- during the early days of the HIV/AIDS epidemic.[9] Chuckling, the director went on to note that the cushioned wooden chairs encircling the drop-in had been donated by the Pfizer company in the past year, at a cost of several hundred dollars each.

More than just a passing irony, this interaction may be seen to encapsulate a historical trajectory of harm reduction in the United States and beyond, one of dynamic rapprochement between activism, government, and medicine. This story should not be read as relating the

[7] All staff and participant names, past and present, have been changed.
[8] The AIDS Coalition to Unleash Power (ACT-UP) is a direct action group advocating the rights of people living with HIV/AIDS. Founded in New York in 1987, ACT-UP gave rise to some of the first syringe exchange efforts in New York City.
[9] In fact, ACT-UP did not lead any actions against Pfizer until the year 2000, years after Bronx Harm Reduction's founder had died. If in fact depicting a protest against a pharmaceutical company, the photographs might have represented the 1989 ACT-UP "die-in" targeting the Burroughs-Wellcome company, which was the original manufacturer of AZT (the first antiretroviral drug).

unilateral capitulation of one actor – "activist harm reduction" – to political or corporate power; instead, it is meant to foreshadow an evolving and imperfect association driven by historical circumstance and complex, sometimes conflicting, interests. In an effort to scale-up the provision of life-saving syringes, harm reduction has sought legality and funding from state governments nationwide, an endeavor bolstered by public health and medical expertise; in turn, harm reduction programs have been integrated within local systems of health care provision, and subsequently recognized as a potential market for pharmaceutical and other companies – just as public monies threaten to dry up. The discourses and practices of harm reduction have proliferated in tandem with its owners and investors, who may possess contradictory understandings of drug use, risk, and addiction.

This chapter will consider both the global and local history of harm reduction in accounting for its current shape in New York City and Bronx Harm Reduction in particular. As a still contested, and thus evolving, strategy (neé movement?), harm reduction cannot be evaluated as a stable or universal program; instead, this chapter sets out to interrogate what it has become within a specific time and place. In short, it will describe a strain of harm reduction that has become progressively depoliticized, professionalized, and medicalized – trends that have in turn promoted a less flexible, more disciplinary mode of service delivery. Though maintaining that harm reduction is not a monolithic entity, this chapter will also lay out a growing body of critical social theory that underscores harm reduction's *fundamental* resonance with the "new public health" and neoliberal techniques of governance, as a low-capital intervention that shifts the burden of responsibility from the state to the individual. Indeed, while sketching the transition of harm reduction from grassroots social movement to public health institution, this chapter will note some surprising rhetorical continuities.

"Junkies know best": The early history of harm reduction

The task of identifying harm reduction's birth date or hometown is admittedly problematic, particularly in light of its ambiguous definition.[10] Undoubtedly, drug users have always practiced "folk" methods for the prevention of infection, overdose, or arrest, methods that vary with the contexts of use. Likewise, an ethic of harm reduction implicitly informed such treatments as opioid maintenance, which developed alongside the theorization of "addiction as disease" in the mid-twentieth century.[11] In the following pages, I attempt to foreground the history of harm reduction in New York City with a description of the first manifestations of harm reduction internationally, in Rotterdam and Liverpool – sites that show the disparate actors and motives underlying harm reduction even in its earliest days. This section is not intended as a comprehensive or even conventional narrative of the global harm reduction movement; rather, it seeks to set up a subsequent discussion of the discursive connections and breaks across harm reduction assemblages forged under radically different circumstances. This history further foregrounds the idiosyncracies of harm reduction in New York and the United States, with their distinct political and economic climate.

[10] It may in fact be misleading to speak of an early history of "harm reduction" – a term initially coined and promoted by public health professionals, and retrospectively applied to the efforts of activists, who reluctantly accepted this label. (See Grund 1995 or Grove 2010.)

[11] Substitution therapy, wherein opiate-dependent individuals are prescribed regular doses of opioid drugs to stave off withdrawal symptoms, was not originally conceived of within an explicit harm reduction framework; however, it has become recognized as an essential tool as harm reduction has reoriented itself around HIV prevention. As in other harm reduction interventions, substitution therapy does not mandate complete abstinence from opiates, but rather provides a regulated dose to its clients, often at low or no cost; thus eliminating, in theory, clients' need to inject, substitution therapy is credited with reducing their risk of HIV infection.

Rotterdam

As a self-conscious and semi-organized entity, harm reduction might be traced with some precision to 1980 Rotterdam, when the first drug user's union or "junkieverbond" was born. Founded by a "group of concerned hard drug users," the Rotterdam union was initially formed as a collective defense against policies perceived to compromise the autonomy of local users. Mobilizing in specific response to a municipal threat of compulsory treatment, the Junkieverbond stood against a system that sought to over-administer drug users, a position summarized in their mantra, "Junkies know best how to help themselves" (van de Wjingaart 1991: 39). Shortly after its ignominious birth, the Rotterdam Junkie League became involved in the provision of radical, independent services that would ultimately implicate its leadership in the invention of the harm reduction movement. In 1981, pharmacists in the downtown area of Rotterdam began refusing to sell syringes to known drug users, thereby inducing an artificial shortage of sterile injecting equipment; the incidence of hepatitis B among injecting drug users subsequently skyrocketed. Absent an official response, the Junkie League assumed responsibility for ending the outbreak by distributing clean syringes to drug users residing in the affected areas - the first free syringe delivery scheme in the world. The League remained the sole provider of free syringes until 1987, when the Rotterdam Municipal Health Service was finally persuaded to fund public syringe exchange programs (Grund 1995).

Beyond undertaking a system of direct service provision, the controversial organization was also invested in actively re-shaping drug policy at both the municipal and national level, by representing the interests of their "constituent" drug users to the legislators directly empowered to amend existing laws and programs. In broad strokes, the Rotterdam Junkie League - increasingly in concert with other user leagues springing up across the country - endeavored to

enact drug policies founded in pragmatism and normalization; in practice, the Junkie League lobbied for services that were responsive to the unique situations of individual users, but did not single out drug users for special management. Insisting that legitimate and effective drug policies must be formulated in consultation with users themselves, the leader of the Rotterdam League, Nico Adriaans, met formally with members of the Dutch Parliament to collaborate upon the revision of standing drug policy in 1985 (van de Wijngaart 1990).

Liverpool

Where the Rotterdam Junkieverbond may be credited with enacting services that were subsequently labeled "harm reduction," it was later, in Liverpool, that this program was named and packaged as a formalized model and public health strategy.[12] In the early 1980s, Liverpool was the site of a media-fuelled moral panic around rising heroin use, earning the dubious distinction "Smack City." As the decade wore on, the existing drug scare was further inflamed by the specter of an injection-fuelled HIV epidemic. Inspired by the nascent movement in the Netherlands, the regional Merseyside Health Authority saw the crisis as an opportunity to implement a more "progressive" public health establishment based upon "consumer-led" strategies (O'Hare 2007). Between 1984 and 1986, the Health Authority overhauled Liverpool's substance abuse services, first making opiate maintenance treatment easily available, and subsequently opening the city's first syringe exchange.

Perhaps the most distinctive aspect of the emerging "Liverpool model" was the rhetoric used to justify a potentially controversial, yet unexpectedly popular project; even Margaret

[12] In a letter to Junkieverbond founder Nico Adriaans after his death, Jean Paul Grund writes: "Nowadays such low-threshold, non-judgemental (sic), user-friendly services are described with a swanky, but increasingly diluted, term: Harm Reduction" (Grund 1995).

Thatcher's conservative national government was surprisingly amenable to the policies taking shape in Liverpool. Where the Rotterdam union framed its mandate in terms of users' rights, Merseyside health officials emphasized the public health and public order benefits of harm reduction – a term in fact coined, and disseminated, by the Liverpool authorities. In 1990, the First International Conference on the Reduction of Drug-Related Harm was held in Liverpool to showcase the innovations of the Merseyside Model to health professionals and policymakers the world over, ultimately evolving into an annual tradition. A key speaker at the 1990 conference, Russell Newcombe of the Drugs and HIV Monitoring Unit at the Regional Health Authority, delivered a presentation defining harm reduction as a "social policy" that had its "main roots in the scientific public health model and in humanitarianism and libertarianism." His speech went on to codify the "hierarchical goals of harm reduction," as well as an explicit framework for the rational analysis of risks and benefits (Newcombe 1990). Overall, Newcombe's talk and the conference at large succeeded in lending a professional patina to a policy founded in pragmatism.

New York

The 1990 Liverpool conference was attended by a handful of US activists who were then involved in the organization of an underground syringe exchange in New York; one such delegate, Edith Springer, noted that the European efforts gave a name to the scattered practices of syringe exchange and drug user education ongoing in the United States (Foley 1997). In the US, the burgeoning harm reduction movement crystallized around the struggle for syringe exchange, which had been available on a limited, discontinuous (and illegal) basis since the mid-1980s. In 1983, Jon Stuen-Parker, medical student and former heroin user, began publicly

distributing sterile needles to injection drug users in New Haven, CT (Curtis 2001). While ejected from medical school the same year, Parker ultimately persisted in his efforts, 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. Stuen-Parker's then-criminal endeavors ultimately led to 27 separate arrests in seven states---an experience common to the first cohort of needle exchange practitioners in the United States, where decriminalization has proceeded painstakingly on a state-by-state (or city-by-city) basis (Rubin and McCampell 2000).

Stuen-Parker was perhaps most famously tried in 1991 as part of the "Needle Eight" – eight ACT-UP associates charged with illegal syringe exchange – in a case that would change drug paraphernalia laws in New York (Szalavitz 1991). Toward their exoneration, the Needle Eight argued the medical necessity of needle exchange in the era of HIV/AIDS, drawing on expert testimony from former New York City health commissioner Steven Joseph (Sullivan 1991). In fact, public health experts had long been a source of tentative vocal support for syringe exchange in the US. Five years earlier, in 1986, the director of the Centers for Disease Control AIDS program expressed openness to a test syringe exchange program, noting that no idea "should be discounted in trying to combat [HIV/AIDS]"; shortly thereafter, Joseph, then in office, took up this proposal (Anderson 1991: 1508). In 1988, the US Congress voted to ban the use of federal funds for needle exchange, while the New York City syringe exchange pilot began under the aegis of the Department of Health, proceeding, in fact, out of the agency's headquarters. Burdened by both location and an excess of rules, the pilot attracted few users, and was shut down summarily in 1990 with the change of mayoral administrations. ACT-UP responded by mounting several "walk-about" exchanges throughout New York City, statements

of outright civil disobedience that openly sought to challenge the law. In fact, the organization's syringe exchange committee courted arrest by publicizing its Manhattan "stroll" and inviting journalists to attend (Anderson 1991).

The defense mounted by the Needle Eight had important consequences for the resulting syringe exchange laws, which in turn shaped the funding and content of harm reduction services in New York. Interestingly, Public Health Law § 3381, decriminalizing syringe exchange, did not overturn the existing criminal law prohibiting the possession of injection paraphernalia (PL220.45); instead, the 1991 mandate merely stipulated a time and space of exception, in the context of the public health emergency generated by HIV/AIDS. The new syringe exchange law further exculpated only documented syringe exchange participants, who could demonstrate enrollment with an ID card from an authorized program.[13] Providing an example replicated across the United States, the harm reduction movement in New York thus found its legal raison d'être in the prevention of HIV, a trajectory further guaranteed by the New York State AIDS Institute's regulation and funding of syringe exchange.

The ultimate shape of New York's syringe exchange law – one of the first in the nation – also reflected the composition of New York City's harm reduction movement, while continuing to influence the latter's maturation over the subsequent years. In New York, as in Liverpool, harm reduction sought and gained the mantle of legitimacy as a program of pragmatic HIV prevention. Where the regulatory structures imposed upon syringe exchange undoubtedly helped to diffuse its early activist spirit, it should be noted that ACT-UP pursued a fairly narrow political agenda with regards to harm reduction – a fringe issue within the group as a whole

[13] Despite the legal protections afforded by Public Health Law § 3381, many syringe exchange participants report ongoing harassment, detention, and arrest by New York City police officers, even in the wake of the 2007 NYPD Operations Order 19 which explicitly advised officers not to detain syringe exchange participants for mere paraphernalia possession.

(Heller and Paone 2011). As an organization dominated by the interests of white, middle-class gay men, ACT-UP was never primarily concerned with the civil rights of drug users (Stoler 1997). Following the 1992 decriminalization of syringe exchange, harm reduction became a topic of waning interest within ACT-UP, thereby allowing public health professionals to assume definitional control over a short-lived "movement" (Grove 2008).

Interestingly, the neighborhoods most affected by injection drug use were among those most initially opposed to syringe exchange in New York City. Anticipating the likely location of syringe exchange programs in their districts, African-American community leaders fought against its decriminalization, decrying such programs as potentially "genocidal" to minority populations. Such resistance was quickly disqualified as irrational, paranoid, and even dangerous by syringe exchange advocates (Watters 1994); yet, reflecting on the history of public health in the United States, it is not difficult to understand the ambivalence of minority communities toward harm reduction. After years of requesting accessible and improved health facilities, including drug treatment, opponents were dismayed by the lack of other services attached to needle exchange, which appeared as a cheap and defeatist tactic that didn't address the deep structural problems underlying drug addiction (Woods 1995.) The failure of the new syringe exchange law to change or even engage the Rockefeller Drug Laws, which had taken a drastic toll on New York's African American population, was perhaps another reason for resistance. Relatively absent from the ACT-UP-led harm reduction movement, African-American opponents may have perceived syringe exchange as a measure imposed without their interests in mind.

Another population underrepresented within New York's syringe exchange battles were drug users themselves. This is perhaps not surprising within a harm reduction movement focused upon HIV/AIDS - not drug use, its criminalization, or structural underpinnings. Yet, in reflecting

upon the New York harm reduction movement against the backdrop of its European predecessors, it may also be salient to note the lack of a comprehensive welfare system in the United States. Members of the Rotterdam Junkieverbond benefited from not only free medical care and cash assistance, but also subsidized housing – benefits that arguably facilitated the self-organization of drug users in the Netherlands. By contrast, the intended clients of harm reduction in New York – homeless, poor "street" users – have only witnessed the continuous defunding of public assistance programs that were already struggling two decades ago. While New York's harm reduction movement-cum-establishment has consistently prioritized HIV risk reduction over economic empowerment, subsequent chapters will show how Bronx Harm Reduction has become part of a de facto "safety net," for both drug users and others struggling to meet their basic survival needs.

"Saving Bronx Lives Since 1996": Enter Bronx Harm Reduction

Granted its waiver by the New York State AIDS Institute in 1995, Bronx Harm Reduction (BHR) was among the first legal syringe exchanges in New York City, but only the third in the South Bronx.[14] ACT-UP's illegal "Bronx-Harlem Needle Exchange" solidified into an authorized program in 1992, alongside another community-based organization that had arisen independently (Grove 2008). Though a veteran of the "Bronx-Harlem" outfit, Kevin Jones decided to start a separate agency that concentrated on outreach to single-room occupancy hotels (SROs), which were known as hotbeds of injection drug use. In its first year, Bronx Harm Reduction operated out of a second-hand van, with a skeleton crew of volunteers serving an

[14] Under Title 10 of N.Y.C.R.R. § 80.135, syringe exchanges approved by the New York AIDS Institute are granted "waivers" from the penal code prohibiting the distribution and possession of drug paraphernalia – language emphasizing the continuing criminalization of these actions by unauthorized persons or groups.

exclusive clientele of SRO inhabitants in Harlem and the Bronx; reliant upon the AIDS Institute's small SEP contract and the odd donation, the organization lacked the capital to rent a permanent space, if not the interest in securing a stable site. Barely established, Bronx Harm Reduction suffered its first existential challenge in 1997, when Jones was discovered dead of a heroin overdose in his Manhattan apartment. Suspected by some as a homicide, the young founder's death came as a shock to friends, colleagues, and the agency's recently-enlisted board members, who appeared ignorant of Jones' drug use.

Scrambling to retain their waiver, Bronx Harm Reduction's board quickly located a new director, recruiting a recent graduate of Columbia University's public health program. Miriam Fuller, a community organizer from Toronto, encountered an agency with little money and no full-time staff. Shortly after assuming her position, the new AD applied for the organization's first competitive grant with New York State – an HIV/AIDS case management contract that promised to at least double Bronx Harm Reduction's limited budget. While all approved SEPs in New York received baseline funding from the state's AIDS Institute, Fuller noted years later that her board was doubtful that the organization could win a contract for HIV services not specific to drug users. Yet, after this first successful application, HIV-related money became the primary engine of Bronx Harm Reduction's (and similar agencies') growth - a reality perhaps predetermined by the ban on federal funding for syringe exchange, and by extension, harm reduction programming.

Upon obtaining BHR's first major contract, Fuller insisted upon hiring the organization's first salaried social worker and procuring a small storefront, where clients could come to do exchange, meet with staff, or simply hang out. Thus was Bronx Harm reborn in a small church basement that could soon no longer handle its increased client traffic. Despite its initial identity

as an outreach-only agency, Bronx Harm Reduction became closely identified with its drop-in space over the following years, particularly after its relocation to a large industrial loft building nearby. Like the swelling of staff that it needed to accommodate, the agency's new space was funded by contracts that provided for case management, counseling, support groups, and client education. In 2001, Bronx Harm Reduction won its first "peer" training grant, dubbed "Blunt Reality" by one of its participants. Deploying a curriculum that combined intensive HIV education with "straight talk about drugs," Blunt Reality ultimately sought to train participant stipend or peer workers, who might eventually ascend within the organizational ranks. Over the course of Fuller's tenure, Blunt Reality and a similar program targeting female participants, Herizen, starkly impacted the composition of Bronx Harm Reduction's staff. One woman who rose to a full-time position through Herizen noted in her interview, "There used to be a big, big lot of us here…it was a very participant-led agency…Participants came here, they worked here, they developed some skills here, and eventually they would find their way into a position here."

Over nearly a decade, Fuller presided over the stabilization of Bronx Harm Reduction into one of New York's biggest syringe exchange programs; from 1997 to 2006, the organizations' budget grew by more than tenfold, from $200,000 in 1997 to $2.5 million in 2006, with the bulk of new monies deriving from AIDS Institute contracts for HIV prevention and care. When Fuller was recruited into a senior-level position at the New York City Department of Health in 2007, Bronx Harm Reduction entered a major crisis of succession that, over two years, jeopardized the organization's financial security and continued existence. Fuller's initial replacement, championed by staff, was quickly removed by the board, who favored a more hierarchical style of management; the board's subsequent installation, hired from within, served for nearly a year before he was revealed to be siphoning money from the agency. As the

organization entered into a sustained vacuum of leadership, private and public funders declined to renew BHR's competitive contracts, inflaming fears that the agency itself might disappear itself alongside Fuller. When a flood put the organization's first-floor drop-in underwater in the winter of 2009, the end appeared imminent.

In June 2009, Victor Rivera was brought on as Bronx Harm Reduction's new director after a prolonged search period. A veteran administrator of several area HIV/AIDS service organizations with fuzzy harm reduction credentials, Rivera proved an instantly divisive choice among staff members. Between June 2009 and July 2010, when this study began, Bronx Harm Reduction experienced a staff turnover rate around 50 percent, while a steady flow of resignations and firings continued through the research period. Internal cohesion and a shared sense of mission were perhaps the greatest casualties of Bronx Harm Reduction's succession turmoil, as its new leadership aroused tensions between old and new employees. Yet, such rifts, which followed from different understandings of harm reduction, its proper practice, and goals, were not unique to Bronx Harm Reduction, but plagued the field as a whole; the next section will consider some causes, consequences, and critiques of harm reduction's "maturation" at large. Possessed by his own vision of a modernized, medicalized harm reduction, Rivera had little interest in dwelling upon the agency's past. In fact, in my first volunteer assignment at Bronx Harm Reduction, I was charged with rifling through over a dozen dusty document boxes in the organization's attic, and discarding anything predating 2006.

More money, more problems: Harm reduction grows up

When I arrived at Bronx Harm Reduction in the summer of 2010, the organization was enjoying a period of peak ascendance in the world of NYC needle exchange. Not merely eager to

discount the past, Rivera further sought to model the future of harm reduction, embracing moves to professionalize and medicalize the field from above. As described in the introduction, BHR anticipated the contraction of public monies by revitalizing their unique organizational brand, pursuing an image based in fiscal responsibility and public health partnership. Though most clearly changed, Bronx Harm Reduction was hardly the only agency to morph with the times. Indeed, few organizations could deny significant shifts in hiring, programming and even service mission since first receiving their waivers, and thus coming under the regulatory purview of their government funders.

Many commentators have previously weighed in on harm reduction's shifting identity as a "mature paradigm," characterizing its increasing bureaucratization as a matter of institutional survival in politically hostile and scarce funding environments (Lune 2001; Heller and Paone 2011). Comparing New York's syringe exchange campaign with other successful social movements, Howard Lune writes that harm reduction's (limited) acceptance demanded compromises between founding advocates and public health guarantors (Lune 2001.) Others have noted more critically that harm reduction's once radical activist spirit – and revolutionary social agenda - have been defused in the name of political palatability and bureaucratic compliance (Roe 2005). Below, I describe three oft-critiqued trends in "late harm reduction" – professionalization, medicalization, and depoliticization – and their manifestations at Bronx Harm Reduction. While discussed separately, the synergistic relationship between these phenomena should not be overlooked. It might also be said that syringe exchange's shift towards institutionalization, though denounced by a few, has been celebrated by many – including some clients, who have enjoyed a scale-up in services.

Professionalization

An organizational sociologist who documented the evolution of harm reduction in New York City, Howard Lune highlights the consequences of syringe exchange's formalization for staffing in particular. Referring to the gradual displacement of the movement's original activists from leadership positions, Lune (2002) submits that "institutionalization has seen the installment of professional managers with no experience in drug issues, instead of recovering users." In the case of Bronx Harm Reduction, this transition occurred relatively early in the organization's lifespan, but could hardly be traced to political machinations; at the same time, Jones' replacement conformed to emerging trends that privileged education over experience. Miriam Fuller, a newly-minted MPH who had completed a thesis on syringe exchange, was a stark, if perhaps necessary, departure from her predecessor. Fuller's skillset arguably allowed the organization to grow and thrive in an increasingly crowded field of players competing for a small pot of public money. Assuming Bronx Harm Reduction's helm in a period of growing backlash, the new AD's connections and credentials may further have helped to ensure the agency's survival during the tumultuous years of Rudolph Guiliani's conservative mayorship (Heller and Paone 2011).

Victor Rivera's ascent, nearly 13 years later, also occurred at a moment of organizational unraveling, if overall political amicability toward syringe exchange.[15] A former administrator within two well-known HIV/AIDS service organizations, Rivera's qualifications in health care management were unimpeachable; by contrast, his understanding and investment in harm

[15] The mayoral administration of Michael Bloomberg has openly supported syringe exchange programs since 2003. One year into his first term, Bloomberg declared "These programs have been operating in New York City for over 10 years. The sky has not fallen. Drug use and drug-related crime have not gone up. In fact, they've gone down." (Heller and Paone 2011).

reduction principles were questioned by staff members, who predicted BHR's transformation into just another "AIDS Inc." Yet, as noted by Lune, specific experience in drug issues has been progressively deemphasized in the job description of harm reduction program directors, as the field has become more characterized by financial, not political, exigency. In order to survive impending budget cuts, BHR needed not a specialist in day-to-day programming and direct advocacy, but rather, a maverick fundraiser and grant writer, fluent in the language of deadlines and deliverables.

Not merely a symbolic offense, the installation of Victor Rivera also posed a material threat to many long-time staff members whose advancement over the years had rewarded loyalty and personal development, not degree acquisition. Rivera's centralized management style emphasized chain-of-command decision-making, staff accountability, and regular supervision. Accustomed to a looser, less formal, and more improvisational work environment, many employees resented the tone of the new regime, while struggling to meet its dictates. Communication problems abounded between administrative and direct service staff; Rivera's reliance upon emailed directives proved particularly problematic, while his consistent demand to put all programming requests and suggestions into writing stifled some enthusiastic staffers. Yet the changes most lamented by old employees were in the composition of new hires, who were less likely to derive from the existing pool of peers. As indicated by the staffer quoted earlier, a significant, if dwindling, portion of employees had begun their careers at BHR as clients, with many pursuing their higher education post-promotion. By contrast, no peers had ascended the organizational ranks since Rivera's hiring, while four peers-turned-employees left during my study period alone.

Medicalization

The shifts in staffing experienced by Bronx Harm Reduction and other agencies both drove and were driven by the growing medicalization of their field. In here referring to the medicalization of harm reduction, I mean to refer to two related, yet distinct, phenomena: first, the *representation* of harm reduction as (primarily) a means of disease prevention and health promotion, and second, the actual adoption of more clinical service models – and the direct provision of health care – within harm reduction agencies. These trends can be traced to a number of factors including and exceeding professionalization: the election of political officials eager to dismantle syringe exchange, the regulation and funding of harm reduction by a public health bureaucracy, and a rising tide of health and para-health workers at harm reduction organizations.

As discussed by Heller and Paone (2011), the conservative political milieu of New York City in the mid- to late-1990s, perhaps best embodied by Mayor Rudolph Giuliani's "quality of life" campaigns, put many newly-legal needle exchange programs on the defensive once again. Facing increased media scrutiny and "Broken Windows" police tactics, harm reduction programs sought to emphasize the public health rationality of syringe exchange, a position rooted in scholarly research. Attempting to make their mission more saleable, programs further painted SEPs as bridges to medical care for a multiply-afflicted population (Roe 2005). While the harm reduction movement in New York was always tied to the issue of HIV/AIDS, early activists linked the prohibition of syringe exchange to the overall marginalization of drug users, if failing to campaign for their civil rights more broadly; over time, these discourses around drug-related "harm" became increasingly confined to the realms of public health and community safety.

Even outside a stifling political atmosphere, such discursive shifts might have been predicted within a service system wholly governed and largely funded by the New York State Department of Health. By 2006, Bronx Harm Reduction received a vast majority of its operating budget from the state AIDS Institute – money that paid for HIV/AIDS-related services far beyond syringe exchange. Despite the loss of several valuable service contracts during the organization's interim crisis, Victor Rivera's BHR drew an even a larger percentage of its funding from the AIDS Institute, while garnering a new HIV prevention contract from the Centers for Disease Control. Such contracts, which introduced medical case management, HIV and Hepatitis counseling and testing, physician-assisted SRO-outreach, and cognitive-behavioral interventions for drug user risk reduction, naturally promoted BHR's increasing service orientation around physical health (and HIV/AIDS prevention and care specifically). In turn, Bronx Harm Reduction became host to a new set of HIV-positive, yet non-user clients, whose usage of the agency more resembled that of a clinic. Typically arriving in time for pre-scheduled appointments with their case managers, HIV-positive clients spent less time hanging out in the drop-in than their syringe exchange counterparts, a trend reinforced by the former's eligibility for subsidized housing.

The agency's ongoing receipt of new monies, and new clients, demanded new staff members as well, many boasting backgrounds in medicine or social work. Like Rivera himself, several of the new AD's hand-picked hires for administrative positions hailed from the fields of health care and drug treatment – not harm reduction. In collaboration with his new Directors of Outreach, Human Services, and Mental Wellness, Rivera sought to introduce a broader range of health-related services to the organization, while pushing an agenda that focused more broadly upon health promotion, and less upon drug use, and drug users in particular. Throughout its

history, the agency had acted as a channel to medical care and drug treatment, providing information and referrals to interested clients; under Rivera's tenure, this channel emptied out just one level above the drop-in, in a new primary care clinic and pharmacy.

Depoliticization

The depoliticization of harm reduction, from unruly social movement to public health technology, can easily be traced to the two trends discussed above. On the one hand, the original activists, artists and (few) users who led New York City's first illegal exchanges have been gradually supplanted by medical professionals, certified social workers, and career managers. Where many employees at Bronx Harm Reduction and other organizations retained an abstract commitment to social justice, the proportion of staffers with personal histories in (and political analyses of) drug use has continuously declined over time. On the other hand, even veteran employees and former clients of harm reduction have found themselves working in a field that has been progressively redefined from both above and below. The medicalization of harm reduction in New York has led to a service emphasis upon the physical well-being of participants; this reorientation has further served to frame drug use as a simple matter of individual and public health. By locating risk in personal health practices, not social contexts, "mature harm reduction" in New York has made individual behavior, not social inequality, the target for intervention.

Yet, as pointed out by Lune (2002: 471), the new faces and framing of harm reduction are more than the simple effects of professionalization and medicalization, representing "active pressures to deny or suppress the political component of syringe exchange in pursuit of institutional détente, and not of institutional acceptance." Despite the recent emergence of local

political support for harm reduction in New York City, its flagship program, syringe exchange, has remained embattled at the national level (and even illegal in neighboring New Jersey).[16] Even in supportive locales like New York, syringe exchange has abided strict state regulations that threaten program termination and/or the loss of funding in the breach. As noted previously, Bronx Harm Reduction's survival was most threatened in recent years by economic turmoil and shrinking state budgets. In turn, the organization faced pressure to present itself as an apolitical and evidence-based program, which delivered the "most health" at the least expense. Of course, the cost-efficiency of programs like needle exchange represents one of harm reduction's oldest arguments, harkening back to Liverpool. Perhaps for this reason, several scholars have characterized harm reduction programs as a quintessentially neoliberal approach to drug use, which invokes individuals as the most efficient agents of risk management.

Junkies know best?: The slippery politics of harm reduction

Harm reduction occupies a strange status in the academic literature, as both an established public health "best practice" and a politically vulnerable policy. The scholarly research on harm reduction is heavily dominated by evaluatory studies seeking to quantify the direct and indirect benefits of harm reduction technologies for the health of drug users and the larger community. At the individual level, the efficacy of harm reduction programs is typically measured in terms of the reduction of "risk behavior," for example, sharing injecting equipment or engaging in unprotected sex (Bastos and Strathdee 2000; Bluthenthal et al. 2000; Des Jarlais et al. 1996). Where individual behavioral change is believed to impact community welfare as a whole, by lessening the potential spread of disease, many studies have also sought to measure the

[16] At the time of writing, the federal ban on syringe exchange funding – instituted in 1988 and temporarily lifted in 2009 – had been quietly reinstituted by Congress at the end of 2011.

effect of harm reduction programs on rates of drug user criminality, or the environmental concentration of discarded syringes (Bell et al. 1992; Doherty et al. 1996; Paone et al. 1995). The major harms of drug use defined herein involve negative health outcomes and the public nuisance/disorder associated with addiction. Increasingly technical, narrowly specified, and rather redundant, such public health studies on harm reduction serve to bolster the "scientific" evidence for programs that are hugely contested and always under attack, as noted above. Vast and ever-growing reviews and meta-analyses summarizing the epidemiological evidence for different harm reduction technologies have been compiled by the World Health Organization, United Nations Joint Program on HIV/AIDS, and the Centers for Disease Control, amongst others, in the face of continued incredulity the world over (McKnight et al. 2007; World Health Organization 2004; World Health Organization 2005). Encompassing a stream of harm reduction research that may perhaps be labeled "mainstream," such studies are supported by a wealth of commentary framing harm reduction as a practical, humanistic, yet moderate policy, that should complement, not replace, law enforcement solutions to drug use (Des Jarlais 1995; Marlatt 1996).

A more overtly politicized stream of research on harm reduction derives from social scientists writing against the human consequences of drug prohibition. Such studies rarely focus on harm reduction itself, but rather discuss programs such as needle exchange as invaluable policies in the era of drug criminalization and first steps in the long-term reform of drug laws. More historical in content and theory-driven than the above research, such work details both the national and international politics of drug prohibition, while describing the major harms associated with drug use as consequences of (inherently discriminatory and unevenly applied) criminal law. Craig Reinarman and Harry G. Levine's edited volume *Crack in America: Demon*

Drugs and Social Justice (1997) is perhaps the seminal work in this vein. Depicting the interplay between macroeconomic changes and conservative politics, Reinarman and Levine narrate the so-called crack "epidemic" as a classically-constructed drug scare, intended to justify the progressive defunding of inner cities as sites of moral decay. Writing the real problems of urban drug use as effects of entrenched poverty and political abandonment, the authors link the violence stereotypical of illicit drug use/rs to a competitive and highly profitable black market industry. Reinarman and Levine celebrate harm reduction as a policy grounded in social justice concerns that may further compensate for the increased danger of drug use under a regime of prohibition. Harm reduction's latent promise as a platform for more generalized social protest has been noted by other theorists and community activists who are interested in taking its emphasis beyond biomedicine; such an imagining of harm reduction implies a more upstream focus upon the inequities that underwrite and exacerbate the risks of drug abuse (Fry et al. 2008; Pauly 2008).

Once unequivocal, the lines of support for harm reduction in the social scientific literature have only recently been complicated by the emergence of post-structural analyses, critiquing both the implementation and underlying theory of harm reduction. The Foucauldian concepts of biopower and governmentality lay at the center of such studies, which speculate upon the potential of harm reduction programming to function as a "better mousetrap" – a less obtrusive, and thus more effective, means of surveilling drug users. Recent critical takes tie harm reduction to the rise of a "new public health" and the growing dominance of neoliberal governance in general. Unlike modalities of drug control founded in prohibition or treatment, harm minimization delegates responsibility for safe consumption onto the individual user, thereby recognizing the role of choice and freedom in the more efficient government of drug use

(O'Malley 1999). Where Steven Mugford has situated the growing popularity of harm reduction within a general transition to postmodern forms of population control, Moore and Fraser have problematized the ways in which harm reduction discourses assume and inscribe a neoliberal subject, autonomous and rational, and thereby neglect the material constraints faced by most drug users (Moore and Fraser 2006; Mugford 1993). Other theorists have considered how specific harm reduction technologies serve to "govern chaotic subjects" – namely, street-based injecting drug users who are not invested in regimes of self-care. Overdose prevention, supervised injection facilities, and methadone maintenance have all been explored as potentially insidious mechanisms of social control, which seek to partially denude injecting drug use of both its dangerous and pleasurable facets (Bourgois 2000; Fischer 2004; Moore 2004; Moore 2008). Harm reduction research itself has come under attack, characterized as a confessional technology that pressures drug-using subjects into declaring their adherence to safer injection techniques (Campbell and Shaw 2008).

By and large, post-structural studies of harm reduction have considered its detrimental impact upon user agency. In their focus upon the disciplinary aspects of harm reduction programs, such analyses somewhat echo "classic" studies on methadone maintenance treatment programs (MMTP) and the medicalization of heroin addiction (Nelkin 1973; Preble and Casey 1969). This research has posited MMTPs as technical solutions to a social problem, which further threaten to remove the "meaningful enterprise" contained within the life of a street drug user. In general, the existing critical literature on harm reduction betrays a focus on its more "spectacular" technologies – methadone maintenance and safe injection facilities – which may be most easily aligned with interests in social control and public order. No existing studies have attempted to analyze the risk discourses perpetrated at specific sites of harm reduction, nor

considered their "productive" impact on drug user subjectivities. While neglecting needle exchange, nearly all harm reduction research in the post-structural vein has also taken place outside the United States, with a concentration in Australia and Canada.

Conclusion

This dissertation endeavors to fill some existing gaps in harm reduction research, in exploring both the disciplinary (Chapter Three) and productive effects (Chapter Five) of one needle exchange program in New York City. Rather than decrying it as a fundamentally neoliberal technology, this chapter has sought to portray harm reduction in the United States as occurring at the confluence of HIV/AIDS activism, evidence-based public health, and the movement toward fiscally-conservative governance. In thus elucidating the current shape of harm reduction in New York, it may be less accurate to speak of a movement's cooptation, than the collaboration of interests with unequal power. The relative balance of forces will be further considered in the next chapter, which demonstrates Bronx Harm Reduction's increasing emphasis upon biomedical risk reduction and health promotion.

Chapter III
Reducing Risk, Producing Order: Needle Exchange as Panopticon

Shortly after the start of the academic year in New York City, the first cycle of "Safety Counts," a cognitive-behavioral intervention for illicit drug users, began at Bronx Harm Reduction. The opening session was attended by all the anticipation and emotions of the first day of school, and maybe even more fanfare. The first-floor conference room had been shut down at mid-day to allow dedicated staff time to outfit the room with program materials, while a generous smattering of condoms, lubricants, and assorted injection paraphernalia on the center table passed as décor. Ostensibly attracted by recruitment flyers that exhorted participants to "change their lives," seven attentive, if wary, enrollees sat around the table when the Administrative Director began his inaugural speech at 3:30 PM; a few curious employees unattached to the project also slipped into the back of the room, drawn by the hubbub.

Earlier in the day, Rivera had laughingly referred to himself as the "principal" of Bronx Harm Reduction, a role further evoked in his welcoming address to the first cohort of Safety Counts. The AD began by describing Safety Counts as a "huge victory" for the organization, which had fought hard to win the contract from the Centers for Disease Control. Throughout his speech, Rivera framed Safety Counts as a "different sort of program" for a different – revitalized, effective - Bronx Harm Reduction. Rivera noted vehemently that Safety Counts was not "just another group," but rather represented a "special program for qualified individuals," which would further confer tangible benefits to enrollees; for example, graduates might be selected to serve on an as-yet unspecified Safety Counts Advisory Board, or even hired to work as peer educators for the program. The Director emphasized that Safety Counts was emblematic of the "new Bronx Harm Reduction," where *real* change could happen – unlike the "old Bronx Harm

Reduction," where participants might "make small moves that never led anywhere but backward." Glancing at his watch, Rivera closed by describing Safety Counts as a "revolutionary" program for a pioneering group of individuals.

After the extraneous staff filed out, and the doors closed, "Group Session 1," the largely-scripted first component of the four-month program, began with a review of some "rules of conduct" written on a white board. Instructed to "maintain confidentiality," "respect others' opinions," and refrain from "sidebar conversations," participants nodded in enthusiastic agreement. Moving on to his lesson plan, Eddy, the Safety Counts facilitator, asked the assembled group, "How can you get HIV?" With little hesitation, one participant offered "through injecting drugs," while another responded, "having unprotected sex." Looking to Eddy for verification, one woman reported a second-hand statement that a person who contracts many STDs would "probably get AIDS." Sidestepping the complexities of probability, Eddy instead confirmed that one risks both STD and HIV infection through unprotected sex. Perhaps seeking to exploit the swell of participation, the facilitator then asked how many people had ever injected drugs; a quick glance around the room confirmed Eddy to be the only individual raising his hand. Issuing a rejoinder repeated throughout the session, Eddy admonished the silence, "We are all at risk."

In the preceding description of Safety Counts at Bronx Harm Reduction, the education metaphor was not chosen haphazardly, nor was the resemblance to a classroom merely passing. This chapter will explore BHR's status as a disciplinary institution not unlike the more formal institutions of education, medicine, or drug treatment with which it contrasted itself. At Bronx Harm Reduction, disciplinary technologies were deployed in the service "risk reduction," a seemingly broad mandate that was in fact applied in very narrow terms. As utilized by staff

members, "risk" was here largely synonymous with *biomedical* risk, or potential damage to one's health (itself an unproblematized concept); risk was further conceptualized as existing at the level of individual conduct, making risk reduction a process of behavioral modification. Following Elizabeth Wheatley's analysis of risk in cardiac rehabilitation, this chapter will more generally consider risk as a "discourse of normalization" in the context of harm reduction (Wheatley 2004). At BHR, risk reduction served as a site for the proliferation of surveillance, confessional, and other disciplinary technologies that sought to monitor and control participants' bodily practices, with an emphasis upon sexual and drug use behaviors.

While the ultimate responsibility for risk reduction was understood to fall upon individual participants, the "new Bronx Harm Reduction" envisioned its mandate as the provision of increasingly aggressive health education and motivational counseling. Indeed, many of the emergent disciplinary technologies at BHR were tied to an incipient conception of harm reduction as a means of health promotion, distinct from what some staff members disparaged as "harm maintenance." Despite defending the definition of harm reduction as a "non-judgmental" perspective on drug use, many staff members at BHR nevertheless advanced discourses of risk that linked poor health outcomes to individuals' poor lifestyles choices. In the views of such employees, participants should not be reprimanded, punished, or explicitly stigmatized for their imprudent heath behaviors; yet, they also should not be allowed to remain "ignorant" of the potentially negative consequences, if they were to receive services at Bronx Harm Reduction.

As noted in the previous chapter, harm reduction's progressive transformation into a disciplinary institution may be linked to its growing medicalization; this chapter will in fact describe the swell of biomedical conceptions of risk among staff members, and new or senior-level staff in particular, in contrast to "old school" practitioners of harm reduction. To some

degree, the infiltration of disciplinary power may also be seen as illuminating BHR's emerging role as a site of *non-health* service provision, a topic discussed further in Chapter Four. Recognizing the diverse ends to which many participants used Bronx Harm Reduction, some staff members, peers, and even clients lamented that such individuals came for the free food, but ultimately "missed the lesson." These complaints were attached to demands that such individuals "earn" their dinner, or carfare, or chair in the drop-in. Implied in such objections was the conviction that the organization's scarce resources should not be persistently wasted upon those unwilling to change. Obeying a disciplinary logic of transformation, these critics believed that Bronx Harm Reduction should not serve as a permanent camp for the socially displaced, but merely represented a temporary stop on the way to recovery and independence. In something of a reversal of its historic mission, some factions of BHR implied that participants should be made to work for harm reduction, rather than harm reduction being made to work for participants.

Of course, the disciplinary project being undertaken at Bronx Harm Reduction was not solely tied to the personal aspirations and opinions of staff, but also reflected ongoing efforts to discipline harm reduction as a whole. At a time of constant cuts to social service funding, Bronx Harm Reduction was under real pressure to demonstrate its efficacy within the parameters defined by the public and private agencies that filled its coffers. The transformation of harm reduction from a non-programmatic site of care into a more linear "treatment lite" was in part directed from above, by regulatory bodies that considered meaningful change to be measurable change. In turn, the workers who administered lengthy questionnaires to clients, or fretted over the coherence of their case files, were themselves the object of internal and external surveillance that gauged employee value through the achievement of contract quotas, or adherence to "evidence-based" models. With the classification of harm reduction itself as an evidence-based

intervention (like Safety Counts), the "technologies of agency" levied upon clients cannot be discussed without some recognition of the "technologies of performance" imposed upon the agencies that serve them (Dean 1998). Consequently, I will here characterize Bronx Harm Reduction as hosting multiple levels of disciplinary power, which circulated between governmental bodies, private funders, administrative staff, first-line workers, and participants – many of whom recognized their own value as data points.

Drawing upon participant observation in diverse realms of Bronx Harm Reduction, this chapter will first describe the ways in which all participants were "disciplined" through techniques of case-making, surveillance, and confession; I will also discuss more generally the ways in which BHR's administration sought to impose more structure, rules, and formality upon the agency as a whole, which took on a more clinical, professional appearance over the research period. This initial section further reflects upon the connection between the technologies of agency that targeted participants, and technologies of performance that drove them. From here, the chapter will describe and compare the discourses of risk employed by staff and peers at Bronx Harm Reduction, considering both interview data and observations around the exchange. I here suggest the correlation between employees' understandings of drug-related risk, and their definition of harm reduction (and "harm maintenance," in some cases.) Finally, the chapter will conclude with a detailed case study of Safety Counts, which vividly illustrated the various disciplinary technologies targeting clients, staff, and the organization alike. Like Wheatley, this section will also depict the utilization of "truth tricks" in discourses of risk, considering specifically the dual deployment of conflicting discourses of chronic, biological addiction and individual agency, among others. With its emphasis upon structure, planning, and documentation, Safety Counts exemplified the major tenets of a newer, evidence-based harm

reduction, while exposing the difficulties of its implementation by a progressively disillusioned and resistant staff. Though intended as a top-down program of prevention education, Safety Counts also revealed the disjunctures between official, expert discourses of risk reduction, and those asserted by clients themselves, a topic to be discussed in detail in the succeeding chapter.

Producing "safe" bodies: Harm reduction as a site of discipline

Among the many definitions of "discipline" that Foucault offers throughout his oeuvre, it may be most useful to conceive of discipline as a "physics" or "economy" of power within the context of harm reduction (Foucault 1977). Misconstruing the peculiar meaning of discipline indicated here, defenders of harm reduction might protest that such programs offer a non-punitive, non-judgmental approach to drug use, in effect constituting a "third way" between established criminal justice or treatment-oriented responses that seek to deter or cure such behaviors. Yet, it is precisely the "non-coercive" nature of harm reduction that implicates it within a larger field of disciplinary power encompassing not only clients, but also workers, and state apparatuses. Operating "without recourse…to excess, force, or violence," disciplinary power, Foucault writes, does not seek to repress certain behaviors or peoples, but rather endeavors to train and organize bodies; moving beyond the binary of il/legality employed by the criminal justice system, harm reduction instead seeks to "separate, analyze, and differentiate" a multiplicity of drug use and drug users, with the intention of stemming the danger or disorder therein posed. Overall, Foucault pens discipline as a "modest" power that operates in the interstices of human behavior – a definition that strongly resonates with harm reduction's own mantra of "little by little" or "baby steps." (Foucault 1977: 170).

The following pages will depict the "minor procedures" through which disciplinary power worked to effectively shape the behavior of clients at Bronx Harm Reduction (Foucault

1977: 170). In this environment, behavior was influenced less through the levying of negative sanctions, such as arrest or dismissal, than via techniques of objectification that submitted clients to continuous examination (and techniques of subjection, which will be discussed in later chapters). Representing an invisible, insidious means of compulsion, disciplinary power "coerces by means of observation," functioning through "an apparatus in which the techniques that make it possible to see induce effects of power and in which, conversely, the means of coercion make those on whom they are applied clearly visible" (Foucault 1977: 171). Observation at Bronx Harm Reduction assumed multiple forms and targets, endeavoring overall to make visible the bodily practices of clients – and the work habits of staff members. Ultimately, through sustained exposure to continuous and automatic techniques of surveillance, individuals were expected to internalize the "gaze" of their case workers, supervisors, or funders thus projected, and adjust their behavior accordingly. The next section will describe the multifarious techniques of surveillance employed at Bronx Harm Reduction, the practices of confession that sustained them, and the storage of their results in files that represented the history and progress of each risk reduction "case".

The code, the card, and the file: Making cases at Bronx Harm Reduction

Staff at Bronx Harm Reduction were quick to point out that participants need not volunteer so much as their name in exchange for a clean needle, yet this statement belied a no-less-intimate system of client tracking at the organization. Upon entering the drop-in for the first time, aspiring clients were required to complete an initial intake assessment, whose duration varied according to the type of services sought. While individuals requesting access to only syringe exchange (SEP) and other "drop-in" services were hustled into the SEP room itself to complete a two-page questionnaire, aspiring case management clients were brought to the second

floor “triage room,” where a more extensive interview awaited them. Yet all newly enrolled participants emerged from their intakes with 3 new forms of identification: a “unique identifying number,” or “code,” a plastic ID card, and a file – or rather two files – both paper and electronic.

Ostensibly intended to protect the privacy of clients, the assignment of codes also initiated the objectification of individuals as cases; a valid code was required for the entry of every staff-participant “encounter” into the online tracking system that monitored BHR’s adherence to contract-stipulated quotas. Ranging between 9 and 12 digits, codes reflected clients’ basic demographic traits – sex, age, race, and place of residence – while including some elements of their referents’ names. As the primary form of identification at Bronx Harm Reduction, codes were typically memorized by participants who attended the organization on a regular basis. Asked to provide their codes in exchange for nearly every service, participants became accustomed to using their codes in the stead of their name in other instances as well. Participants were observed signing handouts, artwork, or personal possessions with their code, while several interview subjects asked if they should write their code on the information sheet.

Bearing little more than each individual’s code, participant ID cards highlighted the paradox of an anonymous service culture that simultaneously relied upon the collection of thick surveillance data. White or red, BHR’s ID cards were mostly inscrutable to outsiders, who might be able to glean no than their bearer’s zip code, and perhaps year of birth. Internally, however, such cards immediately connoted a piece of highly personal information about their holders: namely, their HIV status. In addition to slight differences in the construction of their codes, SEP and case management clients were sorted by the color of their cards, which were white and red, respectively. Presumably a matter of organizational convenience, the bicolor card system made it easier for staff members to maintain separate sign-in sheets, which were in turn submitted for

separate streams of reimbursement by the state. The Administrative Director admitted the use of "red cards" and "white cards" to be a ham-fisted, if expedient, arrangement, which effectively branded HIV-positive participants with a "scarlet letter"; yet, the color of a participant's card also influenced their spatial access within the organization, with "red cards" more readily extended the privilege of entering the first floor staff offices. The shade of one's card, or enrollment within a specific case management program, also affected entrance to certain support groups, while further serving as a shorthand system of identification for individuals who might otherwise remain nameless. Employees who frequently manned the front desk often knew, and called out to, people by their program, typically represented by a short acronym: SEP, HRR, HOME, etc. Attaching clients to certain spaces and staff members, such signifiers also determined the location and thickness of their file, or chart.

Every client's chart began with an intake survey, which was immediately supplemented by proof of HIV (or "at risk") status among those enrolling within case management programs. Such clients' charts expanded quickly, in line with the extensive documentation demands of state funders. Depending upon the specific program, charts would accumulate regular blood work results, psychiatric assessments, information on entitlements, and even housing leases; also contributing to their bulk were the periodic client "reassessments," "service plans," and "progress notes" undertaken by staff - the latter forms drafted after every interaction with a client.[17] Besides bringing Bronx Harm Reduction into compliance with its funder's data

[17] While SEP-only participants were subject to fewer reporting requirements, their charts sometimes served as stable archives for individuals lacking a safe place to store important documents. Indeed, many participants across programs were the major drivers of their charts' growth, exhorting staff members to copy and store any paper of potential significance. Such individuals' stakes in their charts revealed the files to function not only as means of (oft accepted) temporal surveillance, but also as anchors of identity among individuals who feared the loss of what few credentials they possessed. It was not uncommon to encounter a participant

demands, charts facilitated the dissemination of client information across time, space, and multiple staff members – much like medical records. New employees inheriting another worker's "caseload" might consult their charts before meeting their new charges, while regular "case conferences" revolved around the digestion and discussion of a different participant's chart every week. Thus situated in a "network of writing," clients were embroiled in a continuous and semi-permanent field of surveillance that proceeded even in the absence of their bodies (Foucault 1977). Representing the accumulated professional knowledge around a participant, charts guided clients' termination, "successful" discharge, or designation as "lost to follow-up." Indeed, cases might be closed because the associated chart lacked sufficient sustenance, or documented encounters within a fixed period of time, according to the terms set by a funding contract. In this respect, charts were a site of not only participant, but also employee, and organizational anxiety, generated by the persistent threat of external audits by the state. In general, however, paper chart were deployed toward the end of "in-house" tracking, while the electronic files submitted to the AIDS Institute Reporting System (AIRS) served external monitoring purposes. These two systems of client surveillance operating at Bronx Harm Reduction might be seen as exemplifying Mitchell Dean's "technologies of performance," a term that implies their dual function as techniques of organizational disciplining as well.

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clutching a few tattered pieces of paper with a desperate ferocity that reflected the items' practical, as well as symbolic, value. Often requiring a multi-hour, -day, or –month navigation of government bureaucracy, forms reporting a client's Medicaid or Social Security eligibility obviously held enormous significance for individuals without so much as a mailing address. Yet, files further enclosed documents of seemingly sentimental value that might otherwise be discarded in the "straight" world. In addition to notices of lapsed benefits or missed appointments, charts also contained past or present resumes, certificates of completion, or training "diplomas" from programs such as Safety Counts. Though often out-of-date or of questionable value, these items at least served as tangible evidence of client accomplishment in a world that barely acknowledged their continued existence.

"They just need a number": Surveillance at and of Bronx Harm Reduction

In his chapter "Risk, Calculable and Incalculable," Mitchell Dean describes "technologies of agency" as endeavoring toward the surveillance and control of "targeted" or "high-risk" populations, through the use of "multiple techniques of self-esteem, empowerment, consultation, and negotiation" – in short, agential techniques that exhort subjects to "transform their status" and become "active citizens capable of managing their own risk" (Dean 1998: 35-36). This term is simultaneously used to denote the contracting out of once public services (such as health promotion) to community-based organizations, as a means of handing power to authentic representatives of the populations so targeted. As a non-coercive program of risk reduction for drug users and other at-risk individuals in the community, Bronx Harm Reduction quite clearly fit the profile of an organization that both constituted and was constituted by technologies of agency. Dean notes that technologies of agency are "complemented, however, by a host of technologies concerned to monitor, compare and evaluate the performance of those whose agency is thereby activated" (Dean 1998: 36). Such "technologies of performance" function through the establishment of indicators and reporting mechanisms that seek to monitor, measure, and ultimately optimize individual and organizational achievement. Thus, while individuals and communities are charged with regulating their own risk, the state retains the right to supervise their progress, if only to ensure that its money is not being wasted.

At Bronx Harm Reduction, staff sought to monitor clients' risk behaviors during one-on-one encounters of varying durations and levels of formality. Here, technologies of performance took the form of an interview, or even an examination, in which information flowed from client to staff, often in response to a standard battery of questions that scripted the interaction. In turn, such encounters would be recorded within a physical archive - the chart - that tracked clients'

cumulative risk reduction over time. For individuals accessing the SEP alone, formal behavioral surveillance occurred solely at the point of exchange, and focused only upon injection practices. While clients were not asked to identify themselves by name, they were required to volunteer other highly personal information at each exchange encounter. Following a form designed in accordance with state requirements, SEP staff would record each client's code, sex, race, and frequency of injection, as well as the number of syringes collected and distributed. Senior staff members might also inquire about a client's drug(s) of choice and preferred injection sites, sometimes offering advice on the avoidance or care of abscesses.[18] Apart from their initial intake, SEP clients were not required to sit for additional, prolonged interviews. To some degree, these encounters centered less upon the extraction of knowledge from a client, and more upon his or her education about risk reduction. While the intake form contained a small handful of questions around drug use history, it provided an extensive "check off list of education provided to newly enrolled participants."[19] By contrast, case management clients were inducted into Bronx Harm reduction via a highly structured interview that might last in excess of an hour. Following a multi-page assessment form, the intake "assessment" asked clients in-depth questions about their sexual and drug use practices, while further soliciting detailed medical information. Clients were also required to meet with workers on a regular basis for "reassessments," which were used to evaluate participants' achievement over time. In the words of one housing case manager,

[18] While all syringe exchange transactions were logged onto a standardized form, some staff members "forgot" to ask clients for the required information on certain occasions, for example, when a client was in a visible rush. In these cases, a peer worker might enter their own code onto the sheet, or simply provide a generic answer. Depending upon who was working the SEP during a given shift, the log sheet might report that all clients injected twice per day, seven days per week.

[19] Prompts included statements such as "Never share needles, syringe, cookers/spoons, cottons or water" and "Always use a tourniquet/tie-up when injecting."

reassessments served as periodic "recertifications," which were used to confirm that participants were in fact "ready to be housed."

While New York State modeled the basic intake, re/assessment, and progress note forms that populated clients' paper files, the AIDS Institute Reporting System (AIRS), an electronic database, provided a more continuous method of both individual and organizational surveillance from above. As a technology of performance wielded by the state, AIRS perhaps mainly targeted its contractor agencies and their employees. Every individual that received services at Bronx Harm Reduction was entered into AIRS (by either name or code), and daily interactions with staff were similarly tracked. Yet, AIRS primarily served to monitor the overall volume of client traffic at Bronx Harm Reduction, and the agency's attainment of periodic contract quotas. Each day, case managers reported both whom they had met with, and the location and substance of each meeting, using predefined categories of activity. (In this way, AIRS data entry forms could be also used internally, by administration, to track employees' time management.) Bronx Harm Reduction's Data Coordinator went so far as to imply that the accuracy of the client information entered was not as important as the mere act of reporting itself. Responding to my query on how missing data was dealt with, the coordinator responded, "It doesn't matter. They just need a number."

Coming/getting clean: Techniques of confession in harm reduction

The valuation of the act of reporting, or confession, over the information thus divulged might also be seen with regards to client surveillance by staff. As characterized by Foucault, techniques of confession serve not only to bring their objects into the field of visibility, but further advance the ends of individual self-discipline in the long-term. Once accustomed to the ritual of regular examination, individuals may ultimately learn to anticipate their confession,

prepare its content, and perhaps adjust their behavior accordingly; over time, the incitement to confess may itself become unnecessary, as individuals internalize the expectations and judgment concealed therein (Foucault 1977). Framing their explanation in the psychological discourse of mental stress, several staff members extolled the value of confession in itself, as a means of both unburdening the psyche of guilt, and further, divesting oneself of past transgressions. For those who viewed harm reduction as an initial step on the path to drug abstinence, confession was a vital part of the therapeutic process, while a willingness to "be honest" was a marker of change already in progress.

Aside from serving as disciplinary ends in themselves, techniques of confession were necessary to the measurement of client risk and risk reduction – abstract concepts that derived from mostly unobservable behaviors. The medical records and laboratory results demanded of some clients at Bronx Harm Reduction made it possible to monitor changes inside their bodies (and impute their health) over time, but changes in behavior (and presumed risk) could only be brought into focus through questionnaires that relied upon client self-report. As noted, clients were regularly questioned about their bodily practices during one-on-one interviews or transactions in the SEP; they were also prodded to discuss their behaviors among a wider audience at support groups, which were subsequently written up by staff moderators. Given this frequent impetus to confess, many clients became highly accustomed to sharing private data regarding their medical or substance use history, without prompting. It was also not uncommon to hear clients exhorting one another to "come clean" during groups or even in the drop-in, perhaps sensing their ongoing surveillance by the staff surrounding them.

Spatial order and "community management" at Bronx Harm Reduction

Participants were often informed that Bronx Harm Reduction was "their space," and that the assembled staff "worked for them." In the same vein, the changes to the physical space and general atmosphere of the drop-in were undertaken in the name of participant desires, while the move to impose more order was framed as a matter of client respect. Fretting that the agency served as an "enabling" environment, the Director of Prevention noted that the clients needed more "boundaries," in order to progress. At one level, this goal was pursued through modifications in the physical environment of the drop-in. As mentioned in the introduction, the facility received a top-to-bottom makeover at the beginning of the research period which produced a more clinical feel and appearance; walls were repainted in serene shades of light blue and violet, while old couches were replaced by adjoining office chairs. A flat-screen television that continuously streamed "community rules" and events was also installed in the main drop-in. While such renovations followed the line of client convenience and comfort, other changes sought to restrict client access to certain areas of facility. The first-floor staff offices were put behind a new steel and glass door fitted with an electronic lock and buzzer, while the administrative offices saw the installation of a frosted pane of glass in the place of a once transparent window, overlooking the reception desk. Most drastically, surveillance cameras were installed both inside and outside the building, capturing every possible space – except the second-floor administration.

Of course, it is possible that many clients did not notice these particular impingements upon their physical movement, expressing more frustration with their regular exclusion from the second-floor drop-in space during important meetings, or late in the day. Most offensive was the periodic shut-down of the first-floor "participant bathroom," which followed the discovery of a

discarded syringe or cooker in a toilet stall. A reaction to the presumed "bad behavior" of one individual, such lock-outs were intended to punish the participant population as a whole. The administration in fact pursued a proactive defense against on-site (typically in-bathroom) drug use, stationing a staff member or peer just outside during most hours of the day; consequently, clients lingering too long within a stall would receive a knock or shout from the on-duty monitor. Restrictions upon bathroom access were in fact an everyday source of staff-participant tension. Where some staff members reprimanded participants for using the bathroom during support groups, others locked the doors to discourage the movement of people into or out of the conference room. Decrying the constant flow of people to be disruptive, some staff members further fretted that clients who tarried in the bathroom did not deserve to receive a Metrocard, after missing the bulk of the group. Noting that one needed to provide a code to access nearly everything else at Bronx Harm Reduction, one participant joked that soon enough there would be a sign-up sheet to use the toilet as well.

The intensification of spatial surveillance at Bronx Harm Reduction fueled anxiety among, and conflicts between, staff members as well. After the introduction of cameras, employees were well aware that they were also being watched. Curtailing a leisurely cigarette break one day, one community educator looked up at the side of the building nervously, noting that the camera above streamed directly to the AD's computer. Yet the new cameras were only one component in the perceived escalation of staff scrutiny. In whispered tones, a veteran employee noted that he "hardly said anything anymore," hoping to avoid negative attention from his supervisors. Opposition to the new surveillance culture at Bronx Harm Reduction stemmed not only from personal interests, but also from beliefs about how a needle exchange should operate. In interviews, two employees lamented the dampened, if well-mannered, mood within

the once "rowdy" drop-in, fearing that participants felt stifled in their expression. Disputes further centered on the problem of "non-participants," or individuals from the community who were not officially enrolled within the agency. Where some staff members would allow such individuals to enter, sit, or shower without presenting a valid card or code, other noted pointedly that the organization did not receive payment for such services. Such conflicts were perhaps felt most by John, the "community manager," who was charged with signing-in participants and maintaining order in the drop-in. One of the longest-serving employees at the organization, John was a friendly, often silly, figure on the first floor, offering jokes, advice, and sometimes food to the many clients he knew by name; however, he did not hesitate to loose a sharp whistle whenever the noise began to rise above a moderate din.

"The health piece is always first": Staff discourses of risk at Bronx Harm Reduction

In my first few months at Bronx Harm Reduction, I was jarred upon hearing a staff member state that "…drug use can only end two ways: with death or with prison." Initially, it struck me that this statement was not particularly "harm reductionist" – positing two extremely negative ends to inevitably result from drug use, instead of considering harm to be mediated by environments, policies, or behaviors. However, this statement was repeated nearly verbatim by multiple staff members, in groups, and on flyers for detox around the agency. Eventually, this categorization of risk began to organize my observations and interviews at the agency, where two major discourses of drug-related risk and risk reduction were apparent: risks to an individual's physical health (like disease, overdose, or simply put, death), which should be reduced through behavioral modification, and risks to one's social, political, and economic standing (like incarceration, discrimination, homelessness, and poverty), which might be ameliorated through macro-level or policy shifts.

Bronx Harm Reduction addressed the health risks attributed to drug use almost exclusively, in both its services and "official" pronouncements of risk that permeated the agency. For clients who were not HIV-positive, nearly all accessible services addressed their physical health exclusively, while emergency, "low-threshold" mental wellness counseling was also available. Apart from syringe exchange, such individuals were eligible for onsite HIV testing, weekly Hepatitis testing and vaccinations, and enrollment within Safety Counts or Herizen (both HIV education programs). Approximately two-thirds of daily support groups, open to all participants, dealt explicitly with physical or mental health, taking up topics such as overdose prevention, Hepatitis C treatment, or HIV prevention.[20] Only HIV-positive clients qualified for on-site "social services," such as housing assistance and placement, a privilege vocally resented by a large number of ineligible, homeless clients. Of course, many case managers in the "HOME" program understood its aim to be the stabilization of clients' physical health through housing – an objective that further held down the public costs of treating HIV disease.

Even among participants who did little but sit or sleep in the drop-in, the agency's prioritization of health-related risks could hardly be missed. Upon entering the building, one was immediately confronted by a counter stocked with pamphlets on topics as "diverse" as HIV, STD, Hepatitis, and overdose prevention; a similar arsenal greeted entrants to the second floor. For those who declined to pick up a pamphlet, the bulletin boards in the main participant corridor were arrayed with information on Hepatitis C and "safe injection," in both English and Spanish, while a poster detailing the basic steps of overdose reversal hung nearby on the conference room door. Such "environmental" education, supplemented by the occasional health-related video,

[20] While officially available to all participants, a significant number of groups required the enrollment of at least 3 clients receiving case management services (for individuals living with HIV/AIDS), as stipulated by the New York State AIDS Institute, which funded such groups as part of their case management contract.

perhaps sought to reduce the number of clients who "slept through the message," in the words of one peer worker.

For a majority of both regular staff and peer workers, "the message" concerned the potential health risks of drug use, and individual-level techniques of prevention. Among 22 staff members interviewed in-depth (including 6 peers), a majority identified damage to an individual's health to be the primary, or only, risk following from drug use, while all three program directors posited the health risks of substance use to be of the highest importance. Asked to define the risks of drug use, the Executive Director stated:

> "Number one is infectious disease. HIV and Hep C primarily. Then you have …all the others. But primarily that, and so, you know. And then, the risks that they may pass on to other people…that they love, or that they just, you know, hang out with. Um, I think that's primary…"

The Clinical Coordinator, who supervised all counseling and case management services at the agency similarly answered:

> "The immediate risks are the health risks. Potential for overdose, um, not knowing how to inject…safely, clean, you know, with clean works, um, the secondary risks for me, are, um, a lot of the family relationships that break down, leading to homelessness, if you're not able to manage to substance use, than it usually becomes a problem in a couple of areas – keeping employment, keeping family relationships, keeping possessions. Um…so the joblessness, the homelessness, are to me, those are secondary risks. The health piece is always first."

Understanding risk to be an exclusively health-related concept, the Director of Prevention, who oversaw all syringe exchange and outreach at the organization, simply responded:

> In terms of health risks. I mean, health. You…in terms of using drugs period, you're affecting your health, your mental health, your physical health. You're affecting you cognitive abilities, your physical abilities.

While not altogether eschewing the existence of so-called "secondary" social risks, these senior staff members nevertheless identified personal and public health to be most threatened by illicit drug use – a position reflected in the agency's increasingly health-centric mission.

Nearly identical answers were provided by most "frontline" staff members, who often laughed upon hearing the question, as if the answer was self-evident. Repeating the question incredulously, one case manager in the SRO outreach program answered as if bewildered, "What are the risks? Um, yeah…Just getting infected with HIV, or the other related diseases." Other respondents seemed concerned to express the immensity of the health risks involved with not only drug use, but injecting drug use in particular. Prefacing his answer with a low whistle, Eddy, the Safety Counts facilitator responded, seriously:

> The risks is a lot. You have a lot to lose. It depends what you're injecting, what country you're from. Maybe you're in Puerto Rico, you're injecting, um, horse tranquilizers that you took most of your…your veins, and stuff. You see the pictures in SEP? Um, you have abscess, you have hepatitis, you have all types of risk when you're injecting drugs. There's a lot of risk. That means your…your chances of catching something is 90 percent.

The intensified health risks associated with injection inspired a similar level of awe, and fear, among two workers who did syringe exchange as part of their outreach efforts to SROs. While one woman joked that the biggest risk, for her, would be the "fright" of putting a needle in her arm, her colleague responded at length:

> Woooow, the risks is so high with injection drug use. I mean, the risks are high in drugs regardless. But, I'm gonna say more with injection drug use, because, there's so many people who are injecting things within their body that … are man-made. I mean, people put so much stuff into these drugs, un-inpurities, that, I mean, it's like….crazy. Um, horse tranquilizers, different types of opiates, different, just, different types…just to stretch…what they have. And, I mean, your body is absorbing this type of stuff, and your getting all abscesses, you're getting infected with God-knows-what. I mean, who knows what's out there in the next coming years. It, I know, it's gonna be something that's probably worse…than

> HIV, in the upcoming years. And we're just, I mean, people are just contaminating their body with things that they don't know about. And, I don't know…

Other staff respondents hesitated in answering the question, disclaiming their lack of special medical experience on the matter, and thus perhaps highlighting the more intense pathologization of injection drug use even in the context of harm reduction. While focusing on the "medical consequences" of injecting drugs, Juan, a case manager in the housing program, also commented on some of the disciplinary repercussions:

> Risk meaning, you know, health and stability? Well, with injection, I'll first admit that I don't have much clinical experience with IV drug users, meaning that I've never worked specifically in syringe exchange, I've only done the wraparound services. Um, but…specifically for needle exchange, um, my experience, I know that there's a lot of medical consequences for injection drug users. A lot more risk of infections. For somebody that's negative, of course, there's the risk of getting a lot of diseases and infections from it. For someone that's positive, you run the risk of jeopardizing your health, jeopardizing your housing, your benefits, for lack of, um, adherence to all this, because um, IV drug users is as hard as it gets."

While most, though not all staff members, spoke only of health-related risks consequent to drug use, it should be said that all six peer workers interviewed framed their responses in terms of health, sometimes speaking at length about the physiological harms associated with drugs, and the risk behaviors that they followed from. Yvette, a recent hire from Herizen, elaborated:

> It is, um, physiologically, it would be, the impact it has upon your system, the impact it has upon your body, whether or not, you, you know, the, the type of toxification, the concentration of the drugs. Many things. Many, many things become a factor, or a way that it can harm you. You know? Things can shut down… Too much Percoset can shut down your kidneys. Too much heroin can…kill you! Cause you won't breathe.

While expanding subsequently on his answer, a veteran peer first responded emphatically, "The death…the death. That's it!"

Among staff identifying damage to an individual's health as the principal risk of drug use, most went on to express an understanding of harm reduction as a public health technology. Noting that harm reduction meant "treating people with respect," Victor Rivera, the Administrative Director, went on to note that harm reduction was fundamentally a "public health approach" and "health promotion tool" that helped people to "take better care of themselves." Most staff members echoed this characterization of harm reduction as a program of disease prevention, which provided individuals with information that ultimately lead to behavioral change. John, the community manager, responded confidently:

> Well, it's, it's..I've always looked at harm reduction as a way of prevention, of, doing less harm to individuals, of, uh, like say for instance a person that's a sex worker, how to reduce the spreading of any STDs, or anything, by using condoms, that's a form of harm reduction to me. That person would, uh, you know, protect themselves, a person that, um, you know, uh, might be an IV drug user, instead of sharing, make sure that he, you know, cleans with bleach – two part water, three-part bleach – you know, not share needles. You know, that's form of harm reduction. Talking sex, uh, sex also, like say for instance, a person, that's uh, you know, how you say it, very active sex drive, make sure he uses condoms, you know. Uh, and that's, for me, a form of harm reduction. Reducing a behavior.

The characterization of harm reduction as the process of teaching an individual to "reduce a behavior" was echoed across multiple employees, yet broader and narrower conceptions of the eligible behaviors existed. The agency's clinical coordinator described harm reduction as "figuring out where you can make some interventions to live a healthier life," with the spectrum of such interventions including not only syringe exchange or sexual education, but weight management, and regular medical care. By contrast, the Director of Prevention advocated a much more refined mandate for the agency, speaking witheringly of the organization's de facto use as homeless drop-in. He curtly stated:

> "Harm reduction is syringe exchange. Give them sterile syringes to inject. Safely. Educating them how to inject safely, giving them any equipment they need to do

> it safely, educating them on infections, wound care, everything else…That's what I think harm reduction is. This other stuff that we seem to be doing…that's not harm reduction."

Perhaps referring more to her rather limited job duties at Bronx Harm Reduction than to her philosophy of harm reduction, one peer echoed this sentiment, quipping "Condoms and syringes. That's what (harm reduction) means to me."

Yet, not all staff members considered harm reduction to be primarily a public health strategy. Such individuals typically referenced a larger range of risks that derived from injection/drug use, which exceeded the biomedical. This small group of employees who expressed disappointment or ambivalence with the direction of the agency largely represented long time employees, many of whom had a history of drug use themselves. Noting that harm reduction might target not only drug use, but also risky relationships, and "economic situations," Shelly, the Herizen Coordinator and a former peer, criticized the contraction of harm reduction's mandate over time:

> To me, harm reduction can be so much broader. The way we have it right now, harm reduction whittles down to the point…where it's just about drug users and HIV. But it's not and it could be so much more than that, because there's so much other harms in society, that are going…. You know how they have that little general definition that harm reduction is reducing the harms of drug use, but to me, it's more than that. It's not just about drugs, because we can harm ourselves mentally, emotionally, physically, and so many…myriads of ways, you know, like, we have to realize what it really hurting us. You know? I guess, drugs is so obvious to understand how… You know what I'm saying? But we don't really talk, discuss all the other things that goes on in this life that's harming us. Our economic situations can be harmful.

Shelly went on to observe that there were more risks to drug use, beyond sharing needles, remarking that using drugs placed one within risky situations that carried the threat of robbery, arrest, police harassment, and police brutality; in closing, she lamented that "handing out a clean syringe to me is just a little thing that we're doing towards bringing down those risks. You know

what I'm saying? To me, it's not enough." Iris, also a former peer who had ascended the ranks of the organization to become a case manager, similarly focused upon the socially-generated risks of drug use, which she shortly summarized:

> What are the risks? Let's see. Criminal…um…incarceration. Lack of knowledge, access to medical, lifesaving medical treatment. Uh, isolation…stigmatization.

Iris likewise pursued a more open-ended definition of harm reduction, specifying only what it was not:

> Um…it's not penalizing drug use. Not medicalizing it. Um…individuals use drugs. People use drugs. From alcohol to whatever. To food. However, in this society, um…we tend to demonize drug use. We tend to criminalize it. We tend to…wanna control it or medicalize it.

Eschewing a strict or technical definition, a handful of other employees instead framed harm reduction as little more than an "attitude" founded in empathy and support, further denying that any formal training was needed. At the far end of the spectrum, two staff members who found themselves frequently at odds with BHR's new administration described harm reduction as a revolutionary "social movement"; Donald, the director of syringe exchange, quickly qualified this statement with a nostalgic "if you can still call it that."

Where some veteran staff members rejected Bronx Harm Reduction's increasing identity as a pubic health program addressing biomedical risk, the administration in turn disparaged the opinions of the "old crew" as "harm maintenance." Citing the provision of more "assertive education, nutritional guidance, fitness opportunities" to constitute the new Bronx Harm Reduction model, the Administrative Director differentiated harm maintenance as an ultimately irresponsible approach, that declined to promote health:

> Harm maintenance is…you know, the old crew of CitiWide, thinking that it was OK for a diabetic, heroin user in an SRO to…just…further kill themselves with, by eating, a gallon of ice cream with a box of crushed Oreos…um, and not

> addressing the diabetes in a substantive way. In an assertive way. Because they're stuck on the harm maintenance concept, although they may not describe it that way. I'm describing it that way. Where it's OK to let them do what they want, don't judge it, um, instead of really, maybe, providing more assertive education, nutritional guidance, fitness opportunities, all the things that we're trying to incorporate into our model. Uh, that's more comprehensive.

Arguably reflecting Bronx Harm Reduction's new emphasis upon order and accountability, the concept of harm maintenance further included the expectation that participants "get better," a transformation that demanded more aggressive engagement by staff. Invoking the importance of both the interview and confession to harm reduction, Tory, the agency's Clinical Coordinator and motivational interviewing specialist, insisted that BHR ask more of both its clients, and by extension, its staff:

> But harm maintenance is really, for me, leaving people where they're at, which is that kinda laissez-faire, you know, people are gonna use, so let's just provide them with syringes, and to not really have some sort of expectation to engage them in a conversation on their lifestyle. Just get better. Just get better. Just…get better. And if you can get better by managing their drug use, as many people did two and three and four decades ago, when drug users kept jobs and kept their families in tact for the most part and kept a roof over their heads, then do that. Get better at it. Stop being sloppy, stop falling out, figure out a way to manage it in a way where you can still have some left over to use and…but it's not. "Uh…" you now this very no-expectation, just come in and exchange and if you do a group, good, and if you all asleep, fine, and if you don't come, you don't come, and if… That to me is harm maintenance.

The concept of "harm maintenance" that was being progressively articulated by the leadership of Bronx Harm Reduction clearly resonated with contemporary education discourses around "the soft bigotry of low expectations" – a phrase deployed by advocates of comprehensive national standards for learning. Perhaps seeking to redeem those who had been failed by "harm maintenance", the Administrative Director posited that the organization's most incorrigible, veteran clients were the perfect candidates for its new evidence-based intervention, Safety Counts.

No junkie left behind: Safety Counts comes to Bronx Harm Reduction

As described in the introduction to this chapter, Safety Counts arrived at Bronx Harm Reduction to a mix of excitement and trepidation. For BHR's leadership, the evidence-based intervention or "ebbie" opened a previously untapped stream of funding from a federal agency, while reinforcing the organization's new public health agenda. At the same time, the Director of Prevention, charged with overseeing the implementation of Safety Counts, fretted about the program's rigid structure and complicated reporting requirements. A "proven intervention" for HIV and Hepatitis risk reduction amongst "out-of-treatment drug-using persons," Safety Counts recommended a "cycle" duration of 4 months, during which participants would be required to attend 2 "group sessions," 2 "social events," 1 "individual counseling session," and 2 "follow-up contacts" in order to officially graduate from the program. The administration reasoned that registering the agency's most "hardcore" participants might lead to more dramatic evidence of risk reduction – a boon for the agency's reapplication in a year's time; yet, such a recruitment tactic simultaneously threatened low rates of attendance, retention, and demonstrated effectiveness. In the end, such strategy mattered little, as the organization desperately scrounged to meet their projected enrollment estimates for both cycles within the 2010-2011 budget year.[21]

With the start of the first cycle fast approaching in October 2010, peers could be seen hurrying about the drop-in, clutching clipboards stuffed with Safety Counts intake assessments. Flyers posted throughout the building asked clients whether they "wanted to change their lives," yet peer recruiters approached many a potential candidate promising the more immediate reward of two Metrocards for enrollment. Requiring little more than 30 minutes for completion, the

[21] This section will broadly discuss the first cycle of Safety Counts, with an emphasis on programmatic elements, as opposed to specific participant reactions. Participants' reactions to and interactions within Safety Counts will be described in further detail in Chapters 4 and 5.

intake interview was a narrowly-focused document that requested information on participants' drug use and sexual "risk behaviors." In addition to identifying drugs used, drugs injected, and any equipment shared, the short survey asked interviewees to estimate the percentage of sexual encounters during which they had used condoms in the past 90 days (ex. 0%, 25%, 50%, etc.) A final short section requested the date of clients' most recent HIV and Hepatitis A, B, C tests (and vaccinations in the latter case). While serving primarily as a means of eligibility determination, the enrollment form was additionally used as a prompt for on-site HIV and Hepatitis testing, which participants were aggressively encouraged to take up. Following the intake assessment, peer recruiters were technically required to complete a detailed pre-intervention "risk reduction interview," which would be repeated at the end of the Safety Counts cycle. A five-page survey containing 135 questions on enrollees' risk reduction behaviors, the interview was designed as a means of clearly quantifying the EBI's effectiveness; however, in the first cycle, this document was often skipped, filled out improperly, or simply completed by the peers themselves.

The program's true burden of paperwork was revealed in the first group session, which featured three separate worksheets of increasing complexity. Worksheet 1, "Am I At Risk for HIV and Viral Hepatitis?", confronted the nine enrollees with a series of simple "yes-or-no" questions. Asked first whether they had injected drugs, used non-injection drugs, or had sex in the past three months, respondents were subsequently called upon to confess the details of their drug-use or sexual practices. An italicized warning at the bottom of the first worksheet read:

> "If you have circled 'Yes' for any of these questions, you may be at risk for getting infected with HIV or viral hepatitis, or giving it to others. Remember, you can lower your risk by changing your behavior, such as using condoms or not sharing your injection equipment."

Following the somewhat labored completion of Worksheet 1, participants were introduced to the "stages of change," which reflected the program's theoretical grounding

in cognitive behavioral therapy. Eddy, the Safety Counts facilitator, taped a series of five laminated placards – one for each stage – upon the conference room whiteboard, and embarked upon a painstaking clarification of each one. Using his own struggle to lose weight as an example, Eddy lead the group from his initial disinterest ("Not Considering It"), to his earliest ruminations, after being told by a doctor that he was at risk for Type II diabetes ("Planning to Do It"). From here, Eddy described his first, plodding attempts at jogging ("Taking Steps") and progressive development into a daily runner ("Doing It.") Noting that he had lost nearly 30 pounds after taking up daily exercise and cutting back on fried foods, Eddy located himself in the last stage of change – "Staying with It for 6 Months" - yet was careful to note that "relapse" was an implicit component of the Transtheoretical Model. Though he admittedly enjoyed the occasional meal at Popeye's, or took a few days off running when he was feeling tired, Eddy never lost sight of his long-term goal to keep fit.

From here, participants were asked to fill out the more complicated Worksheet 2, "Where Do I Stand in Reducing My Risk for HIV and Viral Hepatitis?" Listing 15 means of "reducing HIV and viral hepatitis risk," the document exhorted participants to link each strategy with the stage of change that they currently occupied. For example, respondents might check that they were "not considering" having fewer sex partners, but were "taking steps" to use condoms for vaginal sex, or "planning" to get into drug treatment. Beyond forcing participants to apply the Transtheoretical Model toward their own behaviors, Worksheet 2 served the more important end of introducing enrollees to an assortment of acceptable Safety Counts goals. As Group Session 1 wound down, participants were encouraged to think about a short-term goal that they would be able to

achieve over four months; each individual would share and officially "lock-in" his or her goal at the next group session, which would also feature collective "brainstorming" upon goal-related tasks, barriers, and mean of support.

Occurring two weeks later, Group Session 2 proceeded in a similar fashion to its predecessor, albeit to a much-reduced crowd. A clearly deflated Eddy repeated his lecture on the stages of change halfheartedly, to an audience of only three participants, who tried to compensate for the low turnout with increased enthusiasm. As the group's conclusion neared, each participant was given two pieces of paper upon which to record their goal. Corresponding exactly to the list of practices outlined on Worksheet 2, the first paper, intended for clients' charts, featured a check list of "general goals," to be specified into a "personal goal," with a "first step" and "barriers and solution" posed just below. All general goals related to an HIV or Hepatitis risk reduction behavior, and took the form of imperative statements (e.g., "Don't share needles"; "Decrease/manage drug use.") In addition to the larger goal worksheet, "wallet size" goal cards were distributed to everyone in attendance – presumably, so they might be constantly reminded of their goal and remain on task. In the absence of detailed instruction, some participants wrote down personal goals that diverged sharply from their pre-recorded general goal, and thus, from Safety Counts' HIV prevention agenda. One woman endeavored to "get a job in harm reduction," while another sought to obtain an apartment. While such deviations were tolerated in the first cycle of Safety Counts, later dismissed as a "trial run" by supervisors, participants in the second cycle were explicitly instructed to erase and amend any goals unrelated to sexual or drug-related risk.

Participants were asked to disclose their goals at the two "social events" that served as an incentive for the completion of both group sessions. While dangling the lures of special

"ordered-in" food, a raffle, and one guest per enrollee, the social events were also intended as a venue to compare and praise participants' progress. Like the final graduation, they were also a site for both the preparation and presentation of participants' "success stories," another key deliverable of the intervention. Every enrollee was urged, and sometimes badgered, to write or record a short story that narrated the achievement of their specific risk reduction goal. For the first Safety Counts social event, Eddy delivered his own risk reduction success story, which described his transition from injecting to sniffing heroin while incarcerated twenty years earlier. Ultimately culminating in his decision to kick drugs all together, Eddy's story set a distinct (if accidental) precedent for participants' own tales; most followed a standard narrative of recovery, replete with "rock bottoms" and fateful turning points.[22] Interestingly, the two Safety Counts "graduations" observed over the research period likewise resounded with discourses of abstinence and recovery, more closely resembling initial meetings of Narcotics Anonymous than harm-reduction-oriented celebrations. Asked to share both their Safety Counts goal, and their current "stage of change," a majority of participants at the first graduation characterized their objective as "staying clean" and their stage as either "doing it" or "staying with it." At the end, every participant received a personalized Safety Counts "diploma," and a grab bag stuffed with small snacks, condoms, and lubricants. Boasting a larger pool of eligible participants, the second Safety Counts graduation was slightly more grandiose, with a special photo-wall prepared for the happy graduates.

What counts most?: Risk, recovery, and truth tricks in Safety Counts

Seemingly out of place within a harm reduction program, the prominence assumed by testimonies of abstinence at the Safety Counts graduation may in part reflect the dominance of

[22] Safety Counts "success stories" will be discussed in further detail in Chapter Five.

such discourses within society at large; at the same time, they may also be viewed as deriving from a gentle if insistent push toward "recovery" at Bronx Harm Reduction specifically. In her 2006 book *Bodies at Risk*, Elizabeth Wheatley describes the dissemination of conflicting discourses of risk by employees in a cardiac rehabilitation facility, terming their sum effect as "truth tricks." In this context, truth tricks were deployed both consciously and unconsciously, as a means of motivating patients to manage their health, without demoralizing them over minor setbacks or stasis; for example, employees simultaneously extolled the importance of "controllable" lifestyle practices and inherent genetic factors in predicting the probability of future cardiac events (Wheatley 2006).

Truth tricks, or contradictory discourses of risk, were also present within Safety Counts, where they served to exhort clients both toward short-term risk reduction and long-term drug abstinence. Eddy, his supervisor, and the Administrative Director himself proudly told participants that Safety Counts was a "different" type of program, that "didn't tell [participants] what their goals should be," nor required that enrollees stop using drugs. In the place of traditional prescriptions for abstinence, Safety Counts – and Bronx Harm Reduction – simply asked clients to "do whatever they were doing, safer." At the same time, progressive abstinence was posited as a normative end within Safety Counts, as shown by the inclusion of "Decrease/manage drug use" and "Enter drug treatment" within the program's 15 "general goals" for clients. Staff also informally stipulated the desirability, if not the necessity, of total recovery from illicit drug use over time. Where Eddy frequently returned to his own decision to quit drugs, he also casually told the group that abstinence was necessary if participants ever hoped to get and hold down jobs. Much as participants were asked to designate a "first step"

toward their overarching goals, techniques of risk reduction, like syringe exchange and regular HIV testing, appeared implicitly as early stops on a longer journey toward drug cessation.

While abstinence was framed as an option available to all participants, "truth tricks" also infiltrated the characterization of drug use and addiction in Safety Counts. On the one hand, "risk behaviors" (both sexual and drug-related) were shown to be susceptible to rational management through education, planning, and social support. Once an individual had made the decision to alter, reduce, or eliminate their risk behaviors, it appeared that little else was required beyond a sound strategy and periodic encouragement. On the other hand, addiction was often defined as an inherently chaotic and chronic disease by Eddy and his peer helpers, who cited not only drugs, but also sex and food as objects of addiction. Eddy made frequent reference to the disease model of addiction, noting that all addictions, to substances or activities, were essentially similar in their recalcitrance and location in the brain. When asked by one enrollee whether addiction might be cured, the facilitator replied carefully, "not cured, but managed." Indeed, Eddy continued to identify himself as a drug addict, whose condition required him to avoid opiates – a type of drug he avowedly could not use in moderation. While not stated as an imperative, this definition of addiction seemed to demand abstinence from at least participants' drugs of choice, whose use was necessarily compulsive, and thus riven with unmanageable risk.

Conclusion

This chapter has attempted to describe the ways in which Bronx Harm Reduction – an avowedly non-coercive and user-oriented service site – functioned to regulate potentially dangerous bodies through technologies of surveillance and largely biomedical discourses of risk. With its emphasis upon dense documentation, public interrogation, and scripted confession, the

CDC-funded program Safety Counts was put forward as a particularly vivid example of disciplinary programming, which was further indicative of Bronx Harm Reduction's increasingly medicalized take on harm reduction. While describing the surprisingly seamless (and often pleasurable) techniques of behavioral management deployed at Bronx Harm Reduction, this chapter should not be read as describing the decisive or successful disciplining of the agency's diverse clientele. Many participants indeed appeared to accept and embody the organization's stress upon biomedical risk reduction, additionally championing the ultimate goal of drug abstinence. Within Safety Counts in particular, a handful of highly enthusiastic clients approached the material with apparent sincerity, writing often within their risk reduction journals and producing typed and proofread Success Stories for submission to the CDC. Yet, for each individual who attempted to make sense of Safety Counts' often muddled message, another openly challenged the discourses of risk presented therein, or simply waited for the lecture to end. Regardless of their level of discursive "buy-in," all who remained within Safety Counts undoubtedly exploited the program toward multiple ends; even those who doubted its disciplinary logic or long-term benefits understood that there were material benefits to be reaped from participation in Safety Counts, and indeed Bronx Harm Reduction at large. Looking both within and beyond this specialized program, the next chapter will deal with the unique ways in which clients used Bronx Harm Reduction to manage the risks that they experienced in daily life, identifying advantages that far exceeded condoms and syringes.

Chapter IV
Surviving the South Bronx: Drug-Related Risk from the Bottom-Up

In October 2010, Bronx Harm Reduction became the first local syringe exchange to open on Saturdays, initiating a wildly successful weekend program that was extended to include Sundays only nine months later. Hoping to get "backstage" on a day of reduced staffing and relative quietude, I began showing up for those early Saturday mornings, only to discover a dense crowd of eager participants. Individuals would begin lining up outside the building thirty minutes or more before the official start time, bursting inside at 10 AM to claim their spots for the next five hours. The first half-hour of the day was inevitably chaotic, as participants fought to find chairs, reassemble their belongings, sign up for the first group, and identify something to eat. Coffee and popcorn served as two special Saturday offerings – atypical "luxuries" demanded by hungry participants, and detested by weary employees.

Peers largely ran the drop-in on weekends, while one or two senior staff would retreat to their offices, pending an emergency. Arriving one Saturday in late October, I found Ronnie, a veteran peer, manning the sign-in desk; his girlfriend Mary prepared small bags of injection supplies outside the SEP room, while another peer concentrated upon the assembly of BHR's ancient percolator in the corner of the room. Despite the early hour, clamors for popcorn could already be heard around the drop-in, and a petite woman, complaining of hunger, asked Ronnie for cereal. He grudgingly offered her the remainder of his own breakfast – eggs and fries from a nearby diner – and she happily dug into her food, pausing only to reclaim an empty methadone vial from a lanky man muttering with gratitude. With many participants benefiting from methadone "take-away" privileges for the weekend, it was hardly the last bottle observed changing hands over the course of the day.

Promptly at 10:30, Ronnie announced the first group, Hepatitis C Prevention and Care, and yelled into the throng, "Who's gonna sign up? Come get your Metrocards!" A line quickly formed

around him, and the group was full in minutes. A half-hour later, fifteen participants filed into the conference room, and a noticeable quiet descended upon the drop-in. The television, set on the Science Channel, became audible once again, and Juan, a soft-spoken participant, turned to me and said, "I love science. I watch this channel on my cable all the time." The reduced crowd watched the program with mute interest, or dozed silently, while I in turn watched them. Suddenly subdued, the only movement in the room came from a man rifling through a basket of cookers perched outside the SEP room; I slowly realized that he was dumping the cookers back into their bowl, which removing the glassine bags that once contained them.

A burst of new arrivals entered the drop-in just before lunch, and a gentle clamor rose up once again. Introducing himself as Rob, an unfamiliar participant sat down next to me, and wondered aloud, "Who here owes me money?" Rob explained that he no longer used drugs, but came to Bronx Harm Reduction on occasion to hang out and "do business" – that is, sell cigarettes. As Rob advertised his competitive pricing at $7 per pack, Juan once again craned his head backward, noting that he sold "loosies" for a mere $0.50 each. Our conversation was interrupted by Ronnie's call for participants in the day's second group, also on the topic of Hepatitis C. Speaking loudly for effect, Rob declared, "I don't go to groups here. But I could use a Metrocard." His statement failed to elicit notice from Ronnie, and Rob resignedly walked over to the desk, to get his code on the list.

As the day wore on, I remained in my seat, and enjoyed a rotating selection of companions. At lunchtime, Juan rose up, and asked if he could buy me a sandwich from around the corner; he noted disdainfully that he didn't eat the food offered at Bronx Harm Reduction, which was typically meatloaf, baked chicken, or hot dogs donated by a nearby temple. Obtaining my refusal, Juan exited the drop-in, and his chair was immediately occupied by Julio, who spoke to me in spurts punctuated by bouts of nodding. In a lilting, almost taunting voice, he inquired, "Do you use meth, Kate?" and then mimicked

my reply, "Noooooooo."[23] The conversation broke off as Julio entered a sustained nod, and another man fell into the seat on my right. In broken English, my new neighbor complained that he was sleepy, as a shortage of beds in his shelter had forced him to sleep sitting up. Awaking momentarily, Julio interjected from my other side, "Stop talking to my girlfriend."

As lunch wound down, a portly white man rushed into the drop-in, depositing his bags two seats down from me. After asking me to watch his belongings, he dipped into the last-call lunch line, and returned minutes later with a plate of food. Back in his seat, the man shot a puzzled look in my direction, and asked me if I got high. I told him that I did not – but rather came to Bronx Harm Reduction as a researcher. The man, who introduced himself as Jack, nodded conspiratorially, admitting that he came in merely to shower and eat. Food in lap, Jack told me that he was staying at a nearby shelter, having recently lost his job; put out at 6 AM by "the sisters," he used Bronx Harm Reduction as one of few spaces where he could spend some time before his curfew kicked in at 4 PM.

Closing time, a process begun thirty minutes before the gates went down, generated groggy moans of protest, and a predictable pile-up in the bathroom. While staff visibly relished the shortened weekend workday, participants complained that they had barely settled in before being shooed out; many would migrate no further than the curb after the doors shut, plotting their next move over a rueful cigarette. The popularity of Bronx Harm Reduction's Saturday program among clients was apparent in such griping, which betrayed a dearth of other agencies open on the weekend. In the two months following the initiation of Saturday hours, the organization recorded an average of 82 participants in attendance each weekend, a number that climbed even higher once the winter weather set in.

[23] In this context, "meth" is more likely to refer to methadone, a synthetic opiate used to treat opiate addiction, than crystal methamphetamine, a stimulant. "Nodding" – a sleep-like state that individuals may enter, and fall out of, suddenly – is a characteristic side effect of methadone (or rather, high doses of methadone, particularly when combined with a benzodiazepine such as Xanax).

Framing its bid for Sunday funding, the organization was perhaps obligated to emphasize the importance of continuous access to such "lifesaving" services as syringe exchange in a borough "so heavily impacted by the twin epidemics of HIV/AIDS and substance abuse"; indeed, the public heath benefits of a 7-day SEP should not be underestimated - particularly in a highly-policed area where individuals might rightfully fear to carry injection equipment. Yet many who worked at Bronx Harm Reduction understood that weekend hours served a more complex ecology of participant needs, not to mention a more varied crowd of participants. While always present, such needs were brought into sharper relief on Saturdays, which, for many clients, were marked by a forcible exile to the streets. For such individuals, BHR afforded access to not only syringes, but also food, shelter, and basic human contact.

The above description of one Saturday at Bronx Harm Reduction was intended to illuminate the diverse ways in which clients used the agency to ameliorate the risks faced in their daily lives. While some individuals undoubtedly came for clean syringes, many others stayed for the hot lunch, free Metrocards, comfortable chairs, and friendly company. In this way, the introductory anecdote reveals the broader social and economic risks related to drug use, such as hunger, exposure, loneliness, dope sickness, and empty pockets – in addition to HIV or Hepatitis C infection. Aside from implicating individuals' substance use behaviors, it might be noted that these risks also derived from factors such as poverty, homelessness, and discrimination that affected a majority of clients at Bronx Harm Reduction, including those with no history of injection drug use. In fact, while 60 percent of the agency's clients reported past or present drug use at intake, over 75 percent were homeless, and nearly all reported annual incomes less than $10,000. As noted in the previous chapter, for many clients Bronx Harm Reduction was as much an institution of quasi-welfare provision as a targeted public health intervention. This is not to say that some participants did not seek out or value services that addressed their physical

health, but rather, it is meant to highlight the agency's multivalent exploitation by a populace embedded in an intricate web of risks.

Looking at Bronx Harm Reduction's full range of programs, this chapter will consider how clients complicated presiding notions of risk and risk reduction, both directly through their words, and indirectly through their actions. I will first describe how clients repeated, rejected, or qualified "official" pronouncements of risk in the context of both interviews and support groups. Where clients rarely articulated their troubles, activities, or opinions in the language of risk, many were quick to respond to staff prescriptions for behavioral change as an effective or sufficient means of risk reduction. Participants did not discount the importance of certain health behaviors wholesale, so much as qualify their feasibility or place of priority in light of other life circumstances – specifically, homelessness. Likewise, few participant interviewees failed to mention the salience of harms such as HIV infection or overdose when asked to define, in their own opinion, the risks of drug use. Yet most subjects also noted other, non-medical hazards and exacerbating factors, or further elaborated on the context of risk. Interestingly, all participant interviewees identified harm reduction as a limited health promotion tool, yet described their own usage of Bronx Harm Reduction as only marginally health-related – a reality reflected in this chapter's first few pages.

Reflecting on such "off-label" uses of BHR, the final portion of this chapter will explore the position of Bronx Harm Reduction in its clients "geographies of survival." A concept theorized by Nik Heynen and Don Mitchell (2009), the "geography of survival" refers to the web of places, services, and spaces knit together by poor, homeless, or otherwise marginalized populations as a means of getting by. Bronx Harm Reduction will here be discussed within a larger constellation of social services accessed by its participant population, many of whom never or no longer injected drugs. Citing both ethnographic and interview data, I will elaborate four "off-label" usages of Bronx Harm Reduction, and other local

NEPs: as places to obtain basic necessities, as sources of income, as safe spaces, and as sites of social contact. As the organization moved toward an increasingly clinical model of care, this chapter will consider these latent functions of BHR within the context of a larger struggle over the content and meaning of harm reduction services. By itself, Bronx Harm Reduction (and other NEPs) was clearly an unsatisfactory solution to the economic and political circumstances that drove a variety of individuals through its doors; yet, in a city – and country - that lacks a comprehensive welfare system, needle exchange arguably represents an important thread within a social safety net that is being woven from the ground up.

"Death! AIDS! Hepatitis!": Clients define drug-related risk

> The major event of my Friday is the Prevention Education group, which is unexpectedly covered by Donald. Donald begins by writing the title and his own subtitle or alternative title for the group on the board: "Prevention Education, or, Stuff We Already Know, But What the Hell, We Get a Metrocard." The unofficial title gets a chuckle from the group, but Danny M. disputes the actual title, in fact, misunderstanding it as the "prevention of education." He tells Donald that the title "Education on Prevention" would be more clear, and Donald obliges. When somebody asks "the prevention of what," Donald opens the question to the group, asking for ideas on what an active drug user might try to prevent. The first three suggestions are AIDS (Angie), relapse (Danny), and overdose (James), though from there, the suggestions become more diverse – homelessness, bankruptcy, (the destruction of) relationships, depression, and loneliness. (June 3, 2011)

In the above excerpt from my field notes, one staff member's subversive subtitling of the group "Prevention Education" reflects many possible motives: to avoid pandering to a population suffused with discourses of risk, to disclaim his status as a bearer of authoritative knowledge, and to highlight his overall weariness with a changing organization. Yet Donald's (otherwise unusual) wink at the audience also served to illuminate the highly ritualistic character of many groups at Bronx Harm Reduction, in which the same prevention messages were repeated daily to the same individuals. As shown in this particular instance, participants were well-versed in the

"correct" answers to Donald's question, or at least, the issues that the group was funded to address. HIV, addiction, and overdose were among a small handful of risks most obviously prioritized by the organization, and this reality was at least partially reproduced in participants' own definitions of risk; however, given the opportunity to speak at length on the topic of risk, many clients noted a variety of other maladies following from drug use.

When asked in interviews to elaborate upon the risks of drug use, nearly all participants led with the potential health consequences, framing answers that likely mirrored an interviewer-induced bias, in addition to the salience of such biomedical harms.[24] Most participants first noted the risk of infection with HIV or other blood-borne diseases, often punctuating their response with a statement indicating the severity of such repercussions. Though providing similar answers to staff subjects, many client respondents answered with uncertainty inflecting their voices, or giggled nervously while watching my face for confirmation. All regular attendees at Bronx Harm Reduction were constantly exposed to discourses of risk that prioritized the avoidance of HIV and Hepatitis infection; it may be that the seemingly self-evident nature of their answers unnerved some clients, who responded as if posed a trick question.

> Um…it's a lot. … Like…it's, it's, it's very deep. (Giggles). (Long pause). … Oh, man. Sh… Death! (Laughs). … That's it! Death! (Laughs). Death! AIDS! Hepatitis! Hepatitis C. Hep C. [*Julio]*
>
> Well…there's diseases…you know. There's…there's disease. (Laughs). You know, cause…you know. When I was growing up, they didn't have no nothing called AIDS. Right? And, Hep C? [*Leon*]
>
> Um, sharing needles. Cottons, waters. Sharing the cooker. Cause, um, you have

[24] As I will discuss in a latter part of the chapter on BHR's "Metrocard economy," interviews with some clients assumed a rather transactional atmosphere. Accustomed to the presence of researchers at the agency, some clients clearly felt the need to provide certain answers as a means of earning their incentive (a 2-trip mass transit card); in fact, one interviewee who no longer used drugs leaned away from the recorder when asked how he used Bronx Harm Reduction, asking in a hushed tone, "I have to say SEP, right?"

> blood inside, Hep C or HIV. (stutters) The Hep C…it stays alive, you know? That's a huge risk. From the water, cotton, needles, even from the alcohol swabs. You use it, I use it. [*Ronaldo*]
>
> The risks are a lot. Um, well, getting HIV, or Hepatitis, or a…STDs. [*Victoria*]

Drug overdose was also a risk mentioned by several subjects, most notably three clients who had recently entered training to become peer educators at the agency. Speaking with more confidence than their non-peer respondents, these participants also spoke at greater length and with more enthusiasm, perhaps eager to demonstrate their accumulated knowledge. Interestingly, none reported any history of opiate or injection drug use, as explicitly noted by two subjects:

> Well, the risks. One, if you're not shooting properly, you hit the wrong vein, or you hit the wrong…that's not good. Oh, I've learned, um, mixing the drugs and shooting is not good, those…could cause overdose. And um, getting high by yourself. I, I'm not an IV user, but I've got common sense. And common sense say, don't be shooting up when you by yourself. Wanna be greedy in using. Yeah, for all drug users. [*Laura*]
>
> Physiologically, they're going to be…um, the introduction of any chemical into the body, and your body's tolerance, and how much, will you…will you over-D? Over-D. That's the Southern. Oh my god. Was that country. OD. Over-d'ed. (Laughs). And we all know what it means! It's the damnedest thing. It is the…anyway. It is, um, physiologically, it would be, the impact it has upon your system, the impact it has upon your body, whether or not, you, you know, the, the type of toxification, the concentration of the drugs. Many things. Many, many things become a factor, or a way that it can harm you. You know? Things can shut down… Too much Percocet can shut down your kidneys. Too much heroin can…kill you! Cause you won't breathe. [*Yvette*]
>
> Um, uh, the risks of crack…is, uh…catch a heart attack. A major heart attack. Um, what else… Um, mess up your T-cells, your viral load…um, I don't know too much about heroin. Heroin…causes an OD. Um…you can catch – if you're sharing needles, you can catch the Hep C virus. Other diseases…that may come up, that…where no scientists ever heard of, nobody heard before (laughs)… Like as far as…the pills, Oxcontin, you can OD, and those…you know both drugs…all the drugs is addictive, and some of them are harder to get off than others, and a lot of them can cause liver, kidney, heart, brain, dysfunction. Like me sometimes. (Laughs). I ain't never did no heroin, I only did, uh, crack. And um, I know certain drugs will, uh, burn your brain cells… Crack, it does, but it refurbishes, but alcohol, it, like, kills your brain cells, they call it wet brain… [*Jack*]

As demonstrated in the above quotations, many clients replied to my question about the

risks of drug use as if being tested – an effect that might be linked to the use of the word "risk" itself, as a term associated with professional or public health discourses around drug use. This pressure might further have been felt more acutely by peers, who were specifically exhorted to think of themselves as community educators and "public health workers." The second two peers quoted above elaborate not only the physical health risks of drug use, but further take pains to describe the biological processes underlying these risks as best they can. Where Yvette notes the suppression of respiratory function associated with heroin overdose, Jack indicts crack as "burning" its users' brain cells. Despite Jack's joking self-reference as an example of "brain dysfunction," these peer interviewees gave more studied answers to the question of drug-related risk, often framed in the third person.

Yet other client interviewees testified to real health problems suffered as a consequence of their long-term drug use. Juan, a middle-aged participant who claimed to have kicked heroin, while continuing to "love" cocaine, spoke vividly on the physical trade-offs of chronic drug use, gesticulating with conviction:

> Oh! OK. You know, like a pipe? It gets you rusted? You know when your pipe gets wet, and it gets rusted. That's what it…it deteriorates the body. After a while. If you don't stop using…your pee starts getting chalky, your skin starts getting chalky. It starts peeling…you just start crumbling. Yeah, it does. It deteriorates the body. [*Juan*]

On one occasion preceding our interview, I had indeed encountered an out-of-sorts Juan inside the drop-in – sweaty, glassy-eyed and agitated. However, it was not possible to attribute his disheveled appearance or erratic behavior solely to a recent period of heavy use. In this instance, Juan made it clear that his distress followed from a near brush with arrest, after a fraught encounter with the police. Beyond matters of health, the major risk that participants spoke to, with the backing of experience, was arrest and incarceration as a suspected drug user – or as a

mere affiliate of Bronx Harm Reduction, a known "hot spot." One female respondent whose husband had recently been arrested while at the agency spoke dolefully about the constant threat of police harassment, a risk exacerbated by the couple's lack of shelter; Juan described his problems with the police in even stronger terms, having been already picked up twice in the past year.

> Oh, it's bad. I don't know. You don't understand, it's hard for me to say it, but it was bad. And no matter what you do, no matter where you go, it's gonna be all around. You know what I'm saying. Right now you don't see so much drug addicts in the street, but, it's getting hard for them to get high, because the police always around now, you know, and they see you smoking that brown thing…whatever you call it, they take you. OK. If you're drinking a beer or sometimes a people be smoking on the street, and here, you know how many times I see mens at CitiWide shooting themselves. … People here, they shoot up… [*Eva*]

> They're busting people for anything, they'll take people off the streets for anything. It sounds like the Nazis, the days of the Nazis, when they got the Jews and all that? It's terrible. … I did six months, when they caught me with my methadone, and they said that I was selling it…they said that I sold him drugs, and they caught me with one coke on… And they dismissed it Monday. And they asked me for $15,000 bail. Thank God the judge let me go. I went through hell. They handcuffed me in the back, like this, and aw, I couldn't deal with it… My arms couldn't even reach in the courthouse, and thank God they didn't give me nothing. It's very sad, it's terrible. For nothing. [*Juan]*

Where the legal risks of illicit drug use were well known to many clients, another respondent indirectly spoke to a more haphazard harm emanating from drug criminalization – namely, an unregulated black market full of adulterated, potentially toxic products. A few minutes spent in the drop-in revealed the effects of one particularly "popular" additive to drugs deriving from Colombia, the chemotherapeutic agent levamisole; several clients bore a telltale pattern of black polka dots trailing down the backs and sides of their legs, indicating cell necrosis. In the below quote, Lola, a veteran client who denied any history of drug use, refers to another highly lethal

cut common in drugs purchased in Puerto Rico, the horse tranquilizer xylazine, which was associate with an increased rate of overdose.

> OK…I could have the risk of STDs, like HIV and Hepatitis C. I could have an overdose. And if I smoke weed or if I sniff something, some coke, or if I inject myself with something, that it doesn't make me happy, and it doesn't make me the way I like to be, they way I like to feel, I could mix it with another type of drug. (Slaps hands together). Woah! It's my time to go away, to pass away. (Laughs). Yeah. A lot of things going on around here. They using, um…rat poison. Inside the drugs. They're messing…mixing the drugs, and, um…you know these injections, they shoot the horses so they could, um, put them to sleep?

At the beginning of her interview, Lola confided that she had been admitted to Bronx Harm Reduction as a favor from an earlier director of syringe exchange. An old friend from Puerto Rico, the former director knew that Lola had never injected drugs, but simply needed a place to eat, take showers, and hang out, unperturbed. Nevertheless, Lola re-asserted the risks of drug use with reference to her oldest son, who had experienced overdose firsthand:

> Yes, um, I'm getting a lot of information that I didn't know before, about harm reduction, because I have one son, that, since he was 13 years old, he used to smoke weed, and, and, sell drugs, on the streets. And one time he had a overdose, so, you know, the person from the block told me, "Put some ice in…put some ice on his dick, and when he wakes up, give him some milk." And that's not the proper way. Now I learned here in the harm reduction CitiWide, that they have a kit, um, Narcon. That I can give him one shot. So I take the training. And I have my kit.

Such client testimony established the indisputable reality of biomedical risk in illicit drug use, and further, the importance of knowing effective measures for its reduction. In fact, interviews among even a small sample of individuals confirmed that participants were familiar with many "evidence-based" techniques of harm reduction, including, but not limited to, syringe exchange. However, clients also identified a greater diversity of risks following from drug use, while indicating that simple knowledge of certain harm reduction practices was not enough. Asserting

problems of implementation in support groups, clients discussed the ways in which behavioral change was complicated by both social relationships and social context – namely, the overriding economic limitations that defined their lives. Clients further spoke to the risks that remained largely unacknowledged or unaddressed in the context of harm reduction, sometimes hijacking a group's official agenda to the dismay of staff members.

People, places and things: Clients contextualize risk

> Closing his group "Drugz and Behavior," Matthew makes the general point that while their symptoms may differ, all illegal drug use ultimately leads to death. One participant, Harold, quips that [the drugs] will lead to incarceration first. [May 3, 2011]

Echoing a theme also asserted by Elizabeth Wheatley, many participants at Bronx Harm Reduction indicated that risk reduction was less an "individually-accomplished task," than an ongoing process of negotiation within structurally-constrained social worlds (Wheatley 2006: 42). These social worlds further hosted a great variety of social and economic harms that sometimes appeared more imminent to clients than the biomedical harms accentuated by Bronx Harm Reduction – a reality indicated in Harold's joke above; the *concatenation* of social risks faced by clients (arrest, exposure, and impoverishment) further undermined their ability to follow the seemingly simple behavioral prescriptions of harm reduction, a caveat frequently noted in support groups. While participants might have been willing and able to change their behavior, they lacked access to the resources and power necessary to alter the contexts that additionally shaped their drug use.

Unemployment, or poverty – and their handmaidens, homelessness and incarceration – were asserted as impermeable barriers to behavioral change on many occasions at Bronx Harm

Reduction. For one, a lack of resources kept individuals embroiled within the poor neighborhoods they had grown up in, surrounded by drugs, yet deprived of opportunity. During a subsequent meeting of the group "Drugz and Behavior," Matthew asked the group to discuss how one might mount a successful recovery from drugs. One participant, Lana, commented on the difficulty of quitting drugs when it was impossible to avoid the (drug-scoring) "spots." Referring to a popular 12-step adage often repeated at Bronx Harm Reduction, she griped, "They say 'people, places, and things,' but a lot of us here can't afford to just up and move. Moving requires money, which a lot of us don't have." Another client, Robert, chimed in, wanting to piggy-back off Lana's point. With exasperation, he said that "the spot" was in his building - downstairs in the lobby, and throughout the hallways – making it difficult for him to pass through without giving in to temptation. As if to illustrate not only the mental, but also the physical obstacles in navigating his environment, he mimicked the gestures and interactions of drug pitchers and buyers that he recognized daily throughout his building.

Participants further made the connection between the entrenched drug markets in poor neighborhoods and an intensified police presence. As in interviews, clients would often denounce their seemingly arbitrary detention by police officers stationed on their blocks, outside their buildings, or in front of Bronx Harm Reduction, noting that simply standing on the corner with a cigarette had become a behavior courting arrest. Of course, participants who did in fact buy or sell illicit drugs were vulnerable to arrest as a consequence of this "legitimate" infraction of the law; yet, some individuals went on to describe the ways in which the risk of arrest was exacerbated by poverty. In the weekly group "Substance Use Management," participants were asked to identify issues that influenced their ability to moderate their drug use, with view to curbing its physical, mental, and financial fallout. Commenting upon the impact of the war on

drugs on substance use management, a new participant, Franco, highlighted the importance of class in determining one's exposure to legal ramifications. Franco observed that rich and poor people alike might become addicted to drugs, yet stressed that wealthier individuals were better positioned to manage their habit over time; those of greater means could better afford the inflated cost of illegal drugs, without having to resort to crime or "looking the way we do." Concluding, Franco declared that poor drug users were more likely to be street drugs users, who lacked the luxury of using in the privacy of their own homes, and thus found themselves more prone to arrest.

Other participants still remarked upon the ways in which poverty and criminal justice experience were mutually reinforcing. Where many clients expressed a desire to find "straight" employment, their search was troubled by not only a sour unskilled economy, but also personal histories of incarceration that rendered them less attractive to potential employers. Thus denied a legitimate source of income, individuals were left facing the options of crime, resumption of drug use, and of course, arrest and imprisonment. This seemingly inescapable Catch-22 became the theme of one weekly support group, "Dealing with Feelings," which typically dealt with the management of a specific emotion each meeting. On the occasion in question, participants nominated "stress" as the topic of the week (a suggestion only approved after the group's facilitator left the room to confirm with her supervisor that "stress" was in fact a proper emotion.) His wife seated silently at his side, one man talked with muted frustration about his inability to get a job as an ex-convict. Izzy struggled to find the right words to describe his situation, and express his growing sense of helplessness in the face of recurrent rejection, repeatedly muttering "I'm not the kind of person who can't work." Lamenting that chronic unemployment had left him cranky – and craving drugs – he stared at the ground sheepishly, as

he admitted to unleashing his anger upon his wife, Victoria. Yet Izzy was hardly the only member of the group wrestling with issues of stress, joblessness, and relapse. Across the room, another participant, Ivan, spoke with a wary smile, seemingly on the verge of tears; he told the group that he had looked everywhere for a job in maintenance, warehouse work, or construction, but to no avail. Desperation in his voice, Ivan reiterated Izzy's fear that his stress would steer him back to drugs, as his drinking escalated steadily.

Both Izzy's and Ivan's long-term unemployment further prevented them from finding apartments. Where Ivan slept at a nearby church, Izzy's relationship with Gloria additionally complicated his ability to secure even emergency housing; consequently, the couple stayed on the street most nights. Among HIV-negative individuals (or "white cards," as termed by staff), the utter impossibility of obtaining safe and affordable permanent housing was a topic of daily discussion in groups. Yet the absence of any feasible solution had the effect of almost immediately paralyzing such discussion once started. Perhaps perversely, more attention accrued to the particular risks faced by those who had apartments – largely HIV-positive clients who received rent subsidies. According to such "lucky" individuals, housing came with its own risks – namely, loneliness and social isolation; however, the relationship between housing and drug use was hardly a matter of uniform opinion, as illustrated in a one lively session of Safety Counts. According to one client, housing had the effect of gradually reducing, if not eliminating, individuals' drug use. Angie, an HIV-positive client who had obtained her apartment through Bronx Harm Reduction, explained to the group that she only got high a couple times of month since she had been housed; by contrast, she had used nearly every day while living on the street, forging a habit that functioned to blunt out the harsh reality she inhabited. Furrowing her brow, another participant Yvette stated perplexedly that she "thought it would be the other way

around," implying that private accommodations might instead increase one's impetus to use drugs. Andy and Joanna, a couple enrolled within Safety Counts, affirmed Yvette's logic, at least in part. Andy explained that upon receiving their apartment, the couple had rapidly escalated their drug use. Newly sheltered from police and passerby, Andy and Joanna further found themselves with an excess of time, once devoted to finding and maintaining street-side shelter. Yet over time, the couple's use had again slackened – a trend that Andy accredited to Joanna, who had become progressively bored with their mutual binge. Finding solo use significantly less satisfying, Andy too began to reduce his habit, until the couple together decided to take a break from drugs altogether.

In the case of Andy and Joanna, it seemed as if the potentially isolating effects of housing were moderated by the social support the two enjoyed within the context of their relationship. For other participants who lived alone, in apartments, shelters, or on the streets, Bronx Harm Reduction served as a crucial site of sociality, a topic the next section will discuss in detail. In addition to providing the information and tools necessary to reducing client's biomedical risks (like HIV infection), Bronx Harm Reduction further served to ameliorate a variety of the "other" risks described by clients in the preceding pages - homelessness, poverty, police harassment, and social alienation – sometimes against its own will. Exploring the concept of the "geography of survival" with relation to needle exchange, the remainder of this chapter will consider the ways in which BHR's clients promoted a broader understanding of harm reduction through their multivalent exploitation of the agency.

Managing risk: Bronx Harm Reduction and the local "geography of survival"

In helping its clients inhabit an ever more hostile urban terrain, Bronx Harm Reduction (and

other local NEPs) arguably took its place in the local "geography of survival," a concept theorized by Don Mitchell and Nik Heynen. The authors poignantly characterize the geography of survival as "the spaces and spatial relations that structure not only how people may live, but especially whether they may live. For very poor people, such as the homeless, the geography of survival is knitted together into a network of public and private spaces and social services" (Mitchell and Heynen 2009: 611). Placed within a wider neoliberal cityscape, the brutal geography discussed by Mitchell and Heynen, and mapped below, is one forged by the wits its inhabitants, yet constrained overall by laws targeting not only the homeless, but also substance users. In New York, needle exchange and other harm reduction programs are perhaps the only institutions that openly solicit the presence of active, unrepentant drug users, while not necessarily allowing on-site drug use.[25] However, by virtue of locations in peripheral and/or impoverished communities, NEPs may serve a more diverse participant population than their mandates may immediately suggest. Bronx Harm Reduction accommodated many individuals whose interests strayed far from HIV/AIDS, while participants who did exchange injection equipment employed the drop-in for a much vaster range of reasons. In this way, an agency designed as a relatively limited public health tool was reimagined by its users as a general welfare center, occupying a paramount space in their personal geographies of survival.

In the following paragraphs, I describe the ways in which various individuals (e.g., housed and homeless, HIV-positive and HIV-negative, active and former substance users) used Bronx Harm Reduction to manage many risks during my twelve months of research. Participant observation and interviews pointed toward four “off-label” functions of Bronx Harm Reduction, which are elaborated

[25] Interestingly, drug treatment programs also have a place in users' geographies of survival, serving functions that are hardly straightforward or sanctioned by their overseers, as ensuing paragraphs will discuss.

below: Obtaining Basic Necessities, Hustling/Income, Safe Space, and Sociality.[26] Other organizations and spaces situated within participants' local geographies of survival are addressed in a subsequent section. The final discussion ponders the implications of these user-end functions of needle exchange for the philosophy and practice of harm reduction in New York, which was simultaneously being molded from the "top-down," by funding streams.

Obtaining Basic Necessities

Perhaps the most legible latent function of Bronx Harm Reduction was the provision of basic sustenance to a sizable population of hungry and often homeless individuals. By "sustenance," I mean to refer not only to food and drink, but also to the basic tools of survival more generally, including toiletries, clothing, and blankets. This usage of needle exchange may appear unremarkable at first, until one considers the ways in which these mundane resources structured participants' relationships to and time at Bronx Harm Reduction, while attracting a diverse group of service users. The importance of food in particular was manifest in both daily and monthly patterns of attendance that followed meal schedules. Asked what initially brought her to, and kept her at Bronx Harm Reduction, Yvette exclaimed, chuckling, "free food!" On a daily basis, the drop-in population would spike without fail around 11:30 AM and 4:30 PM, when sign-up sheets for lunch and dinner were respectively made available. Similarly, festive dinners and parties for major and minor holidays alike drew participants rarely or never seen on a regular basis; indeed, infrequent visitors called in advance of Thanksgiving, Christmas and Easter to confirm the dates and times of special dinners. Consisting largely of

[26] By "off-label," I mean to refer to the exploitation of BHR toward ends that were not formally sanctioned, or seen as reflecting its official raison d'être as a public health, and specifically HIV prevention, program. Of course, this definition is specific to a context in which needle exchange has been progressively redefined from above as a public health technology first and foremost (McLean 2011; Smith 2011).

microwavable meals, the quality of everyday lunch and dinner was often disparaged, and sometimes denounced as an indignation. Service users of greater means often held out for the "outside" food ordered for participants in certain support groups or service programs; for example, take-out pizza or fast food served as a carrot promised to potential attendees at bimonthly community meetings.

As implied above, the material goods to be gained by attending Bronx Harm Reduction served as explicit tools of organizational recruitment in a neighborhood hosting three "competing" needle exchanges. At the time of writing, Bronx Harm Reduction was commonly ranked second in terms of food provision by participants who patronized several programs. Indeed, many participants made no secret of attending a nearby exchange for its superior, "home-made" lunch, only wandering over to Bronx Harm Reduction in the late afternoon, for dinner. This second-place status was a source of light-hearted irritation to some staff members, who sought to attract individuals by offering other goods, often branded with the organizational logo: t-shirts, backpacks, sleeping bags, and coats. Participants in special training programs, such as Safety Counts, were promised weekly "grab bags," typically containing soap, sweets, and sometimes soup; while some would joke about the predictable contents of the bags ("My weekly soap!"), others bore out each meeting impatiently, declaring openly that they only came for their grab bag. The ability to offer such resources was a point of organizational pride – and perhaps organizational survival in a time of drastic budget cuts to publicly-funded programs like needle exchange. At one observed community meeting, a peer worker fretted that Bronx Harm Reduction's "puny" hygiene kits containing a small shampoo, soap, toothpaste, and razor were insufficient, and in fact embarrassing, by comparison to those offered by other organizations. Where participants relied upon this particular exchange for certain tangible goods, Bronx Harm Reduction also relied upon participants to show up, and justify revenue. While the agency's funding contracts did not stipulate any quotas for daily or yearly attendance, Bronx Harm Reduction's baseline funding was based upon the

volume of individuals served each period. In light of local “competition,” and rumors of dwindling turnout, some workers at Bronx Harm Reduction realized the need to attract potential “patrons” using unique lures.

Hustling/Income

While Bronx Harm Reduction provided the above necessities *gratis* to its users, it also served as an informal marketplace in which participants could buy, sell, and exchange a wider array of products amongst themselves. In general, participants used Bronx Harm Reduction to generate income in ways that traversed the spectrum of legitimacy. In this setting, "income" might be considered to encompass not only money, but also "Metrocards," i.e. New York City mass transit passes. As in many social service organizations, Metrocards were the ubiquitous currency paid for user participation in meetings, support groups, and other odd events at Bronx Harm Reduction. Consequently, the pursuit of Metrocards or "carfare" might represent the most iconic hustle at Bronx Harm Reduction, which was (for the most part) amiably tolerated by staff. It was not unusual to see staff and participants joking about occasions on which participants had "gotten over" by taking more than one Metrocard; in fact, such anecdotes were told repeatedly, like old family stories, while the “shifty request” and “adamant refusal” of extra Metrocards played like a scripted interaction between service users and staff. Likewise, the inquiry “What group is this?” was frequently met with the laughing response “The Metrocard group!” Where some participants obviously employed their carfare for transportation to and from the organization, many commanded an impressive wad of unused Metrocards that simply accumulated within their wallet or pockets, openly fretting when their stock was “running low.” As noted previously, this study also participated in the local carfare economy, offering clients a prepackaged $4.50 (2-ride) Metrocard as an interview incentive – resaleable at local bodegas for three dollars.

Bronx Harm Reduction also offered its users opportunities to make real money through a handful of short- and long-term jobs, whose salary ranged from $10 per day to $100 per week. All such positions were fiercely coveted, despite limited pay, tedious work, and strict supervision. Part-time "peer" positions, garnishing the highest income, were officially held for a year, and came with lengthy application processes; the opening of one such job during the study period attracted dozens of applications, from both regular and infrequent visitors to the exchange. Less desirable day-to-day jobs in maintenance or food service were generally filled on a first-come, first-served basis, while one individual might informally claim a position for weeks or months at a time. Though less competitive than peer positions, such positions had the advantage of being "off the books" - and thus did not threaten individuals receiving cash benefits from public assistance. Many clients voiced an interest in permanent full-time (i.e., non-"peer") work in any area of Bronx Harm Reduction, yet no such positions were made available during this research.

Populated by individuals boasting limited money and oftentimes, recreational drug habits, Bronx Harm Reduction also served as an ideal site for more entrepreneurial participants looking to engage in less-than-legal sales. While several participants were terminated and/or arrested for selling illegal drugs on-site, individuals were also observed selling cigarettes, clothing, jewelry, electronics, and medicines during the study period. Noting that they offered lower prices to individuals who lacked the time, or simply felt uncomfortable patronizing regular stores, some "salesmen" saw themselves as providing an essential service to the drop-in community. With the exception of illicit drug sales, staff typically turned a blind eye to these transactions, and occasionally succumbed to a good deal – particularly after New York State raised the cigarette tax in July 2010, resulting in a $10-plus price tag per pack.

Safe Space

When asked simply "what participants got out of" coming to Bronx Harm Reduction, nearly every staff member and service user noted the organization's de facto service as a "safe space," with varying degrees of approbation. In using this term, most individuals meant to refer to the use of the drop-in as a proxy home for participants lacking stable shelter. Indeed, short of providing an overnight bed, Bronx Harm Reduction mimicked many of the amenities of permanent housing for twelve hours each day. Participants were allowed to sleep, undisturbed, in chairs, on couches, and even during support groups (so long as they didn't snore). A spacious shower and washer/dryer were available on a sign-up basis, and rarely lacked for users; the popularity of these facilities sometimes resulted in conflict between service users, and further, between staff members, particularly when "non-participants" from the community attempted to access them. Given the large number of homeless participants who visited the drop-in daily, competition extended beyond shower and laundry time to locker space, and in fact, wall outlets - for charging cell phones. Irrespective of their housing status, many clients chose to receive mail at Bronx Harm Reduction, while listing the organization's main phone line as their primary contact.

Though the dangers from which Bronx Harm Reduction protected its users often remained implicit in its "safe space" labeling, they were readily apparent in group discussions and participant observation in the drop-in. As described in the previous sections, the most commonly reported risk faced by housed and unhoused participants alike was police harassment. Many participants complained of being detained, questioned and searched by police regularly, for no legitimate reason; the rationale for this harassment typically proposed by participants referenced their status as often homeless, largely minority, past and present drug users. Some perhaps accurately attributed their targeting by police as consequent to their affiliation with Bronx Harm Reduction - an organization visited by local police officers with some regularity. While the possession of syringes by needle exchange participants was

fully legal under New York State law, it was nevertheless not uncommon for users to report detention for carrying syringes. On multiple occasions over the study period, police vans were seen parked within a block of the drop-in, prompting staff members to dissuade participants from standing in front of the building.

While thus shielding participants from treatment as criminals, the drop-in further protected its users from victimization by criminals. Individuals living on the street were obviously at a loss to reliably keep their belongings from thieves, particularly those whose alertness was compromised by legal and illegal substances. Overall, the individuals who appeared most vulnerable - to police harassment, muggings, or "getting punched in the face," as one participant put it - were those maintained on relatively high doses of methadone, who were allowed to "nod" at Bronx Harm Reduction, for the most part, unperturbed. With a significant portion of service users enrolled within local methadone maintenance programs, this study in many ways illuminated needle exchange and methadone maintenance as complementary programs in unintended ways. Many studies have noted that needle exchange programs boast high rates of participant referral to substance use treatment programs like methadone maintenance, thus (in theory) advancing such individuals' struggle toward long-term drug abstinence (Hagan 2000; Riley 2002). Yet, for many homeless, methadone-maintained participants, Bronx Harm Reduction remained ensconced in their geographies of survival, whether or not they continued to use illegal drugs.

Sociality

Perhaps the most moving latent function of Bronx Harm Reduction was its use as a site to reestablish or maintain social contact. Feelings of alienation and loneliness were problems that appeared to unite clients presenting with vastly different housing, medical and substance use concerns. For

participants living on the streets (or within shelters that were scarcely better), the drop-in provided an opportunity to interact with others in what might be termed a "normal," non-judgmental context (see also Macneil and Pauly 2011). In the words of one staff members, the drop-in gave such individuals "the chance to become human again." While this statement may read as pejorative to those described, its author meant rather to convey the dehumanizing conditions, and treatment, experienced by many homeless participants. Indeed, describing his initial enrollment within Bronx Harm Reduction, one participant admitted, "I wasn't sure whether I was an animal or a human anymore." Others described a gradual process of social re-immersion upon first arriving at BHR, which initially proved an overwhelming setting for those coming off the streets or out of prison. Having honed a system of self-preservation that relied upon laying low and trusting no one, such individuals admitted that they spent their earliest days at the agency occupying corner seats in order to best observe their new surroundings; only after weeks, or even months, did they allow themselves to develop a rapport with other clients and staff. By "validating the humanity" of those who feared it lost, Bronx Harm Reduction allowed such individuals to re-develop basic social skills requiring a fundamental level of faith in themselves and others. Even among those less fretful of unfamiliar social situations, BHR helped to assuage the inevitable isolation that accompanied life on the streets. Quipping that BHR was "like Peyton Place" for its participant populace, one homeless interviewee named Leon explained that many clients came simply to socialize, and bear witness to "all kinda dramas that take place during the day." In a more serious voice, Leon stated that "being homeless is a lonely, lonely experience," that had left him essentially friendless. Welcome within few other social milieus, Leon identified Bronx Harm Reduction as a relatively open community.

At the same time, Leon noted that many participants who were housed and financially stable used Bronx Harm Reduction as a means of fending off the solitary existence that came with having their

own apartment. In his opinion, such individuals came primarily for the "camaraderie" offered by the organization. Living off public assistance and occasional part-time work, such service users reported that they came to the drop-in simply because they had nothing to do at home. Many housed participants received their apartments with the assistance of the New York City HIV/AIDS Service Administration (HASA), and had relatively limited choice regarding neighborhood. In the end, individuals thus housed were often forced to accept apartments in places far removed from friends and family. Coming to Bronx Harm Reduction to "make a group," volunteer some hours, or just watch TV in the drop-in provided such participants with some temporal structure necessary to avoiding a sense of aimlessness or depression. The inception of Saturday drop-in hours during the study period was heralded as an obvious boon for homeless participants, who otherwise might suffer two straight days on the street; yet, housed participants also celebrated the Saturday program as a too-short antidote to otherwise too-long weekend. Having attained some modicum of material stability, such individuals perhaps felt their persistent lack of close friends or significant others more acutely. Jack, a friendly peer who would often apologize for his own gregariousness, joked darkly about his long days spent at the agency, even after his receipt of a new apartment. Living alone without so much as a working television, Jack said that he'd rather come to "watch other people fight over food" than waste his days at home.

Like many others, Jack in fact reported an extended network of social survival, weaving beyond the South Bronx, to include other New York City social service organizations offering free classes, trainings, or weekly dinners. Perhaps ironically, some clients, like Jack, also maintained case managers and attended support groups at nearby abstinence-oriented programs such as NarcoFreedom. Yet the particular service setting and its category of clientele seemed to matter less to such individuals than the mere opportunity for sociality itself. Rather than seeking the specific company of other active users, recovering addicts, or persons living with HIV/AIDS, these clients simply desired "to be" in the world,

around other people who acknowledged the validity of their presence. The situation of these individuals might be seen as pointing to enduring holes in the local geography of survival, which failed to fully integrate individuals like Jack through the provision of full-time, permanent employment opportunities. Peer educator positions at Bronx Harm Reduction and similar organizations appeared to be the most accessible line of paid work for participants; however, these jobs too were maddeningly scarce, and stipulated lengthy applications processes that rejected candidates experienced as arbitrary or "political." Of course, the persistent absence of work in the South Bronx may also be understood as highlighting the perfect, inescapable continuity of this geography, which guaranteed little beyond mere survival.

Mapping the Larger Geography of Survival

Participants described broader geographies of survival that, for the most part, remained within the boundaries of the South Bronx, and within the purview of harm reduction, substance use or HIV/AIDS services. Such geographies were both spatially- and temporally-patterned, as participants cited daily, weekly, or seasonal schedules of attendance at different organizations and spaces. The spatial and temporal constraints fixing these geographies were clearly related, as individuals bemoaned not only the cost of moving around the vast city, but also the time required to reach other potentially fruitful services in the often far-flung, peripheral neighborhoods that tended to host them. Given otherwise baroque schedules of appointments with clinics, public assistance workers, and shelters, leaving the neighborhood seemed a near impossibility for some participants. Obviously, such "formal" institutions comprised vital links within many participants' survival networks, granting health care, income, food, and a bed to sleep in. Yet, following the discussion above, this section will again concentrate on the off-label exploitation of different community organizations.

Fulfilling a multiplicity of participants' needs, the two other needle exchange/drop-in centers in

the neighborhood appeared to assume comparable importance to Bronx Harm Reduction in the individuals' geographies of survival. Located less than ten minutes away in either direction, these programs may be seen as giving rise to a "participant stream" that flowed over the course of a day or week. As mentioned previously, another local needle exchange was famous for its hot, homemade lunches, resulting in a massive queue of individuals each day at noon; accordingly, some service users strategically spent their morning at this program, hoping to avoid the line, while others would attend Bronx Harm Reduction for their "first lunch," only wandering over to their second once the crowd had subsided. Likewise, the third local drop-in was known to distribute grocery store gift cards every other Tuesday, thus drawing a biweekly turnout of informed individuals.

Despite the service similarities between these three organizations, participants often described them as representing very different, discrete, and almost insular communities. For individuals who had been officially "terminated" or unofficially alienated from one program, refuge might be sought at either or both alternatives; indeed, on several occasions, participants who felt persecuted by staff, or unfairly passed over for peer positions at Bronx Harm Reduction threatened to "take [their] talents elsewhere." At the same time, some service users seemed to relish the relative independence of each program, describing each as comprising a unique social circle, which they visited according to the time, the day, their needs, or moods. Taken together, these drop-in centers formed a web of social obligations that kept such participants comfortably busy, out of their apartments, and/or off the streets.

Apart from such "low-threshold" organizations, which offered little in the way of formal structure or participation requirements, clients also mobilized more regulated and rule-bound institutions toward creative ends. Despite attending Bronx Harm Reduction, a site ostensibly aimed at active drug users, many individuals were simultaneously enrolled in outpatient drug treatment programs, which formally prohibited or discourage illicit drug use. While enrollment might accurately reflect an

individual's desire to achieve or maintain abstinence, such programs also met a multiplicity of user needs. For example, individuals receiving methadone were also allotted monthly transportation checks, which represented a crucial source of income for participants struggling to pay mounting bills. In fact, this seemingly modest financial incentive, intended to promote treatment adherence, was experienced by some participants as a form of treatment compulsion, binding them to a regimen they might have yearned to stop. Discussing his dependence on monthly carfare checks, one individual exclaimed that he would immediately detox from methadone if he were otherwise able to pay his monthly electricity bill. Detox programs, which sent daily pick-up vans to Bronx Harm Reduction, were employed by participants not only looking to cease or reduce their habits, but by those simply seeking a warm place to sleep, particularly in the winter. For individuals' lacking insurance, or simply wary of committing to any treatment program, the emergency room at the neighborhood hospital was also an option of last resort on a cold winter night.

Conclusion

Upon seeing the drop-in for the first time, one visitor to Bronx Harm Reduction asked, perplexed, "What is everyone waiting for?" Given many participants' long-term "careers" at the organization, this question seemed particularly poignant. Seen in the worst light, the needle exchange drop-in could appear as a crowded waiting room where there was no end in sight. Indeed, for participants who were not HIV-positive, and thus ineligible for housing assistance from the New York City HIV/AIDS Service Administration, there were few prospects for improvement. In accepting its role as a way station for socially displaced individuals, Bronx Harm Reduction implicitly defined its diverse users as lives worthy of intervention; at the same time, the organization did little to openly challenge the politics of abandonment that led them there (see also Evans 2010). This is not to blame this, or any other

needle exchange program in New York City, which are simply not authorized or paid to address the social, political, and economic risks underlying and following substance use. Instead, Bronx Harm Reduction and other NEPs were charged with providing services and disseminating information that framed HIV as the major risk attendant to drug use. Ultimately, harm reduction programs are encouraged to empower their users as subjects of public health interventions – not to advance their basic rights as citizens and city residents. Evoking Sônia Fleury's notion of "inverted citizenship," these individuals are extended limited health and social assistance in the absence of real civil or political rights (cited by Biehl 2001: 136).

In describing the geographies of survival mobilized by the participants of Bronx Harm Reduction, this chapter does not seek to show how individuals "scam the system," but rather endeavors to discuss how their behavior illuminates its enduring gaps. As theorized by Mitchell and Heynen, geographies of survival reflect individual attempts to live in the face of economic and social policies that may condemn them to death – from exposure, hunger, and other socially-generated pathologies, such as drug addiction and HIV. A strategy developed largely in response to the American "War on Drugs", needle exchange has become an important tool of survival for street-based substance users, who require not only clean works, but a respite from a society that harshly punishes and stigmatizes certain types of drug use. As this chapter has shown, the non-judgmental philosophy and service environment that characterizes needle exchange programs may attract many non-users in need of basic amenities as well. Such unlikely service users spoke to not only the relatively inviting atmosphere of Bronx Harm Reduction, which demanded little of its participants, but also to the dearth of options faced by many chronically poor individuals in a country that lacks a comprehensive and adequate system of public

assistance.[27] In the absence of a public system of social protection, Bronx Harm Reduction served as a useful site for managing not only biomedical risks such as HIV infection, but also social and economic harms such as hunger and homelessness.

[27] In New York, for example, single adults are eligible for merely two years of severely limited welfare benefits – for which over 40 percent of applicants were denied in 2007, the last year of data available (FPWA 2009).

Chapter V
Reducing Risk, Producing Selves: Needle Exchange as Technology of the Self

Nearly four months into my fieldwork at Bronx Harm Reduction, I was invited to attend my first support group - Overdose Prevention, a city-funded session that ran at least three times per week. After a short cigarette break in front of the building, that day's facilitator, Rosa, pulled me up the stairs and into the conference room, noting that she went out of her way to ensure her groups weren't "boring," despite the overwhelming apathy of all involved. She summarized, "I don't want to be there, and they just want a Metro."[28] Following this assumption, Rosa bragged that she kept the group lively by forcing everyone to participate, and further, framing its lessons via examples and language that were "real" for clients. As I discovered over the ensuing months of observation, Overdose Prevention was perhaps the most formally choreographed group held at Bronx Harm Reduction. Each meeting posed the same questions and dispensed the same advice, largely to the same group of people; nonetheless, the group hardly lacked for spontaneity, client pushback, or unexpected comedy. Where some individuals had clearly learned the script by heart, performing it back seamlessly, others used their familiarity as an opportunity to improvise.

On this particular Friday in mid-November, the group hosted a full house of fifteen participants, many of whom were regulars, or daily visitors to Bronx Harm Reduction. Depositing me in a free seat at the back of the room, Rosa disappeared into the staff offices to claim the group's requisite props: two overdose reversal kits, and a battered demonstration dummy, whose foam torso was ridden with the punctures of past meetings. Trying to remain inconspicuous, I marveled at the variety of activities occurring around me in the moments preceding the group. One woman adjusted her makeup using a compact mirror, while her

[28] Rosa is here referring to a single-ride Metrocard, given to clients in exchange for attending her group.

neighbor worked diligently on a Sudoku puzzle, graciously donated by a man one seat down, himself absorbed within a newspaper. In the room's far corner, Martin, a talented artist, was huddled over a bar of soap, from which he was delicately excavating a smiling bust. Several others beside me simply dozed or nodded, surfacing periodically. Improbably, the most vocal cluster of participants was seated between the conference rooms' two doors – a position typically reserved by those seeking a quick exit. Today, however, Dave, Gene, and Isaac waited expectantly for Rosa to reappear, visibly eager to engage, even as their colleagues went on with other tasks. Flashing me a warm smile from his perch, Gene exclaimed amusedly, "I don't even inject!"

Rosa wasted little time with introductory remarks before launching into her interactive lesson. Grasping the dummy by its armless shoulders, she introduced the group to its ill-fated protagonist, "Flaco." Rosa wiggled the dummy across the table, and set up the group's defining scenario: "So your friend Flaco just shot three bags, and he's on the way to the bodega to get himself some Newports and a Cobra." Suddenly, the dummy flopped backward, as Rosa released her grip and announced, "Uh oh. Flaco's down. What're you gonna do?" A few clients looked up and giggled, while Dave interjected with a stylistic complaint. Ignoring Rosa's question, Dave instead objected to the race and class overtones of her story: "Why does it have to be Newports and a Cobra? Why can't it be Marlboros? And a Heineken." Rosa shrugged the comment off, rolling her eyes, but Dave's revision quickly spawned comedic suggestions from the rest of the group, with Gene offering "Some Pall Malls and a Night Train!" Giving in to the room's infectious laughter, Rosa protested, "It's not 1973!" Before she could proceed with her lecture, Dave chided the facilitator again, now for her excessive use of the word "nigga," noting that she wouldn't denigrate people of Hispanic or Asian ethnicity so casually. Reacting to Dave like a

pestering parent, Rosa nodded exasperatedly, and redirected the conversation to the long-ailing Flaco.

Rosa balanced the dummy on its side, demonstrating the "rescue position," and then asked the crowd whether they should report the incident as an overdose when phoning 911. As if in response to a well-worn joke, a chorus of "no's" rang out through the room. Pleased, Rosa confirmed that the caller should rather describe their friend as unconscious or not breathing. Mario, glancing up from his paper, idly questioned the reason for this deception, and received a patient explanation from Isaac. He informed Mario that if drugs were mentioned to the emergency operator, the ambulance simply wouldn't arrive. Rosa indicated her approval, then steered the group's attention to the two blue bags before her, each containing a single dose of Narcan – an opiate antagonist used to treat overdose. Before describing the proper administration of Narcan, Rosa contrasted its usage to other "completely ineffective" folk methods of overdose reversal, i.e. immersion in cold water, or injection with bleach or saline solution.

At this point, a groan of dissent arose along the wall, as Dave spoke up against Rosa's wholesale dismissal of such "old school" methods, with Gene's backing. Trumpeting his experience over 24-year-old Rosa's training, Dave protested that such techniques *had* worked in the past, even if no one understood why. He offered that drugs might have been different "back in the day," suggesting that the unique adulterants found within heroin today – such as other opiates, or psychotropics – increased the necessity of a targeted intervention like Narcan. Though not disputing the relevance of Rosa's chosen technology, Dave fiercely resisted its depiction as the sole legitimate means of overdose reversal. The outcry continued, as others in the group shared their own stories of overdose and its remedy, past and long past. Sensing a lost battle,

Rosa shifted the group's focus once again, and requested a volunteer to demonstrate the correct means of Narcan utilization on Flaco.

With a slight gesture, Isaac offered himself, and strode confidently to the front of the room. Where Rosa had been irreverent and scattered in her presentation, Isaac proceeded slowly and seriously, demanding the attention of his audience. Starting again from Flaco's point of "collapse," Isaac first led the group through an initial bout of rescue breathing; gently raising the dummy's head, he mimed checking its airway for obstructions, before retrieving a cellophane mouth guard from the overdose kit, and performing a brief round of CPR. Isaac then expertly simulated both the intramuscular and intranasal delivery of naloxone, further noting the importance of recapping the syringe post-administration. As the group wound down, Isaac solicited questions from remaining participants, while Rosa went to fetch a cache of Metrocards for their reward.

As shown in this introductory anecdote, my first group at Bronx Harm Reduction easily defied its moderator's preliminary appraisal. Many employees at the agency spoke of overwhelming client indifference to all but incentives, as a matter of course; yet, this evaluation wasn't entirely borne out by the nearly hundred groups I observed at the organization. While some clients certainly "slept through the lesson" (both literally and figuratively), such an approach to harm reduction could not be generalized to all, or even most, individuals at the agency (nor should such behavior be immediately labeled passive or apathetic.) Indeed, a variety of styles for "doing harm reduction" – interpreting, performing and/or disseminating its mandates - are showcased in the above excerpt alone: while Dave disputed, others "nodded," and where Isaac showed off his knowledge, Gene polished his jokes. Clients' multiplicity of approaches to harm reduction, or performed "risk identities," hinged upon differences in

demographics, personality, biography, and current living circumstances; they perhaps also reflected the differential engagement and material investment of certain bodies by the organization, its staff, and funders.

Where Chapter Three described the ways in which BHR sought to discipline its clients' bodily practices, this chapter will consider how clients themselves made sense of harm reduction, its discourses of risk and recommended techniques, and incorporated such directives into their own bodily projects – or didn't. In short, this chapter will ponder harm reduction as a site where Foucault's "technologies of domination" and "technologies of the self" intersected, producing a varied range of risk reduction styles. While suggesting some clients' apparent absorption of risk reduction into a dominant, and enabling identity, I will focus mainly upon the *performance* of different risk reduction styles. Given both the nature of my data and my status as a (young, white, female) researcher, it may be impossible to determine the actual extent to which people genuinely subscribed to rigorous risk identities; it further can't be doubted that such performances were contextually grounded, and perhaps deemphasized outside the exchange. With these limitations in mind, I will describe how clients deployed different risk identities to achieve distinct ends at BHR and further, how the staff reception of client performances affected the latters' enthusiasm for harm reduction.

Creating a bridge from the early to the late work of Michel Foucault, this chapter will begin by recalling the centrality of "techniques of subjectivation" within harm reduction, as an approach to drug use founded in non-coercion and incentivization. This section will frame harm reduction as a contested site of neoliberal governmentality, which works upon individual behavior remotely, by shaping both the physical environment and personal identity. While thus re-illuminating the potentially disciplinary effects of BHR, I will also consider harm reduction as

spawning multiple regimes of self-care that are experienced as agential and empowering – as ways to control otherwise "out-of-control" lives." Here I will further draw upon client interviews, wherein subjects were asked to comment on how attendance at the BHR influenced their subjectivity or self-concept. Lastly, this chapter will elaborate a typology of risk reduction styles or "risk identities" performed by clients at Bronx Harm Reduction, as a means of organizing and analyzing the disparate subjectivities spawned by the agency.

Creating careful subjects: Harm Reduction as Technology of Domination/Self

In describing how Bronx Harm Reduction participated in the surveillance and normalization of its clients, Chapter Three may be seen to reveal one manifestation of governmentality in the context of harm reduction. A term first proposed during Foucault's 1978 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: 353). By providing drug users with instructions and equipment intended to facilitate "safe injection," harm reduction endeavors to, at best, prevent, and at worst, monitor, the circulation of infectious diseases or the incidence of overdose within a population often lamented as "hard to reach."

Harm reduction seeks to produce certain behaviors (e.g. the use of clean needles) not only through the manipulation of the material conditions in which injection occurs (e.g. the provision of clean needles), but further through the shaping of users' subjectivities. The discourses of risk that underpin harm reduction posit their listeners as rational subjects who are inevitably

interested in preserving their health status through strategies of HIV prevention; they further encourage users to take responsibility for the welfare of others by declining to share injection equipment, or disposing all syringes at the exchange. In this way, prudent individual health behaviors become framed as a form of civic responsibility – a defining characteristic of Lupton and Peterson's (1997) "new public health." Even if illicit drug use retains its label as a high-risk practice, clients are encouraged to think of themselves not as reckless, but rather as responsible, conscientious drug users.

Long accused of harboring neoliberal influences, harm reduction also addresses service users through the language of consumerism and self-enterprise, terming them "clients" or "participants," while disdaining the passive and disempowering label of "patient." Ultimately, clients are exhorted to see themselves as informed consumers of not only drugs, but also health and social services.[29] As in other consumer discourses, the supremacy of individual choice is emphasized. Indeed, Bronx Harm Reduction not only saw itself as selling certain behavioral strategies to its users, but further sought to develop specific "brand loyalty" amongst its clients, appealing to its customer base through promotional perks like free bags or t-shirts.[30] As a governmental strategy, harm reduction produces desired behaviors amongst its targets by

[29] Interestingly, Bronx Harm Reduction not only sought to stimulate its users' "entrepreneurial" impulses, by encouraging them to volunteer their time as a means of securing stable employment as peers, but further appealed to the pleasures of consumerism as a rationale for reducing or ceasing drug use. On multiple occasions, staff members were heard advertising the ability to buy and accumulate possessions as a major perk of abstinence. One peer, Ronnie, extended this discourse further, equating his newfound role as a good consumer with that of a "productive member of society."

[30] Bronx Harm Reduction also may have attempted to shape its customer profile to one that predicted the greatest rewards and the lowest risks. In the waning months of my fieldwork, two staff members reported to me that they had been asked to turn away any client applicants who did not inject, and who were not HIV-positive. Such individuals would presumably do little to improve the organization's syringe exchange data, and were also ineligible for reimbursable HIV/AIDS services.

effectively aligning the interests of individual users with a larger institutional logic emphasizing disease prevention; in this way, behavioral change is effectively framed as an individual decision, rather than a governmental imperative. Concluding his final lecture of 1978, Foucault describes such respect for freedom as "an element that has become indispensable to governmentality" (Foucault 2004, p. 353).

To this point, the idea of governmentality has been used to flesh out the ways in which client behavior is shaped from the top, down, characterizing harm reduction as a "technology of domination." At the same time, this analysis of one needle exchange and the real practices of its clients may also generate a more agential rendering of governmentality. An ambiguous term within Foucauldian theory, this concept also carries important implications for self-cultivation and the elaboration of identity (Foucault 2004). The complex rituals emerging from needle exchange and the instruction of 'safe shooting' may also be understood as 'technologies of the self' that may positively influence drug user subjectivities. As will be laid out in subsequent paragraphs, some of the "risk identities" that arise in needle exchange are certainly in line with the governmental projects pursued therein. Many participants at BHR developed and pursued identities as responsible and/or recovering users, who were knowledgeable about their risk and devoted to multiple techniques of HIV prevention and health promotion; some further strove to serve as formal or informal peer educators, who were charged with motivating and educating less enthusiastic participants. Such "positive" risk identities often outlived the specific practices on which they are based; at Bronx Harm Reduction, many clients who no longer reported active drug use, nor sought needles, continued to haunt the program offices, maintaining old relationships with other participants, and in fact, forging new ones as peer educators – a

phenomenon that perhaps points to the meaning and satisfaction some individuals derived from this particular regime of self-care.

Harm reduction may also give rise to so-called "oppositional identities," as users learn to use organizational interests and bureaucratic irrationalities for their own purposes. Drawing on the contributions of Alan Petersen, this study also interprets 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 (Petersen 2003). As the previous chapter demonstrated in detail, clients enrolled at Bronx Harm Reduction for a variety of reasons, not all of which related to the institutional goals of HIV prevention and public health. Where harm reduction programs offer a spectrum of services broadly aimed at health promotion, they may also provide comfortable chairs, 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 still obtain sterile needles for the purpose of street sales, or for distribution to friends or family members in need. Participation in needle exchange and other harm reduction 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, needle exchange programs may sometimes serve as sites for criminal activity or facilitate associations that conspire thereto – a suspicion borne out during police sweeps of Bronx Harm Reduction.

Of course, between these two proposed extremes of risk identity – entirely invested and decidedly not – lays the majority of harm reduction participants. Most users of Bronx Harm Reduction appeared to accept some portions of its program, while demonstrating a measured wariness of its governmental power, by disputing program rules, refusing to provide certain

information, or lightly mocking staff member's self-seriousness. Where the following typology tends to divide clients into subjects of interest (oriented toward risk reduction and eventual abstinence) and subjects of resistance (oriented toward continued, unregulated drug use), the reality was inevitably more complicated. It should be noted that the peculiar pleasures of (subjection to) power were observed to link diverse participants at Bronx Harm Reduction. As predicted in the writings of Foucault, pleasure derived from both submission to and elusion of disciplinary tactics like surveillance, competition, and confession. The thrill and self-satisfaction of those individuals who managed to twist or wholly evade organizational policy – by claiming a second lunch or an "unearned" Metrocard – is perhaps more intuitive; diverse scholars of drug use have written on the feelings of agency and accomplishment that follow from a successful hustle (Bourgois 2000; Preble and Casey 1973; Spunt et al. 1986). But the pleasures of discipline were equally apparent around the agency, and not just for the material rewards conferred among BHR's best "students". As I learned relatively early in my fieldwork, many clients appeared eager to share "their stories" with little if any solicitation on my part. While this phenomenon initially made me sensitive to my perception as "confessor" in the drop-in, I also began to understand my role as a mitigator of loneliness, whose mere attention passed as acceptance for some. Among individuals lacking for concerned company, it is not hard to imagine that the constant interrogation of harm reduction may also be experienced as a sign of care. The next section will in fact discuss interview data in which participants link the transformational power of harm reduction to its provision of long-absent support.

"I can accomplish": Clients talk about harm reduction, identity, and change

All of my interviews with clients at Bronx Harm Reduction concluded with the same question, often repeated or rephrased several times for understanding: "Has coming to Bronx Harm Reduction effected the way you think about yourself, and if so, how?[31] As the final item in sometimes long (and two particularly hurried) interviews, this question was met with shorter answers on the whole, and an occasional response in the third person. All subjects answered affirmatively, a trend that likely points both to an organizational effect upon subjectivity and my own interviewer-induced bias. Bronx Harm Reduction made clear its desire to help clients achieve self-transformation, and thus, the "correct response" to this question was perhaps wholly obvious. Nonetheless, subjects described several different forms and mechanisms of change experienced since arriving at the organization. While some responses explicitly echoed BHR's own oft-repeated axioms around harm reduction, their speakers were often individuals whose "change" had been accompanied (or achieved) with material benefits, namely a job, at the agency.

Interestingly, answers to this question seemed to diverge with gender. Two women, one recent and one long-term peer, both described the seamless operation of Bronx Harm Reduction upon client subjectivity. Characterizing herself as initially indifferent to messaging around risk, Yvette joked that she had been drawn in by "free food"; Beatrice similarly said that she began coming to BHR just for the "Metros." Yet over time, both women began to absorb the lessons

[31] This question originally asked "How has coming to Bronx Harm Reduction changed the way you think about yourself, *or your drug use?"* With several clients disclaiming any past or present drug use (including my first interviewee), I altered this question in practice, not wanting to implicitly challenge subjects' previous statements. Despite this truncation, many clients did go on to speak to the effects of the organization on other participants' experience and understanding of their drug use.

and ethic of harm reduction, against expectation and seemingly without trying. Yvette noted that others too benefitted from the surprising, and unobtrusive, effects of Bronx Harm Reduction, declaring, "People come up from being on that couch."

Pressed to account for the agency's effectiveness, Yvette, Beatrice (and other female respondents) went on to describe the ways in which attendance at BHR alleviated feelings of stress, anxiety, and depression, thus enhancing participants' ability to work upon behavior. In this way, biomedical risk reduction became integrated within a larger project of self-care – not merely physical, but emotional. Where Yvette noted that injectors simply "feel better when [they] have a whole bunch of clean needles," Beatrice rooted the success of Bronx Harm Reduction within ongoing work to stimulate participants' sense of self-worth, explaining: "People think that that's why it comes to the self-esteem thing…you know. If you don't believe in yourself, don't love yourself, how you gonna help yourself?" With daily groups such as "Mental Wellness," "Dealing with Feelings," and "I Love Me," the depiction of risk reduction as both cause and effect of mental health was a well-worn trope at Bronx Harm Reduction; yet its repeated invocation by female respondents perhaps speaks to the relevance of this theme. Three other women also spoke to the emotionally empowering effects of Bronx Harm Reduction, remarking that their enrollment had assuaged some of the sadness and isolation they experienced living on the street. In the words of Lola, relief came from not only having people to talk to, but from having a place to be. Claiming a diagnosis of major depression, Lola explained that Bronx Harm Reduction functioned as an informal method of treatment: "Because I spend my time here with the people, talking, doing some volunteer stuff, doing groups, I go window shopping, I go out there, I run there, I can live by myself without medication." Victoria also described herself as

"under depression" upon her arrival at Bronx Harm Reduction, crediting the agency with helping to easing her loneliness, and subsequently, her desire to get high.

Where this small sample of female participants described how BHR had altered their emotional states, several of their male counterparts drew upon the language of responsibility in relating shifts in their own subjectivities. Emphasizing both the educational and moral impact of harm reduction, three men reported that the agency made clients more conscientious about their behaviors. Julio, rushing to finish his inquisition, hastened "How, it d – it makes me think more about my, my being safe…and you know, safe sex, safe needles, safe with everything." By contrast, Leon spoke at length about BHR's effect upon client reflexivity, despite equivocating that "some don't really care":

> Yeah. I think…um…it do change the way people think about themselves because the information that they get. You know…out of the groups. Uh, and…it changed the way they…some of them use drugs, you know. Because I know some that's very…conscious of what they're doing. So, some don't really care, you know. And I say there's more that don't care than those that do…I can't really put a number on it, but there's a lot that's already sick, and they might've gotten it through sharing or whatever, and they're saying "Wow…I gotta, like…I can't give it to nobody else like that. You know, because, here it is. I'm suffering. I know what it's like. I got this monster, and I… I really gotta make sure I don't spread it." And being conscious of, you know, yourself and your health, and caring about other people. You know, caring…to the point where you won't do the harmful thing. And you'll do the right thing, the good thing. Right. "Oh no, no brother. You're can't use my needle. Here's one."

Characterizing a learned health behavior (refusing to share syringes) as the "right" or "good" choice, Leon invokes harm reduction as a site of not only bodily, but also ethical training – a point echoed more explicitly by Juan, a sporadic user, who in the previous chapter described his frustrations with the police. At several points in the interview, Juan credits Bronx Harm Reduction with profoundly altering his entire attitude towards drug use, and life more generally. Asked what he had learned during his time at the organization, Juan responded:

> I learned to take life seriously. To take life more seriously. That the government is not…the government is not handing out their hands no more…they're not giving handouts no more. You know, you gotta take care of yourself more. More independent, by yourself…Yeah. It's tough. You notice that it's tough out there. You see other people's trouble, and other people are homeless, and start reflecting on your…you don't wanna go that…I don't know.

Juan went on to explain that harm reduction had "made him a better person," by "giving him a different outlook on life" – and "taking the pleasure away from drugs":

> Cause you can get needles and all that… It takes the, the…the cat chases the mouse, the mice…it takes the, the, the…game out of it. The government is giving you the needles…so it's not the hide-and-go-seek thing, you know, you're playing that game, it's, you know, it's out in the open. And it's not as…it's different. Before, you had to get the needles, and…used the same needles and clean them. I don't know. Now you go to here, and you pick up the needles, and it's not…cat and mouse game no more. I don't know. It takes the fun away.

In his responses, Juan spoke to another salient theme in both organizational and client discourses of harm reduction's efficacy, namely, its power to activate participant agency. Within Juan's account, harm reduction promoted client empowerment through a stark "reality check," teaching participants that they were solely responsible for their own welfare. Where Juan's appreciation of his "new outlook" seemed half-hearted, several other respondents – all peers – talked with reverence about the ways in which harm reduction had opened their eyes to possible achievement in the straight world. Ronnie, a long-time peer with an obvious attachment to the agency, pointed out that BHR had given him perhaps his only shot at white collar work within an economy that valued higher education. Explaining that the staff had taught him "that all the times [he] thought [he] was having fun, [he] wasn't," Ronnie likened the organization's tough love approach with that of stern, but caring parents. Another prominent peer who chaired the agency's Participant Advisory Board, Ronaldo, gushed with winking, if also sincere, gratitude for his subjective transformation at Bronx Harm Reduction:

> Oh yes. OK, yes. Now I get it. Yes, it has. Before, I thought I was a nobody. Really. I thought I couldn't do anything, I couldn't achieve anything. I couldn't do nothing. I couldn't help nobody, I couldn't help myself. And that's bullshit. Cause now I changed. I helped myself. I'm somebody, I'm doing something. I help other people. It has changed my own perspective, yes it has, my own insight. Oh yeah. Thumbs up for that. Yes. I can accomplish. I can do it.

Jack, who had been hired as a peer only one month prior, talked more seriously about his gradual transformation at the agency; his account acknowledges the power of both positive role models (such as Ronnie and Ronaldo) and tangible rewards (a weekly check.)

> Yeah, definitely. I used to be an everyday smoker, and by going to mental illness groups, uh, substance use…but mainly all the groups, helped me identify my…I'm really getting high, because…how you say it…put it this way: I have a problem. And so, you know, by staff running the groups, and you know, talking, and me hearing other clients saying…they was in my position, smoking every day, that was even worse. I seen 'em, what they accomplished, what they said they accomplished, so that made me look at myself. That could be me, you know, accomplishing things that I want to accomplish. So it helped me slow down from everyday. I may slip and go to maybe 3 times outta the month… I thank [Bronx Harm Reduction], because they gave me a peer worker shot. Now, I feel like part of society. You know? I'm getting a check. I got Social Security, but you know, a check from a job. You know?

Beyond asserting its *promotion* of self-efficacy, Jack's response confirms the power of harm reduction to *reduce* dependency - upon drugs, and upon public assistance. This was, in fact, not the first time Jack had boasted that his peer position had made him feel like a "productive" member of society, a role he equates with earning a paycheck, if a small one.[32]

[32] In requesting to be interviewed, both Jack and Ronaldo made implicit reference to the limited amount of their earnings ($100 per week). Approaching me for the interview, Jack reproached me for not telling him sooner that I was "giving out" Metros; noting with satisfaction that my $4.50 MetroCard incentives were sealed in plastic, Jack informed me that they could be sold for $3 at many bodegas. My final interviewee, Ronaldo ran up to the office to find me, eager to claim his spot. He joked that if I could do more interviews, he could happily pretend to be other people, and thus claim multiple incentives.

While invoking the importance of seeing other "accomplish," these peers also spoke to another mechanism or motivation for change experienced at BHR – one's confrontation with, and judgment of, others who were worse off, as determined by severity of illness or drug use, or simply smell and appearance. By acting as a frightening "funhouse" mirror of what he could become, Bronx Harm Reduction allegedly gave Ronnie the impetus to "be better," "dress better," and "smell better." Asked what drove him to seek such improvement, Ronnie replied: "Seeing everyone else that was doing less fortunate than me. And doing things that I wasn't even doing myself." Ronnie went on to note that his work as a peer kept him clean, as others' struggles to go straight forced him to constantly reflect upon his own trajectory:

> It keeps me from wanting to use. Every time I come to work, I look at the rest of the population, and I see the ones that struggling and the ones that just don't wanna change. Right, and then, I always reflect. I'm telling you, I always reflect about how I used to be, you know what I'm sayin'?

Ronaldo echoed this characterization of his peer work as an opportunity for reflection, which secured his continued abstinence:

> OK, the way I got clean? I got clean, because I came here and I started seeing people the way they were. I wasn't there *yet*. And I said I don't want to get like that. And the more I see them, the more it made me want to stop. That's what made me change. Coming in here dragging like zombies. I didn't want to get like that. Let me, you know, let me pull back. That's what made me stop. Watching these peoples. And I would reflect on that. Everytime I have a little thought or whatever, I'd reflect on that. I don't want to see myself like that. I just don't. That keeps me away. It's a good attitude…

While referencing his own past drug use, Ronaldo's comment rings with disdain for the "zombies" who patronized Bronx Harm Reduction. Indeed, he was not sparing in his judgment or occasional mockery of long-term clients who failed to make comparable progress, often chiding such individuals to try harder. Expecting other to match the discipline he saw in himself, Ronaldo enacted a hyper-vigilant style of risk reduction, described in the following section.

Reducing risk, producing selves: Participants perform harm reduction

In her 2006 ethnography, *Bodies at Risk,* Elizabeth Wheatley attempts to characterize different "styles of reskilling" that are produced among cardiac rehabilitation patients; more specifically, she tries to illuminate the ways in which her subjects "negotiate clinic directives, interpret expert claims, and fashion a way of living with heart disease" (Wheatley 2006: 93). The different reskilling styles identified therein are meant to reflect clients' varying acceptance of and investment in the discourses of risk and risk reduction that circulate in the clinical context. Like Wheatley's cardiac rehabilitation unit, it is possible to understand harm reduction as a context wherein "expert" recommendations (around safe injection or safe sex) are refracted through clients' sensibilities and personal agendas. In analyzing Bronx Harm Reduction as a site of governmentality, it is necessary to recognize its diverse manifestations within clients who occupy unique material positions and mindsets and subsequently enact different risk reduction styles or risk identities.

Drawing upon both interviews and field notes, this section will elaborate a typology of risk reduction styles observed at Bronx Harm Reduction. Like Wheatley's text, this section will focus upon the performative aspects of harm reduction in proposing several "ideal types" of client behavior, which should not be perceived as fixed or exhaustive. The styles of risk reduction, or risk identities, offered below are meant to showcase the ways in which harm reduction produces a multiplicity of subjectivities and practices related to drug use, which can be described as enthusiastic or evasive, "top-down" as well as "bottom-up." Unlike Wheatley's subjects, the participants of Bronx Harm Reduction enrolled at the agency for a wide range of reasons, not all of which were related to health; it cannot be doubted that most participants harbored multiple motivations in seeking services – motivations that further multiplied,

dwindled, or shifted over time. While referring to individuals within specific categories, this typology does not deny the fluidity of clients' roles and practices, nor definitively posit their status as "dominated" or "resistant."

Enthusiastic Emissaries of Risk Reduction – and Recovery

Individuals enacting a highly enthusiastic, tightly disciplined risk identity were typically peers, or peer aspirants. Exceeding (or inventing) their official work obligations, such participants were almost always present at Bronx Harm Reduction, arriving early, departing late, and volunteering weekends. Such individuals fully subscribed to organizational discourses of risk, and actively proclaimed their investment in staying healthy – by being tested or treated for HIV and Hepatitis, practicing safe sex, and eating well or keeping fit. While frequently instructing others in the importance of safer injection, these emissaries of harm reduction ironically advertised their own abstinence from illicit drug use, typically attributing their sobriety to Bronx Harm Reduction. Such participants endorsed needle exchange and other services at BHR as necessary and effective tools that would ideally protect clients *en route* to drug cessation; long-term clients who made little progress toward this goal were pitied, if not denounced by these enthusiasts. Interestingly, such individuals pointed to the superior social status claimed by "former users" (if still lifelong "addicts") compared to "responsible users," with many noting that abstinence was an undeniable, if unspoken, prerequisite for employment.

Ronnie and Ronaldo, the two veteran peers quoted in the previous sections, were obvious adherents to the disciplined risk identity, which resembled Wheatley's "ethic of exactitude." Both men had clearly gained a great deal through their devotion to the organization and its agenda – Ronnie commanded the authority, if not the salary, of a full-time employee, while

Ronaldo, as co-chair of the Participant Advisory Board, was perhaps the best-known man at Bronx Harm Reduction. Yet, another peer, Nancy, seemed on the verge of trumping both men's accomplishments through her zealous advocacy of harm reduction. Friendly, if serious, Nancy bragged that she had been clean since first setting foot inside BHR – an experience that further motivated her to acknowledge, and address, her HIV-positive status. Perpetually in motion, Nancy stressed that "[her] work in the community was never done"; to this end, she boasted of distributing condoms, if not syringes, to her friends, family, and neighbors in need. Near the end of my study, Nancy's willingness to promote the agency and its role in her personal transformation earned her a reward that remained remote to most other peers – white-collar work outside of Bronx Harm Reduction, namely, an apprenticeship at a non-profit radio station.

While Nancy and Roger claimed nearly a decade at the agency, other participants' enthusiasm showed signs of wear over time, if left unrewarded. Like Nancy, Beatrice was an indefatigable cheerleader for Bronx Harm Reduction when we first met in October 2010. Hired out of the Herizen peer training program, she fluttered around the agency in constant search of work, sometimes usurping other peers' assigned tasks. Humble, yet ambitious, Beatrice was vocal about her desire to ascend in the organization, a move that would allow her to return to school, and move out of her shelter. Nevertheless, Beatrice's primary investment in harm reduction hardly appeared financial; a frequent attendee of support groups, she was quick to chime in with facilitators on the importance of safe sex and safe shooting practices. Noting my preference for vegetarian food, Beatrice congratulated me on my "healthy" dietary patterns, and further, sought tips for food preparation and exercise that would help manage her diabetes. While continuing to display her discipline throughout the study period, Beatrice's enthusiasm for her work waned markedly in its final months, after being passed over for two "full-staff" positions

that ultimately went to outsiders. Increasingly tired and embittered, Beatrice joined a long-term peer, Jana, in her resigned attitude toward Bronx Harm Reduction. Often seen grimacing with efficiency, Jana was a stickler for procedure, and could be heard rebuking other peers for their negligence or laziness on numerous occasions. Yet Jana was visibly exhausted by her devotion to an agency that reimbursed her little; in whispered tones, she told me that she "didn't like to complain," but struggled to survive on $100 weekly, without Social Security Disability or food stamps.

Despite their frustration, Jana and Beatrice were loathe to give up much coveted peer positions, and even commiserated with those who desperately sought to join their ranks. Working hard yet getting nowhere, a handful of other clients attempted to demonstrate their discipline through unrelenting, and unsolicited, volunteer work. Jamie, a recent arrival to BHR and New York City, could be seen sweeping and mopping the drop-in throughout the day, only stopping to make a group; Genesis, an old-timer, tried to distinguish himself by loudly schooling other participants in the virtues of harm reduction. Ultimately, neither man was "called to serve" during my yearlong tenure at the agency, although their exasperation surfaced on multiple occasions. Where Jamie continued in his pursuit of peer work – ignoring some staff members' exhortations to look elsewhere – Genesis's voice steadily diminished in the drop-in, until he ceased to appear at the agency entirely.

Comedians of Risk Reduction

Standing in marked contrast to the quiet restraint of Jamie and Jana, a handful of male participants could be counted on to make light of the drop-in's persistent gloom. The agency's self-appointed jokers traversed a wide spectrum of irreverence; though many paid little attention

to the men's antics, it was possible to hear subtle points of pathos in some of their skits. In general, the clients who claimed a risk identity as class clowns appeared to ask, and expect, little of the organization; however, this is not to say that they were uniformly positioned in terms of risk, medical or socioeconomic. While roughly half of the group had its major materials needs met – receiving HIV-related rent subsidies and cash benefits – the others endured an assortment of problems that clearly exceeded BHR's capacity for aid.

Gene, who featured in this chapter's opening anecdote, was perhaps the most amicable, and least acerbic, of BHR's comedians. A client of many years who had found his apartment with the agency's assistance, Gene was typically a relaxed and smiling presence around the organization; by his own admission, he continued coming to Bronx Harm Reduction primarily for the company of others. On a particularly quiet day, Gene broke up the monotony of the drop-in by asking female participants for a dance. Lightly mocking my standing position against the wall, he eventually swung over to me, dancing absorbedly, as I stood frozen in position. As we became better acquainted, Gene would sometimes playfully interrupt my conversations with other male participants or staff members, acting like a jilted boyfriend. This prank eventually spawned an entire comedic routine performed by Gene and one of BHR's more flamboyant jokers, Brad. Like Gene, Brad was happy to relieve the dreary repetition of groups at his own expense, telling outlandish tales of his copping days to the amusement of staff and other clients alike. He also enacted a more playful, less militant style of harm reduction than those occupying the previous category in this typology. When departing BHR for the day, Brad frequently announced that he was leaving to "get his drink on" at home, thus flouting many peers' advocacy of total abstinence from intoxicants, legal and illegal. Volunteering an example of risk reduction practices in the group "Substance Use Management," Brad offered that he limited himself to beer

while drinking in public; he was allowed to proceed to hard liquor only once home, where could pass out comfortably.

Alcohol was the drug and comic prop of choice for two other participants who did not share the luxury of having an apartment in which to retire. If Ronaldo and Ronnie served as the beaming, enviable faces of Bronx Harm Reduction, Sammy and Abuelo were its most famous denizens. Typically un-showered, unshorn, and mildly intoxicated, these two men could be found in the drop-in most days, for the full duration of operating hours. Reassuring in their consistency, Sammy and Abuelo were targets of both scorn and sympathy, which followed from both men's advanced age, good humor, and pitiful condition. Abuelo, who sported a dense, gray beard, was clearly best known for his grizzled appearance. Quiet but watchful, he was also appreciated for his sly commentary and well-rehearsed deceits – such as sneaking sips of wine while "sleeping" in the drop-in, or slipping into groups just in time for Metrocard distribution. Abuelo perpetrated such ruses with a wink, easily relenting when caught; however, his wit could be more cutting. For example, at one Participant Advisory Board meeting, BHR's Executive Director Victor Rivera informed the group that they could register any comments or complaints by using the second-floor "suggestion box"; nodding with exaggerated approval, Abuelo quipped that a similar system was used in prisons for addressing inmate grievances.

Unlike Abuelo, Sammy rarely appeared in group settings, preferring to stand and talk in the drop-in. Given his rather off-putting appearance, he managed to engage clients and staff alike through self-deprecating jokes; any female passing by was sure to be met with a marriage proposal, or a courtesy spritz of air deodorizer – a reference to his own smell of unwash. Sammy was also quick to mock his preference for malt-alcohol, specifically large 16-ounce cans of "Cobra." Asked whether he would attend the group "Drugz and Behavior," he protested, "I don't

do drugs. Maybe if it were called '*Cobras* and Behavior.'" Disclaiming illicit drug use and HIV-negative, Sammy didn't qualify for any particular services at Bronx Harm Reduction, yet his levity made it easy for staff to brush him aside as a harmless nuisance. In fact, Sammy might have been more noticeable in his absences; hospitalized for alcohol poisoning that rendered him comatose, he received daily visits from several staff members until returning months later to the agency.

BHR's Disciplined Deviants

Where Abuelo offered the occasional coded critique of Bronx Harm Reduction, other participants approached risk reduction as an ongoing exercise in reflexivity and debate. Such individuals were quick to qualify staff members' – and other clients' – pronouncements around drug use, risk, and health. This is not to label such individuals as naysayers of harm reduction at large; on the contrary, these "disciplined deviants" openly embraced risk reduction as a site of both bodily reform and personal development. Such participants viewed harm reduction as an opportunity for empowerment via education and exploration – of different ideas, practices, or health and social service providers. In thus recognizing harm reduction to be an intensely individualized project, these participants were uneasy with expert discourses around risk, particularly those that contradicted their own experience.

All of the individuals considered in this category harbored aspirations of employment at BHR or similar organizations, and several were selected to serve as peers. While less confrontational with full-time employees, peers workers such as Yvette, Laura, and Isaac reserved the right to follow their own, sometimes heretic, risk reduction regimes. Laura, who defined her "drug of choice" as alcohol, spoke openly of her history of heavy drinking. Though

Laura reported that she had since cut back sharply on her alcohol consumption, she continued to enjoy a daily glass of wine or gin and tonic; she also made little effort to hide her occasional indulgence with marijuana. For Laura, continued, moderate use of these substances was unproblematic – an opinion out of line with those of most peers, and many staff, who spoke of total abstinence as the ideal.

Yvette and Isaac too noted that they enjoyed drinking, though only on weekends, and in limited quantities. As peers, however, these two individuals were more likely to upstage other staff members than to contradict their recommendations. As illustrated in the description of one Overdose Prevention group, Isaac was eager to share his learning with other clients, ultimately earning his own weekly group on buprenorphine. Perpetually seen with notebook in hand, Isaac prepared extensively for each week's meeting, indeed, more so than many staff members. Attending the first session of a case manager's new group, "Methadone Myths," Isaac almost immediately hijacked the discussion, taking it upon himself to preemptively address participants' misconceptions. Yvette too was known to rapidly assume leadership of groups she was ostensibly attending as a client. During a different meeting of the above group, Yvette asked the moderator's permission to tell the group about the "real" (presumably sublimated) history of methadone maintenance. She proceeded to narrate an insidious origin story for methadone as a Nazi-developed means of euthanasia, ultimately warning the group of the drug's "known" toxicity.[33] Just as she condemned one method of harm reduction in general, Yvette was also

[33] The multiplicity of (critical) histories around methadone was undoubtedly the inspiration for the group "Methadone Myths," whose moderator tentatively supported methadone and other forms of opiate maintenance. The version related by Yvette was often repeated, with different variations. While diverging from official histories of the drug, this alternative account of methadone does serve to reveal many clients' deep distrust of a government-sponsored rehabilitation program that was arguably instituted to reduce the criminal activity of heroin users (Musto 1999: 249).

willing to offer Bronx Harm Reduction polite criticism in particular. At one Participant Advisory Board meeting, Yvette took issue with the organization's disciplinary procedures, which appeared to function rather arbitrarily for many clients. While remarking that she herself could never discharge an individual from the program, she offered that termination often occurred as a result of client ignorance, not intransigence, toward the rules. In addressing this knowledge gap, Yvette suggested that clients should be informed of the agency's most important mandates orally, as many might be unable to read the rules flashing across the drop-in television.

Despite her candidness, Yvette was on good terms with many employees at BHR, and was even chosen to feature in the organization's 2011 Annual Report; by contrast, more outspoken critics experienced turbulent relationships with staff, who perceived their input as disruptive, or shrugged off their challenges as ill-informed. Dave, who featured prominently in this chapter's introduction, consistently contested employees' assertions in groups, and bore the label of a troublemaker in turn. Though rarely mean-spirited, Dave's combative stance seemed to belie a distrust of expertise, if not an irritation with authority. In the context of another overdose prevention training, Dave faced off against Dennis, a nurse practitioner whose credentials Dave quickly dismissed. While Dennis maintained the necessity of using a sterile mouth guard in performing CPR, Dave waved off his advice as unrealistic and thus inapplicable to real overdose situations, positing that rescuers might instead breathe through their t-shirts if so inclined. Dennis persisted, pointing out that a t-shirt would become too wet to function as an effective filter, yet Dave refused to back down. Though the discussion proceeded, Dave waved off the remainder of the lesson, muttering "we know, we know," with every "new" piece of information. Rather than functioning as a pure contrarian, Dave actively sought a role in the organization he so often critiqued, applying for a peer position and running for co-chair of the PAB. Denied both, he

nevertheless remained a frequent attendee at BHR, until being terminated unceremoniously in the winter of 2011, after attempting to intervene in an argument in the drop-in.

Discipline Dodgers

Individuals in the previous category were unreserved in their suspicions of expert discourses of risk; at the same time, these participants immersed themselves within their own self-imposed regimes of harm reduction. Such subjects did not so much reject the gaze of power, as engage and attempt to refocus it, embracing modified practices of bodily restraint. By contrast, the individuals I've characterized as "Discipline Dodgers" found agency in the evasion of BHR's behavior-molding techniques – while simultaneously fulfilling one of harm reduction's most-invoked participant roles, the "hard-to-reach" drug user. Individuals here considered might have visited BHR on a daily, weekly, or monthly basis; they might have enrolled in multiple voluntary services, or simply sat in the drop-in dozing. Regardless of the frequency or depth of their participation, such clients sought to avoid staff attempts at surveillance and control. By declining to confess, or stubbornly stating the "wrong answer," these participants performed resistant risk identities while on stage at Bronx Harm Reduction.[34]

Where some may balk at silence as a style of risk reduction, a participant's consistent refusal to speak indeed constituted a notable pattern at Bronx Harm Reduction, where exhortations for information abounded. Here I refer less to those who remained reserved out of inattention, than to participants who stood impervious to specific solicitations to speak.

[34] I here describe individuals who "refused confession" or described their drug use outside of the accepted discourses of risk reduction. This focus on speech (or silence) derives from the fact that participants' drug use behaviors were not in fact on display at BHR. Other forms of deviance, such as the hustling described in Chapter Four, may be understood as another form of "discipline dodging," though in fact, such practices were not necessarily an indicator of an individual's investment in harm reduction.

Accompanied more often by a polite smile than a stony stare, a client's muteness was not typically perceived as openly antagonistic act. While some staff members would press on after an initial rebuffing, most would relent, with an expression of mild befuddlement, if resisted after two or three attempts at rephrasing; a mild chastisement might reference the agency's sizable Spanish-speaking population, joking, "I bet you'll speak English when I hand out the Metrocards." Participants' reasons for reticence were no doubt diverse. While some clients expressed wariness about "everyone knowing their business," others appeared specifically discomfited by the incitement to discourse, refusing requests to narrativize their drug use or risk experience. This was particularly apparent within Safety Counts, which encouraged all participants to write or record their personal "success story" of risk reduction (and later, read it aloud at social events or graduation.) As one form of mandated deliverables to the program's funders, success stories were a hard sell for staff. Where most clients ultimately bowed under the pressure to "tell their story," a steadily reluctant few managed to escape the record.

Among those who did produce success stories, a small group sought to evade the disciplining of the narrative itself. Rejecting a standard story arc from problematic drug use to gradual abstinence (by way of harm reduction), these individuals instead wrote stories that declined the language of regret and humility, in favor of excitement, nostalgia, anger, or indifference. They further gave little credit to Bronx Harm Reduction or other organizations in discussing what progress they had made vis-à-vis their drug use. Relating his past work as a "hit for hire", Robert's story noted with pride that "[he] was good at what he did," concluding that "[he]'d do it again, if he had to." He further attributed his declining drug use to the birth of his children, closing sharply with "with kids on the way, the action had to cease." Another participant's story began with the statement that he could never get clean in New York, a place

he so deeply associated with drug use. While ostensibly relating his attempts to go sober outside of the Bronx, George's account instead focused on his drug-related love affairs in different cities, and concluded with a botched robbery – in which his partner went to jail. Asked if he'd like to amend his story to encompass his current success at staying abstinent, George smilingly demurred.

Most Likely to Drop Out: BHR's Frustrated Fringe

As noted in the introduction to this typology, participants at BHR likely enacted multiple risk identities over the course of their risk reduction careers. Several client interviewees in fact described the shifts in subjectivity they experienced while enrolled at the agency, morphing from disinterested drug users to increasingly enthusiastic abstainers; for most, this transition was accompanied, assisted, and perhaps cemented by the receipt of an apartment (with the aid of BHR) and a job (working at BHR). Of course, not all motivated participants were offered employment or eligible for housing. Such slighted individuals might retain their discipline, while surrendering their optimism or ambition; despite their disenchantment, Jana and Beatrice plugged on with their peer duties, if unsmilingly. Lacking the economic incentive to stay silent, others embraced their growing frustration and sought to voice their anger. Such individuals openly questioned the logic of harm reduction when it failed to help them transform their lives, locating their continued problems in a fractured and impersonal system of public assistance. Ironically, these clients were often dismissed or loudly rebuked by staff members and other participants, who located their lack of improvement in a poor attitude or inadequate effort. Thus reinforced, depression or anger appeared to define a terminal risk identity for some participants.

Mario, an "old-timer" in both age and duration of enrollment at BHR, was less a target of scorn than utter exasperation by staff and clients alike. Entirely earnest in his desperation, he was eager to explain his sorrows at a slow, painstaking pace that quickly tested the patience of his listeners. Mario suffered a host of health problems, from diabetes to depression and self-diagnosed dementia, conditions he partially attributed to his maintenance on methadone for over forty years. Yet, despite these ailments, he could not qualify for subsidized housing, a "reward" reserved for individuals with severe mental illness or symptomatic HIV disease. Often appearing on the verge of tears, Mario continuously solicited help for his predicament, repeating his story to persons already thus acquainted. If allowed to speak in groups, Mario was often shut down after a few minutes, if not chastised for wasting too much time. Perhaps on account of his age, Mario was permitted to voice his despair at small intervals, although little encouragement or advice was offered in return.

Comparatively young and more openly resentful, Danny was more likely to receive harsh feedback from staff members in particular. Danny was generally a quiet, if mournful, presence in the drop-in, yet would occasionally voice his troubles in group – to little consolation. After another participant related his success in obtaining an apartment, Danny followed up bitterly, noting that he had never received housing assistance in his three years at Bronx Harm Reduction. The moderator first confirmed that Danny was a "white card" (HIV-negative participant), before proceeding to admonish him for his lack of initiative. Exhorting Danny to "advocate for himself" more effectively, the moderator recommended that he ask another staff member to connect him to another agency that helped HIV-negative individuals with housing. On another occasion, Danny asked a different staff member if he could talk to the group about his current depression, which had lead him to contemplate suicide. The moderator quickly identified suicide as a sign of

personal weakness, informing Danny that if he was strong enough to stop using drugs, he should be strong enough to get past his depression. Backing down, Danny quickly rescinded his request for support, and sat through the rest of the group in silence.

While eligible for much desired housing help, HIV-positive individuals too expressed frustration with the pace of services and perceived "red tape" that limited their access to case managers. After failing to find an apartment after several months, some clients became bogged down by doubt, sometimes questioning the sincerity of their workers' efforts. Others simply became worn down by the sheer amount of footwork involved in finally getting situated, which required the coordinated consent of landlords, Bronx Harm Reduction, and the city's HIV/AIDS Service Administration (HASA). Many participants passed the limbo between shelter and apartment in one of HASA's "emergency" hotels – SROs notorious for low levels of regulation and high rates of crime. The indignity of occupying an SRO, where residents received few services in return for little privacy, chafed against many clients who realized their dubious "risk reduction" value. Such was the case with Bernadette, a transgender participant who complained of constant harassment and disrespect from other occupants of her SRO. Calling the office one afternoon, she raged about being thrown out of the hotel she so detested, convinced that her complaints had triggered her eviction. Unsure of how to proceed, I offered to connect Bernadette to her case manager, receiving in curt response, "I don't deal with administration, managers, social workers, HASA workers." Bernadette went on to explain that she was "fed up" with not only the "corrupt individuals" who ran SROs, but also with the bureaucracy of HIV services. Again refuting my timid offer to send over a worker from BHR, Bernadette yelled hoarsely, "No. Send an activist. Send an activist." Her qualification was in fact irrelevant; after rushing down to the first-floor offices I was quickly informed that nobody was willing to meet her.

Conclusion

As cautioned in the introduction to this chapter, the risk identities sketched above, which describe different clients' performance of and investment in harm reduction, are far from fixed, exhaustive, or determinate of individuals' every action at the organization. Nevertheless, this typology was intended to showcase the essential *productivity* of harm reduction as an ambiguous technology of power. In addition to spawning distinct regimes of self-care (or defiant neglect) that extended outside its doors, Bronx Harm Reduction encouraged participants to forge new understandings of drug use, disease status, and their relationship to identity. For a select few, "positive" harm reduction risk identities were further underwritten by the material and social support that attached to peer work, or eligibility for HASA benefits.

Such support not only rewarded, but also helped to shape many clients' risk reduction "success stories" – by influencing their attitude and openness toward harm reduction, and further, providing them with a clear incentive (and baseline stability) to address their drug- or health-related risk. Indeed, in accounting for the diverse ways in which individuals "did harm reduction" in this study, it is necessary to first acknowledge that Bronx Harm Reduction operated upon its client population asymmetrically. Much like the peer selection process, clients' adoption of different risk identities hinged upon more than individuals' personalities and so-called "readiness to change"; specific programmatic factors, like staff "style" and composition, and broader structural factors, such as the lack of assistance for HIV-negative clients, were undoubtedly influential as well. The following and final chapter will continue to ponder risk identity as a reflection of not only different clients' uneven investment in harm reduction, but harm reduction's uneven investment in different clients. Employing biopolitical theory from Michel Foucault to Nikolas Rose, the conclusion will maintain that while the state retains in

interest in cultivating the health of its population, this interest operates inequitably, resulting in policies that allow a few to thrive, and many to merely survive.

Chapter VI
Conclusion: The Neoliberal Biopolitics of Harm Reduction

In my first month at Bronx Harm Reduction, I frequently stayed several hours beyond the official working day, in the hopes of talking to participants with less interference from wary or suspicious staff. Yet, these late nights afforded as much unguarded access to employees pulling the second shift or simply playing catch-up on their paperwork. Leo was one such staffer, a part-time maintenance man charged with fixing lights and cleaning floors. A former client who had progressed beyond peer work, he took extreme pride in his trade, picked up during a longer prison bid. Leo spared little effort in fulfilling his duties, however circumscribed; he claimed to regularly spend 14 hours sweeping, mopping, and waxing the floors, squeaking with discontent when scuffmarks inevitably began to reappear. Naturally, I only learned of these Herculean efforts after slipping out of the administrative offices late one evening, onto newly buffed and gleaming linoleum.

While catching an earful on that particular occasion, I developed a quick rapport with Leo, who would often usher me out of the building in those early weeks. One balmy Wednesday in late September, we leaned against the building's service entrance as Leo told me about growing up in Washington Heights, a largely Dominican neighborhood just across the river in upper Manhattan. Laughing at my bland characterization of the Heights as "nice and quiet," he denigrated his childhood home as a "drug-infested" ghetto in the 1980s, if not still today. Despite this grim label, Leo's tone was nostalgic as he described wandering through the neighborhood's parks and commuter rail tracks, and taking cocaine for the first time at age 13 at a local club. Leo noted that he was quickly addicted to the drug from that time forward, staying up for days, if not weeks, at a time. While recounting drug use as a common pastime in his circle of friends, Leo

added that it was not long before he suffered the consequences of his habit, becoming infected with HIV by age 14.

Twenty-five years later, Leo attributed his continued health to the power of positive thinking – and the beneficence of the city's HIV/AIDS Service Administration (HASA). Declaring that "stress is what kills people," he claimed that the government provided HIV-positive residents with subsidized housing, cash benefits, and free medical care as a means of keeping them relatively worry-free, and thus healthy. I joked that Leo seemed to be actively *seeking out* stress, given his penchant for working overtime, and laboring exhaustively on floors that would only be smudged by morning. Shrugging, he explained that he stayed at work only because he had nothing to do at home; his apartment, though large and free, was remote and empty. Besides offering him a daily sense of accomplishment (if modest wages), Leo's job was an opportunity to socialize and make friends.

Rattling off the highlights of his resume, Leo inserted that BHR was not his first employer in the world of harm reduction. In fact, he had previously held several positions in the field, once ascending to management of a transitional housing facility nearly a decade before. Leo's tenure at that job, as with many others, had ended with his re-incarceration on drug charges. Laughing at his past foibles, Leo waved me off to the subway, quipping that our conversation would soon attract police attention - in his experience, "blanquitas in the ghetto" always brought trouble. The next time I spoke to Leo was nearly a week later by phone, when he called the agency to say that he'd been locked up, caught while copping. Though several days absent as a result, Leo returned in early October and reclaimed his ownership of the floors; nevertheless, his job security seemed tenuous. Encountering Ronaldo, the ascendant peer, mopping the floors two weeks later, I asserted playfully that he was doing Leo's work. Ronaldo

explained with a wry smile that Leo was no longer an employee at Bronx Harm Reduction. Jailed three times in as many weeks for drug possession, he had finally been let go.

His legs studded with track marks as thick as measles, Leo's drug use appeared an open secret at the agency. Likely as a direct consequence, Leo lacked favor with BHR's new Administrative Director, but enjoyed a close relationship with the head of Human Resources – another former client who fought to save his friend's job. Others, such as Ronaldo, openly cheered Leo's dismissal, perhaps perceiving some hubris in his situation. Indeed, for many peers and clients, Leo occupied an enviable position. Handsome and affable to boot, he enjoyed two major privileges rarely afforded an active drug user: regular work and stable housing. Despite their ready proclamation of twelve-step ideology, such fundamental necessities eluded many disciplined veterans of the organization; among those constantly shuttling between shelters and sofas, Leo's receipt of an apartment might have been especially galling.

Upon claiming symptomatic HIV disease, Leo became a beneficiary of limited state support, which effectively ignored his extra-legal activities. Indeed, by his aforementioned logic, HASA, a program financed by New York State's Department of Health, aimed solely to keep HIV-positive individuals healthy, regardless of their past or present misdeeds. Of course, as demonstrated by both Leo and others, HASA assistance alone could not entirely assuage recipients' stress. Where Leo earned regular wages in maintenance, most clients struggled to obtain stipend work as peers – positions that not only supplemented their monthly $350 in cash benefits, but also provided them a means of spending their days. An excess of time was a problem lamented still by those with jobs, who often found themselves isolated within the peripheral neighborhoods that accommodated HASA housing. Yet Leo's story highlighted the biggest vulnerability faced by even BHR's most "well-off" participants: the cyclical arrest and

imprisonment of illegal drug users, a problem that linked HIV-positive and –negative clients alike.

This chapter will attempt to make sense of the post-welfare state's uneven investment within the different "high-need" – or "high-risk" – populations who utilized Bronx Harm Reduction, and needle exchanges services more generally in New York. As noted in the above anecdote, and indeed, throughout prior chapters of this dissertation, HIV-infected clients at BHR were able to access many life-saving amenities from the state and city governments as a result of their disease status; at the same time, other participants presenting with equally severe health (and socioeconomic) problems remained ineligible for housing, financial, and sometimes basic medical assistance.[35] This chapter will suggest that from the perspective of day-to-day, material survival, clients infected with HIV were perhaps better off than their "healthy" peers.

In parsing this close coexistence between state investment, and state abandonment, I will utilize the Foucauldian concepts of biopolitics and biopower, and their elaboration by later inheritors such as Nicholas Rose, João Biehl, and Craig Willse. Where some such authors have declared the demise of biopower alongside that of the providential state, this chapter will posit that an examination of harm reduction may yield the contours of a neoliberal biopolitics. which aims less to maximize health than to minimize cost. An exploration of neoliberal biopower may further illuminate the experiential limitations of emergency state-funded services (such as needle exchange, or HASA benefits) when unaccompanied by a simultaneous expansion of civil and political rights for recipients, who further remain excluded from the service-oriented economy of

[35] Technically, only individuals diagnosed with "symptomatic" HIV-illness qualified for HASA assistance in New York – that is, in addition to a positive HIV serostatus, eligible persons must have received a diagnosis of a recognized opportunistic infection associated with HIV/AIDS. With the assistance of a well-informed social worker, most individuals meeting the income restrictions stipulated by HASA were able to acquire such a diagnosis from a doctor.

late capitalism. Thus noting the ways in which harm reduction serves to triage, but not challenge, the structural conditions that underwrite drug use and other HIV-risk behaviors, this chapter will close by suggesting not only the proximate coexistence, but further the direct overlap, of state investment in, and abandonment of, illicit drug users.

Making live and letting die: Understanding biopower, past and present

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. In the first volume of his tripartite *History of Sexuality*, Michel Foucault (1990) coined the term "biopower" to describe a new modality of power, emergent in the 18th century, which took life itself as its target. Biopower is here further broken down into two forms, or poles, which often work in concert: an anatomo-politics of the human body, and a biopolitics of population, representing disciplinary and regulatory modes of power, respectively. 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: 139). Foucault writes biopolitics not as a variety of political theory, but rather as a cache of "mechanisms, techniques, and technologies" that problematize, monitor, and seek to affect population-level phenomena (Foucault 2002: 241). 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 arose in the late-18th century and seemingly culminates under the 20th-century providential, and at times eugenic, state. Yet given the centrifugal forces associated with the neoliberalization of governance at the beginning of the 21st century, it has been argued that the biopolitical age of population has given way to an ethopolitical age of self-care. Writing under the banner of the post-genomic era, Nikolas Rose (2006) has claimed that the state is no longer concerned with the "quality" or health of populations as a whole, but has rather devolved responsibility to the individual, who is implicated within pastoral forms of "soft" power. In Rose's account, the neoliberal state operates under a distinct and different rationality of governance, which no longer seeks to discipline bodies or regulate populations; instead, it endeavors to encourage a new ethical relationship between individuals and their biology through diffuse methods of public education and consumer incentives.

Perhaps proclaiming the contemporary co-ocurrance of bio- and ethopolitics, this dissertation has argued that harm reduction may function as both technology of domination and technology of the self. On the one hand, needle exchange – a state-funded and regulated program – seems to clearly reflect ongoing governmental interest in the practices of individual bodies. Utilizing literature and guidelines officially disseminated by public agencies such as state health departments, needle exchange programs overtly attempt to promote a safe/r or correct means of consuming illicit drugs. To this end, "classic" disciplinary tactics such as surveillance, confession, and examination are deployed against participants, who are continuously exhorted to change their behavior, and thus lower their risk. Yet, the very concept of needle exchange points to its identity as a form of "discipline lite"; indeed, its foundation recounts the limitations (and cost) of more rigidly disciplinary institutions such as prison and abstinence-based drug treatment,

which aim to stop, not shape, individuals' drug use. Guaranteeing basic services to all – even the most unrepentant – of substance users, needle exchange removes the punitive sting and explicit judgment associated with the public services of the welfare state. Linked by the continuing public health emergency of HIV/AIDS, all clients are deemed "deserving" of at least minimal assistance.

The continued framing of HIV/AIDS as largescale emergency, in need of state-directed securitization, further points to ongoing governmental interest in the "quality of populations." More generally, 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 avian and swine 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 national security and economic growth (Garrett 2005; Piot et al. 2001). 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. In rebuttal to Rose's fatal pronouncement, I propose that needle exchange hosts an interaction between anatamo-political and biopolitical power, wherein the fitness of the larger population is willfully engineered through the instruction, manipulation, and surveillance of problematic bodies.[36] In the words of one New York City Council member supporting the installation of new NEPs, "HIV/AIDS is a "terrible scourge that must be confronted. It benefits everyone if the program succeeds" (Kaiser Health News 2004).

[36] In New York State, harm reduction is in fact partly monitored by the Department of Health's "Special Population Management Unit."

Yet, Rose's work may also anticipate the unique thrust of a neoliberal biopolitics. Where the providential state of past rooted welfare services within a paternalistic logic of care, stipulating public responsibility for the ill and unfortunate, neoliberal state services abide by a wholly new principle: to cut costs through strategic, "evidence-based" programming. This imperative further follows macroeconomic changes within the urban contexts most associated with public assistance; with the decline of the industrial economy in inner cities, the state may be less interested in maximizing such populations' labor market utility, and more concerned with minimizing their drain on government coffers. In determining the technologies favored by new biopolitical state, cost-benefit ratios reign supreme, and thus, the appeal of needle exchange and other harm reduction programs comes into sharp relief. The institutionalization of illicit drug users, within prisons, hospitals, or other publicly-funded treatment facilities has been shown to be spectacularly cost-inefficient, producing poor data at a high price (Stevens 2011). While failing to quell the problem of illicit drug use, such programs may do little to stem the spread of HIV/AIDS – or even provide more fertile conditions for an endemic outbreak.[37] By contrast, harm reduction advocates inside and outside the government have long trumpeted the financial logic of strategies such as needle exchange, methadone maintenance, and supervised injection. Pleading the establishment of a new NEP, the former New York City Health Commissioner argued: "If it prevented two infections, it would pay for itself. Operating a syringe exchange program would cost $150,000 to $200,000 annually, compared to the cost of treating one person with AIDS, $150,000 in New York City" (Paybarah 2004).[38]

[37] Such rigid and often inhumane methods of dealing with illicit drug use may also generate an unacceptable *political* cost within an era more attuned to discourses of human rights – and patients' rights.

[38] While I here cite state supporters of needle exchange, it should be noted that grassroots advocates have also long used economic arguments to advance their cause. Subsequent sections

"People can survive addiction, but they can't survive AIDS": Making breaks among IDUs

Spoken by one of New York City's first syringe exchange agitators, Yolanda Serrano, the above quote reflects early activists' attempts to align harm reduction with the more mainstream campaign against HIV/AIDS. Here, Serrano justifies a strategy that swerves from the drug policy status quo – allowing users to attain services without mandating abstinence – by asserting AIDS to represent a more pressing threat to the public's health than drug addiction. As discussed in Chapter Two, this argument indeed carried the day for syringe exchange, allowing its institutionalization as an evidence-endorsed means of disease prevention, and its development into a primary site of HIV-related services for drug users. Yet, this prioritization of HIV/AIDS among the diverse medical and social needs of active drug users has arguably led to long-term consequences unimagined by Serrano, who herself died barely one year after the legalization of syringe exchange in New York. Where harm reduction has become almost wholly identified with the cause of HIV/AIDS, HIV-positive users have become eligible for a diverse range of life-saving services typically denied to their more "healthy" counterparts.

In making sense of this seemingly arbitrary disparity in service provision, it may be helpful to return to the ideas of biopolitics outlined above. While introducing the concepts of biopower and biopolitics to a wide readership in his introductory *History of Sexuality*, Foucault further elaborated these terms in his 1975-76 lecture series at the Collège de France, posthumously published in the collection *Society Must Be Defended* (2002). Here, Foucault identifies Nazi-era Germany as perhaps the culmination of the 20th century biopolitical state – a seemingly irresolvable conundrum, giving the Third Reich's murderous purges against its own population. Developing a unique, if not iconoclastic, definition of state racism, the philosopher

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of this chapter will consider the potential consequences of discourses that frame needle exchange as an expedient solution to a costly problem.

explains that a government's interest in the vitality of its population does not imply a commitment to the health of each subgroup or individual; instead, the continued existence of certain members of the national corpus may be seen as undermining the population's potential. Foucault acknowledges that the genocide undertaken by Hitler's state is a particularly extreme (if wholly rational) application of biopower, yet maintains that state racism persists through less spectacular, more passive policies that "let die" (Foucault 2002: 256.) In seeking to maximize the public health within fixed budgets, modern states continue to "make breaks" or de/prioritize certain subsets of their populations – decisions that typically disadvantage already marginalized populations like injection drug users. Craig Willse's recent definition of biopolitics as a "political economic analysis of population" is particularly resonant here, and may further assist in understanding the prioritization of HIV/AIDS within neoliberal health policies (Willse 2011: 157).

One explanation might assert the relatively diverse cross-section of the population affected by HIV/AIDS, as compared with a similarly severe disease suffered mainly by injection drug users, Hepatitis C. While needle exchange and other harm reduction technologies retain their social significance as HIV-preventive technologies, injection drug users constitute an increasingly slim proportion of new HIV infections in the United States; from a high of nearly 50% in the late 1980s, IDUs were estimated to represent only 9% of newly diagnosed cases of HIV/AIDS in 2009 (Centers for Disease Control and Prevention 2008; Wejnert et al. 2012).[39] Throughout the entire duration of the American epidemic, HIV has shown a strong correlation with poverty and (ethnic, sexual) minority status, yet the disease garnished popular attention – and extensive government funding – through the grassroots advocacy efforts of its more middle

[39] Undoubtedly, this steep decline in part reflects the efficacy of syringe exchange and other harm reduction techniques.

class "victims" and their allies. As noted earlier, groups like ACT-UP and Gay Men's Health Crisis mobilized their political, social, and economic capital in the early phases of the HIV crisis, changing the disease from a stigmatized secret to a cause célèbre (Stoler 1997). Faced with a rising clamor to acknowledge and address the need for policies effecting HIV prevention, education, and treatment, the abandonment of HIV-infected and at-risk individuals might have precipitated a catastrophic loss of public sympathy for politicians.

Where MSM-led activism might have signaled the political price of ignoring HIV/AIDS, the ultimate adoption of policies that "make live" were likely also driven by the threat of economic costs. The provision of free medical care, housing, and even cash assistance undoubtedly works to promote the health of HIV-positive persons who would otherwise be homeless, hungry, and vulnerable to opportunistic infection. Given already astronomical rates of "inappropriate" ER usage among injection drug users, the increased burden of emergency admissions for HIV-infected individuals would represent an intolerable drain on hospital budgets and/or Medicaid. Johnny, a case manager at Bronx Harm Reduction so rationalized the state financing of HASA housing:

> Uh…so my understanding is that…the way it's designed is, by housing them stably, you know, by giving them stable housing, then they're gonna be, uh, they have an easier time stabilizing the health, stabilizing mental health, stabilizing substance abuse, if, if, it's present or not. So the contract was designed to save Medicaid really. Keep somebody off the streets, out of the ER, we save millions of dollars in Medicaid. So they grant that fund for, for the programs to run a housing program.

Indeed, the economic rationale for subsidized HIV/AIDS housing hardly remains mere postulate; the retention of "rent caps" for individuals in HASA housing has survived an era of sharp budgets cuts due to its prevention of long-term housing instability and increased ER usage (Fader 2011).

Of course, ER admissions remain frustratingly high among users who do not qualify for HASA benefits, a point made by the New York City Health Department during a special onsite presentation at Bronx Harm Reduction. Such data was hardly a surprise to many employees who noted a similarity in some participants' utilization of the drop-in, and the local hospital ER that lay just across the street. Discussing BHR's primary function as "safe space" for its large homeless clientele, the same employee quoted above reflected on the existence of "two class" system at the agency – a product of the asymmetrical benefits appointed to HIV-positive and – negative individuals by the state. Johnny described BHR's HIV-positive clients – or "red cards" – as the "service set," participants who mainly visited the agency to see their case manager, and thus access discrete services on an appointment basis. By contrast, the clients who occupied the drop-in nearly all day, everyday, were "white cards". While noting a vacuum of specific services for such individuals, Johnny further postulated their likely futility in the absence of housing options:

> I think we have a set of chronically homeless individuals, that have mental issues, cognitive issues, and then that's, that's the set that, there's no strategic plan for. Those are the ones that need the mental illness services, the ones that need the DHS application, the NY-NY application, I mean, of course they have substance abuse issues, but those are individuals that are chronically homeless. It's hard to get them to stop using drugs. It's almost impossible, unless you properly house them. And get them to stabilize their mental health issues.

In this quote, Johnny refers to two housing program run by New York City's Department of Homeless Services (DHS) that were available to HIV-negative clients (in addition to its traditional shelter system); offering a miniscule number of apartments to an ever growing population of individuals in need, such programs were a frequent topic of bitter conversation among clients, who recognized them as merely another guise for effective abandonment.

By the numbers, there was in fact very little left for homeless participants who lacked a "diagnosis." Another case manager, Nell, explained to a group largely composed of shelter residents that the city offered a mere 488 apartments to chronically homeless individuals who were neither HIV-positive, nor mentally ill. She went on to describe one other program accessible to the assembled clients, at least in theory: the Mayor's Advantage program, which provided time-delimited rent subsidies for market rate housing, expecting beneficiaries to sharply increase their earned income in the interim.[40] While independent housing thus remained out of reach for most BHR clients in need, even emergency placement in shelters had become precarious. Referencing newly installed eligibility restrictions, participants in the same group complained that they had been thrown out of the shelter system, following the state's determination that a nearby relative possessed space in his/her apartment. In the words of one disgusted participant, the city would consider any friend or family member with a place responsible for housing their homeless relations, with little regard for their demonstrated willingness. Like the inhabitants of João Biehl's Vita, such participants witnessed the state's progressive divestment of responsibility for the homeless, and its cynical invocation of families that only existed on paper. In turn, Bronx Harm Reduction filled in the places where public and private support had dissolved.

Biological life and social death: Assessing harm reduction's complex politics

In *Vita*, João Biehl (2005) explores the *ad hoc* treatment facility cum general human repository from which the book derives its name – little more than a ramshackle squat near the center of Porto Alegre, Brazil. Forced into existence by economic policies that shed the

[40] Subsidies granted under the Mayor's Advantage program officially ended in March 2012.

terminally ill, old, and impoverished from state institutions, Vita is darkly portrayed as a waiting room for death, which few could hope to escape. As at Bronx Harm Reduction, subtle gradations of privilege, or prognosis, divided the camp into a so-called "infirmary" and "recovery area," with denizens of the latter section afforded (limited) hope for progress. Yet despite the "selective life extension" enjoyed by some, Biehl maintains that all Vita's patients had been condemned to social death, their lives effectively deprived of political meaning in a nation undergoing structural adjustment.

Like Vita, Bronx Harm Reduction arose as a grassroots refuge for individuals living at the limits, if not in the cracks, of an otherwise thriving city. Enjoying modest economic (though little moral) support from the state, BHR was surely a less grim establishment than Biehl's field site – cleaner and brighter in terms of both space and organizational atmosphere, which had become insistently optimistic with the change in administration. New programs such as Safety Counts sought to motivate even the most "hardcore users'" self-transformation, while simply sitting in the drop-in was increasingly framed as an act of offensive passivity. However, for many, if not most participants, an oppressive reality endured: there was truly little to do and nowhere to go. Unhoused and unemployed clients quickly tired of running around to secure public assistance that didn't exist, while their more well-off counterparts often found their lives similarly circumscribed; as demonstrated by Leo, the benefits enjoyed by clients "with a diagnosis" served to perpetuate their lives, but not integrate them into the broader society.

This final section will explore the shortcomings of harm reduction as a strategy that ultimately endeavors toward the economic management of unproductive, and often infectious, bodies. To be clear, I am not arguing against such programs' stated imperative to "save lives;" instead, I would like to consider how they function within a larger society that systematically

places such lives at risk. While failing to address a system that forces individuals into the social and economic margins, it also facilitates policies that banish them to the urban periphery. As hinted at in Chapter Two, harm reduction further rests upon discourses of risk that may stigmatize its clientele – and in the long-term, undermine its own survival. Much like the individuals they serve, harm reduction initiatives in the US are in a perpetually precarious situation; arguably, this permanent state of emergency experienced by workers and clients alike derives from an over-reliance on economic and security, not political and moral, rationale.

Previous sections of this dissertation have illuminated Bronx Harm Reduction's near monomaniacal focus on the biomedical risks faced by clients. While addressing injection drug use as primarily a problem of individual and public health, BHR did little to assuage participants' principal complaint (and risk factor): poverty. Of course, as noted in Chapter Four's discussion of clients' "geography of survival," there was perhaps little the agency could do to challenge the complex economic forces that had disadvantaged many clients since birth. Nevertheless, I would like to here consider how harm reduction not only abides, but further enables the economic and urban policies that steer clients through their doors – an argument first made by Craig Willse (2011) in his analysis of Housing First.[41] Willse write that such "harm reduction"-style programs for chronic homelessness function both to reduce costs for the state and to generate profit for private entrepreneurs; the latter occurs through the clearance of homeless individuals from high value spaces in gentrifying inner cities, and additionally, the invention of self-perpetuating not-for-profit industries.

[41] As the name suggests, Housing First programs offer the long-term homeless immediate shelter (as available), with little or no eligibility requirements. Given its "low-threshold" service mandate, Housing First is often compared to harm reduction programs for drug use.

Without suggesting the conscious complicity of its staffers (or direct overlords), both such arguments may be applied and even extended in the case of harm reduction. The concentration of programs such as Bronx Harm Reduction on the urban fringe in part follows the topography of injection drug use in New York City; at the same time, the exclusive construction of new and relocation of old programs to the outer reaches of its five boroughs testifies to the appreciation of property on the interior. Where the heart of needle exchange in New York City previously sat in Manhattan's Lower East Side – once gritty, now glitzy – the weight of such programs has decidedly shifted to Upper Manhattan, the South Bronx and East New York (Brooklyn). At the time of writing, several uptown Manhattan agencies were considering further moves north, as rental rates in neighborhoods such as East Harlem and even Mott Haven crept higher as well. In a city experiencing seemingly endless gains in real estate value, harm reduction thus serves a two-fold function of containment.[42] While the drop-in constitutes a welcome refuge for homeless users stuck on the street, it furthers removes such individuals from the blocks and parks they might otherwise blight.

In maintaining users at the edge of the city, harm reduction programs prevent their infiltration of its thriving center; similarly, by progressively increasing the qualifications attached to its staff positions, such programs – or rather, their regulators – inhibit users' integration into the regular economy. Though often decried by employees, harm reduction has arguably become co-extensive with the so-called "non-profit industrial complex" – a white-collar service sector

[42] Other researchers have made this point with reference to another harm reduction technology, safe injection facilities (SIFs). For example, Fischer et al. (2004) posits the significant installation of an SIF pursuant to Vancouver's successful bid to host the winter Olympics in 2010. The authors note that SIFs may be read as concealing an ugly problem and population within an area that would soon draw millions of tourists (and which was further experiencing an influx of young, creative professionals.)

that does little to stem the social problems at its foundation.[43] Employees' desire to "work themselves out of a job" was a frequent refrain at Bronx Harm Reduction, yet this eventuality was most likely to be fulfilled by budget cuts and/or the loss of state contracts. In Willse's words, harm reduction has shifted from a "social program" to an "economic industry", which sustains jobs by sustaining the pathologies it ostensibly seeks to allay (Willse 2011: 168-169). Here, I would add to Willse's account that this new service industry disproportionately benefits "credentialed" individuals, who hold college or advanced graduate degrees. In this way, harm reduction perpetuates existing mechanisms of economic exclusion within the communities it allegedly serves.

The transformation of harm reduction into economic industry may have consequences at the discursive level as well. Contemporary harm reduction programs have secured their mandate by framing injection drug use as an individual medical problem with economic repercussions for the (tax-paying) public. On the one hand, this representation effectively suppresses alternative understandings of drug use as an issue rooted within economic inequality and racial subjugation, best redressed through policies seeking social justice and the redistribution of wealth. Additionally, this depiction indirectly portrays illicit drug users as a costly, and perhaps dangerous, public burden, whose bad habits should be engaged proactively to avoid long-term financial drains upon law-abiding citizens. Indeed, such an understanding of IDUs and the condemnation it engenders can be seen within harm reduction clients themselves. Near the end of my tenure at BHR, a man I had never met pulled me aside to chat, excited to share his recent receipt of an apartment from HASA. The man, Jerry, interrupted his animated account to indicate

[43] In an interview with the ACT-UP Oral History Project, New York City syringe exchange pioneer Donald Grove lamented the institutionalization of harm reduction within the "non-profit industrial complex" (Grove 2010).

another participant across the way, slouched and dirty. He commented scornfully that the man "want(ed) people to pity for him," but that he wasn't deserving of their concern. Where Jerry saw himself as prudently using the state's investment to improve his health and kick his habit, he accused his foil of impudently wasting others' time and money. Guessing that the man was probably selling his HIV medications in order to fund his drug habit, Jerry moralized, "You can't care about a person who doesn't care about themselves."

In the long term, harm reduction "as we know it" may trigger its own extinction through overreliance upon arguments that emphasize economic rationality. As rates of HIV infection continue to fall among injection drug users - and treatment becomes perceived as an easier form of prophylaxis - there is perhaps a foreseeable future in which stand-alone harm reduction programs will no longer be deemed cost effective. Services such as needle exchange may be discretized and divorced from drop-in settings, and relocated to more traditional medical venues like hospitals. In turn, the extensive "off-label" benefits experienced by clients at BHR will be lost, forcing them to seek new quasi-legal spaces of survival – perhaps like Vita. Having grown accustomed to continuous waves of disinvestment, participants themselves often postulated that the state wouldn't keep paying forever. Sitting in the drop-in one day, I encountered a new client named August who pitched me several ideas for screenplays he wanted to write. Billed as a "thriller", his first movie narrated a government plan to segregate all people with diseases, namely HIV/AIDS, on a militarized island that prevented escape. Asked to elucidate the reasoning behind this plan, August explained that it was conceived as an effective means of stopping public subsidies for AIDS prevention, treatment, and care. Allowed to die off, such individuals would no longer encumber the state or threaten the public health. At the time, August's as-yet-unwritten script reminded me of an old poster opposing the legalization of

syringe exchange in early-1990s New York. Bemoaning their depletion of both public funds and community morale, the flyer lamented, “When will all the junkies die so we can go on living?” (Anderson 1990: 1512).

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