# CHEMICAL INTENT: IMAGINING THE DRUG USING CLIENT AND THE HUMAN SERVICE WORKER IN HARM MINIMISATION POLICY

Submitted by

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**Statement of Authorship and Sources**

This thesis contains no material published elsewhere or extracted in whole or in part from a thesis by which I have qualified for or been awarded another degree or diploma. No other person's work has been used without due acknowledgement in the main text of the thesis. The thesis has not been submitted for the award of any degree or diploma in any other tertiary institution. All research procedures reported in the thesis received the approval of the relevant Ethics/Safety committees.

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**Abstract**

This thesis is based on an Australian Research Council funded research grant. Fifty-one qualitative interviews were conducted with human service workers to gain an understanding of their interpretations of their clients' 'drug problems' and of their own role, the service system and wider policies. Although harm minimisation has been Australia's official drug policy since 1985, little is known about how harm minimisation is 'enacted' in the helping culture. To date human service workers have not been recognised in their constitutive role in harm minimisation discourse. Whilst a significant part of drug policy interventions are delivered via human services, the helping subject has not come under scrutiny. The drug using subject remains ill-conceived as a result of neglecting its partnering others or indeed its overlapping with other subject positions. Moving beyond recognising workers only in terms of staff opinions and attitudes, a relational and multi-level approach is adopted to introduce more complexity into the debate.

After a brief historic discussion of the creation of the 'human service worker' and the 'drug user' (as client) and methodological considerations about discourse analysis, the thesis proceeds with the introduction of a conceptual framework consisting of four levels: the individual, relational, institutional and cultural political economic level. These levels are used to examine the existing literature on 'drug problem factories' and for the analysis of the data. By focusing on these levels the critical analysis of the interview material shows that 'harm' and 'minimising' are themselves contested categories and that different harms and different harm producing and minimising practices can be identified some of which have come into discourse, others are excluded or entirely absent. The human service workers struggle to make sense of their own role and to define how drug users are being 'helped' and could or should be helped. Their understanding of harm minimisation discourse aligns with, supports and/or resists other discourses such as (neo)liberalism, neoconservatism, prohibition and economic rationalism. The workers are portrayed as having substituted increasing complexity for initial simplicity in the course of working with 'drug users'.

In summary, this thesis offers a poststructuralist analysis of how harm minimisation is constituted, negotiated and undermined from the perspective of human service workers and shows how the service systems' *helping cultures* enrol human service workers in harm producing and harm minimising practices. Harm minimisation consists of discursive and non-discursive elements and is a product of deliberate social forces as well as messy contingencies and unintended consequences.

**Acknowledgements**

My parents' intellectual arguments helped me to become curious about this world. Living with David, my husband, has given me the courage and strength to ask *my* questions. David and Sophia, my daughter, have been a constant source of support, inspiration, laughter and love, without them I could not have written this PhD. David's patience and his dedication to Sophia when I was busy have made a huge difference. My family and my friends in Berlin and in Melbourne have given me much emotional and practical support which I appreciate enormously.

In the PhD journey I was not looking for comfort but stability in movement, not seeking answers but embarrassment by asking seemingly obvious questions and confronting my own ignorance. This wish was promptly fulfilled in 2003 when the interviewed workers (whom I thank for their time and sharing of their experiences) and my newly born daughter Sophia showed me on a daily basis just how ignorant I was and still am. I am sure the next addition to the family will do equally well.

My PhD community consisted primarily of Anna (whose friendship made the PhD journey a shared one), Daniela (who was always just an Email away from supporting me), Dr Grazyna Zajdow and Dr Mandy Leveratt, both of whom generously offered to read the first draft of the thesis and who are real scholars, and my supervisors Assoc Prof Ruth Webber who always supported my candidature with the university and has given me valuable teaching and research experience and Dr Jacques Boulet whose infectious academic spirit, cross-cultural insights, intellectual generosity, commitment and trust kept me going through the ups and downs of thesis writing, and I thank him for doing so much work. Last but not least the Borderlands postgraduate discussion group, the online community of PhD students as well as other befriended (ex) PhD candidates all showed me how much fun communal learning is and shared the concrete dream of making a difference in this world.

With love and admiration, this thesis is dedicated to my grandparents.

WARNING: Parts of this thesis have been written under the influence of caffeine, Keflor, Paracetamol, Pseudoephedrine, pregnancy hormones and vitamins, herbal teas, cacao, sugar as well as various spices.

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# Introduction

## Locating the social and drug policy intersection

> *A person who feels himself predestined to observe rather than to believe finds all believers too noisy and insistent: he fends them off. (Friedrich Nietzsche)*

At first, I shared Nietzsche's sentiment and identified with its characterisation of *noisy believers*, but I later thought that believing in a cause and observing the real contradictions are not mutually exclusive. I can reconcile being simultaneously 'believer' and 'observer', but it undoubtedly represents a juggling act of a lifetime. It is with this in mind that I have written this thesis: I have tried to observe what harm minimisation meant to people, in documents, budgets and talk.

In daily usage and government documentation, 'harm minimisation' has often stood for the Australian drug policy approach and its policy[1] mix of demand, supply and harm reduction[2], whereas 'harm reduction' has been identified with a set of principles and most commonly with particular drug interventions,[3] such as needle and syringe programs, methadone or other pharmacotherapy substitution and supervised injecting rooms.[4]

Hamilton and Rumbold (based on Erickson et al 1997) summarise the conceptual and practical underpinnings of harm minimisation, asserting that harm minimisation is a 'humane and pragmatic' (2004, p. 143) approach:

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[1] There has only quite recently been an admission for the need to study drug policy in more complex and integrated ways (Ritter, Bammer, Hamilton, Mazerolle & The DPMP Team 2007).

[2] '*Harm minimisation does not condone drug use, rather it refers to policies and programs aimed at reducing drug-related harm. It aims to improve health, social and economic outcomes for both the community and the individual, and encompasses a wide range of approaches, including abstinence-oriented strategies. Australia's harm-minimisation strategy focuses on both licit and illicit drugs and includes preventing anticipated harm and reducing actual harm. Harm minimisation is consistent with a comprehensive approach to drug-related harm, involving a balance between demand reduction, supply reduction and harm reduction strategies*.' (Ministerial Council on Drug Strategy, 2004, p. 2)

[3] Ritter & Cameron's review of harm reduction identified the following harm reduction interventions: '*Needle syringe programs (NSP), outreach, education and information (aimed at harm reduction not use reduction), non-injecting routes of administration, brief interventions (aimed at harm reduction not use reduction), overdose prevention interventions, legislation and other (tolerance zones, pill testing)*.' (2005, p. 4) The Alcohol Use Disorders Identification Test (AUDIT) and many other instruments to measure drug and alcohol intake and levels of use for diagnostic purposes are constantly updated.

[4] Darke, Degenhardt and Mattick report that injecting drug users accept such facilities (i.e. they use them) but their efficacy and impact on overdose fatalities remain disputed (2007, p. 124).

> a value-neutral view of drug use; a value-neutral view of users; a focus on problems or harmful consequences resulting from use; an acceptance that abstinence is irrelevant; a belief that the user has, and should continue to have, an active role in making choices and taking action about their own drug use […] seeks to maximise those strategies that lead to harm reduction; supports pragmatic programs that can be eclectic and flexible; incorporates any scheme that will assist in net harm reduction; aims to be user-centred, by including users in planning; emphasizes choices, by taking account of the users' own interests and the responsibilities they retain in their societal context. (2004, p. 136)

The effectiveness of harm reduction[5], abstinence and harm minimisation programs remains a site of contestation and harm minimisation policy is not consistently applied or fully implemented across Australia's states and territories (Lennings 2000). Hepatitis C infection rates have not been brought under control, particularly in injecting drug use and prison settings[6]. Zajdow, in fact, argues the stemming of the Human Immunodeficiency Virus (HIV) infection rate is the only success of harm minimisation to date:

> Indeed, the very low rate of HIV infections among injecting drug users (IDUs) because of the early introduction of needle and syringe exchanges was the signal for the wider introduction of harm minimization into Australia. However, this was really the only clear and outstanding success. (2005a, p. 193)

Harm minimisation has received much critical scholarly attention in the last few years; Crosbie argued that it simply represents a nice set of principles and motherhood statements covering up struggles and contradictions manifesting themselves in practical and policy settings (2000). Miller critiqued it for being a middle-class paradigm, more concerned with the welfare and protection of the (middle-class) public than with drug users themselves (2001). Zajdow has urged us to reflect more on the underlying assumptions of harm reduction programs, on the assertion that scientific and political claims-making are entirely different and on harm reduction's long term 'management' of the 'addict' (2004a, p. 80). Heather Brook has reasoned that the management of family troubles in a no-fault divorce environment could serve as an example of

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[5] Ritter and Cameron argue that the evidence base for adopting harm reduction programs is more developed for illicit drug than for licit drug interventions (2006).

[6] '*The total number of people living with hepatitis C will continue to increase while treatment levels and general awareness of the behaviours which place people at risk remain low […] People who inject drugs are at greatest risk of contracting hepatitis C. Approximately 80% of current infections and 90% of new infections are estimated to be due to unsafe injecting drug use practices ii. In 1997 it was estimated that 100,000 Australians regularly inject drugs, with an additional 175,000 involved in occasional injecting without dependence or social disruption. Hepatitis C continued to be reported at high levels in 2003 among attendees at NSPs, with prevalence rates of 57 per cent for males and 61 per cent for females […] It has been estimated, however, that hepatitis C prevalence is in the range of 30 to 40% for all prisoners, and between 50 to 70% for female prisoners xvi. This indicates that hepatitis C prevalence in custodial settings is much greater than the prevalence of approximately 1% found in the general community*.' (Department of Health and Ageing 2005, p. 5-6)

how to manage drug troubles, moving it from criminal to civil proceedings (2002) – a pertinent suggestion, given the Howard Government's preference to let *families* address drug problems.

The welfare and social policy debates have been equally vigorous in the last decades worldwide; the '*Washington Consensus*' has imposed new welfare regimes, based on senior public management agreeing on some '*ingredients*' for good social policy, including the imposition of fiscal discipline, tax reforms to increase economic participation, public investment and expenditure into areas which are economically productive and the deregulation of labour markets (Pierson C 2007, p. 180). The advent of the '*new public management*', based on public choice theory, sums up the regulatory and organisational framework in which human service workers operate:

> A belief in the superiority of the market and therefore an attempt to introduce markets and quasi-markets into the public sector; the notion that organizations should be flexible and responsive rather than hierarchical; decentralization and the de-layering of decision-making, with the disaggregation of government into agencies; the use of performance indicators and output targets as mechanisms for the creation of incentives for more effective work practices; a focus on efficiency; management by results and a much greater emphasis on the role of managers and their freedom to make decisions; the use of new technology; an increased role for audit. (Pierson C 2007, p. 181)

Meanwhile, the political-economy of the welfare state had elements of welfare expansion and,welfare contraction, culminating in welfare *recalibration* (Pierson C 2007, p. 171ff). Depending on the different populations, welfare regimes have worked in conjunction with tax and policy decision-making to disadvantage some and advantage others.

In the following, I treat and investigate harm minimisation as a set of *discourses* and *practices*, trying to probe their very assumptions within a context that has been neglected to date[7]: *the helping culture and its dealings within harm minimisation policy*. With this intention I interviewed fifty-one human service workers working in so-called non-drug related community services agencies, such as emergency relief, youth residential, homelessness, family/domestic violence, family support and legal services[8]. The workers' views and experiences working with

[7] I only know of one Australian study explicitly interested in human service worker and harm minimisation (Lambert & Marsh 1999), all other studies seem to be more interested in service provision, workforce development and staff attitudes towards drug users (see Chapter Three).

[8] Bell conducted a literature review of adolescent drug service provision and found that the overwhelming majority of studies concentrated on epidemiological, diagnostic or intervention questions, missing were multi-disciplinary, multidimensional perspectives, instead studies '*tended to be atomistic, focusing on a particular element of service delivery*' (2007, p. 98).

'drug using clients' painted a much more complex picture and one that showed how drug and social policy intersect.[9]

In this thesis I argue that to date human service workers have not been recognised in their constitutive role in harm minimisation discourse. Whilst a significant part of drug policy interventions are delivered via human services, the helping subject has not come under scrutiny. The drug using subject remains ill-conceived as a result of neglecting its partnering others or indeed its overlapping with other subject positions. By identifying governing mentalities and rationalities, this thesis presents various and contradictory discursive constructions and practices in drug and human service settings based on the above-mentioned interview study with workers. Moving beyond recognising workers only in terms of staff opinions and attitudes, a relational and multi-level approach can introduce more complexity into the debate.

For this purpose, I will pose the following research question:

***Which practices and discourses constitute the drug user and the human service worker, particularly in the service relationship, in the drug welfare service system, in the 'war on drugs' and harm minimisation and how do these discourses and practices change within the helping culture?***

There are six chapters; the First Chapter unfolds the historical journey to achieve drug user and human service worker *subject positions* and the Second Chapter offers an extensive discussion of the epistemological, ontological and methodological assumptions and the use of discourse analysis when researching and interpreting data.

In the Third Chapter, I outline a conceptual-theoretical framework, consisting of a four level approach: the individual, relational, institutional and political-economic level. They are not only delineated by their *theoretical* sources but also used to provide illustrations of how they are and can be applied. The chapter deals with the achievement of harm minimisation as a national policy and reviews the literature as read through the levels-lens.

Chapter Four, Five and Six are the data chapters and continue to use the conceptual framework when critically discussing interview findings. Throughout the data chapters, I will juxtapose the literature with the findings from my interviews. According to the levels, Chapter Four investigates the individual and relational levels of the worker-client relationship, Chapter

[9] For published discussions of the findings refer to Campbell (2006a, 2006b, 2007).

Five reasons with the institutional level and Chapter Six summarises the discussions of previous chapters, challenging the political-economic level dynamics of the worker-client interaction. The last part concludes the thesis and summarises the arguments.

Through the prism of human service workers' narratives who work at the intersection of alcohol/drug and social policy we will encounter ***chemical intent*** at all levels: in individual's desire to intoxicate, in people's relationships with drugs as medication, remedy and spiritual source and in drug using relationships (having a beer, a smoke, partying with 'e' etc), in federal, state and local governments' policies and industries making p-*harm*-acotherapies and drug-related goods and services available, in government's taxation of legalised drugs and prohibition induced black markets for illegalised drugs.

# Chapter one

## ‘Drug users’ and those who ‘made’ them: a brief historic account

This chapter introduces the users of substances; whilst traversing familiar historical and contemporary territory, it questions the very notion of ‘drug users’ and the social logic behind identifying them as such. Each section chronologically and reflectively problematises the ‘drug user’ subject position and demonstrates how it was achieved and produced in a historically contingent manner through the interplay of various societal interests. Although written chronologically, there is no suggestion that the chosen units of time constitute a coherent logic or ‘order’. Whilst the ‘human service worker’ – the other ‘subject position’ investigated in this thesis - is recognised as one of those involved in the ‘creation’ or ‘making’ of the ‘drug user’, the main emphasis is on the historical creation of the latter in Victoria, Australia, the locus of this research.

I realise that writing ‘a history’ in chapter form is a difficult proposition because such brief account cannot possibly encompass nor express the complex processes that have taken place in constituting the human service worker and the drug using client. I have nonetheless decided to offer this account in chronological form so as to historicise these two subject positions and to start the historical discussion we are yet to have and to illustrate the following point: It is only by speaking about drug use and by addressing a drug user that we constitute them – together with tools (e.g. drug use equipment), institutions (e.g. drug services or regulating regimes), behaviours (e.g. discriminating or stigmatising) etc. Similarly, problematised drug use does not precede its treatment (or other interventions), drug treatment generates its content in the problematisation of drug use and of the drug user (in particular ways). In other words I am drawing on the Foucauldian insight that the (drug using and human service working) subjects can only be conceived of in the historically and currently operating knowledge systems and the power/knowledge nexus that have generated them (Foucault 2002a).

## Knowing the 'drug user' and the 'human service worker' today

I introduce the subject positions of 'human service worker' and 'drug user' as we 'know' them at present, hoping to de-familiarise readers with their taken-for-granted identities and, by discussing problems of definition, preparing the ground for a historical journey.

### The 'human service worker'

Whilst largely taken for granted, the '*human service worker*' appears - at least - as a six-fold construction: s/he is an employee, representative of an organisation, representative of the State, executer of statutory regulations (duty of care), professional equipped with a body of knowledge and a person with a particular set of life experiences and interpretations (of her/his role). Professions cannot be treated as 'fixed' givens; they come into existence (sometimes cease to exist) at a certain time, develop codes of ethics and boundaries to other professions, claim propriety over particular and unique kinds, ways and 'sections' of knowing and intervening. Contemporary professions and scientific disciplines operate in a competitive context and (re-) align and expand their 'knowledge territories' constantly in regard to each other and the wider environment they operate in.

I use the term 'human service worker' as a generalised expression of the 'helping professions' and, therefore, more broadly than within the strict 'professional' boundaries other authors apply. This umbrella term includes social workers, community development workers, community or welfare workers, youth workers, etc. The term is even used generically for someone working in a human service organisation, which could then apply to lawyers, psychologists, counsellors, mental health professionals, drug and alcohol workers, etc. – all worker-subject positions grouped along a continuum of para-, semi- and professional statuses and institutionally vying for dominance and expertise. When referring to *social work* throughout the thesis, I take this profession to be symptomatic and exemplary for significant trends within human service work more generally, agreeing with Jones and May that some distinctions between occupational groups are 'increasingly difficult to sustain.' (1992, p. 13).

Many professions have attempted to establish – especially in their literatures - why they have the 'right' knowledge to be involved in decision making about and the surveillance of drug

problems or why they at least ought to play a major part in it, from the policy 'bureaucrat' and auditors to psychiatrists, psychologists, clinicians and social workers '*who occupy strategic locations in the social world, and who are living thesauri of spontaneous knowledge about its functioning*' (Bourdieu & Wacquant 1992, p. 201). The professions can be seen as discursive projects, protecting the security and survival of the domain of specialisation of their adherents as their main endeavour (in fact, professional associations often act like unions); discourses and professions are interdependent, the latter usually considered the products and effects of discourses.

Being beyond the scope of this thesis, suffice it to say that different human service work and drug treatment discourses constitute (professional) *relationships* and imagine themselves to operate through these. The '*relational*' always requires at least two discursive parties: for the purposes of instituted and instituting discourses, no 'drug user' exists as a client without a counterpart, often the 'human service worker' but also the police woman, medical professional or lawyer. Both are temporal-spatial (situated) constructions, in that their relationship is temporary, often very short-lived (governed by how social service programs are imagined – through funding, regulations, policies, procedures, service paradigms, etc.), taking place in a particular setting (streets, offices, home visits, courts, etc.) and framed by the organisational, institutional and legal conditions or contexts of the time.

**The 'drug user'**

Who can classify drug users? Who identifies her- or himself as a drug user? Who is classified as a drug user? Who do we *imagine* as 'the drug user'? The barrister's 'performance enhancing' drugs, the 'professional' swallowing MDMA or ice (methamphetamine) at a party, the mother of five taking Valium, the hash-smoking academic, the amphetamine-using truck driver, the diazepam-using pilot, the alcoholic Vietnam veteran, the homeless 'addict' – all invoke entirely different images, responses and all are stereotypes.

Throughout this thesis, I use the notion of *situated context*, capturing not only the context of a particular social encounter but its *ongoing* qualities: situations are snapshots of processes and relationships. The different time/space intersections matter, because we live in situations and we generate practices that are 'appropriate' for these situations. When Fitzroy Legal Service (2004) issued a service directory for 'drug users' and wrote on its cover page that the directory would be '*free to users*', the phrase automatically evokes an inventory of social meanings associated with

'the drug user'. *Obtaining a free manual because one is a drug user* beautifully illustrates the meaning of a 'situated context'; finding the appropriate 'situated context' to be identified as a drug user would involve sending people with different dress styles, ages, genders, ethnicities, etc. to bookshops to try and obtain the manual for free and discover 'which' drug user is *imagined* by the respective bookshops' sales personnel. What would an inventory of potential social markers of 'the drug user' look like in such bookshop encounters? Would my chances of not having to pay increase if I wore shabby clothes? If I were older or younger? If my skin looked bad? If I used different words or slurred? If I were rude? Would I have to show my veins? What – if anything – would I have to *do*, *say* or *appeal to* in order to be recognised as a '*drug user*'? If I asserted that I was a drug user, would they believe me? Would they demand proof and, if so, what could I use as 'evidence' of being a drug user? Would I have to do anything at all to invoke or conform to the 'drug user' imagery or would my social recognition as a drug user depend on the discretion of bookshop sales personnel? If we studied or staged such encounters, we would discover the social logic – the '*logic of practice*' (Bourdieu 1990) – and the '*situated context*' of the varying contemporary uses of 'drug user'.

This entire inventory would be useless and socially meaningless, however, if there were no subject position named '*the drug user*': a person who uses drugs. Arguably, the social *practice* of taking drugs is socio-culturally and social-politically *translated* into a subject position, named '*the drug user*'. Discourses could not operate and compete to define the drug user if no 'drug user' subject position would exist. This is why discourses - first - constitute the drug user subject position and - subsequently - rely on his/her existence to constitute claims about him/her, thereby shaping and reshaping different drug user identities. We can only think about how we ethically approach the 'drug user' if there *is* a drug user, we can only think about making laws 'for' him/her if there *is* a drug user, we cannot think of drug user organisations if there were no drug users, etc.

Throughout this thesis I identify the '*drug user*' as someone who uses substances, legal or illegal; however, given the type of data I collected, I do *not* specifically talk about the '*average*' person who uses drugs; an '*average*' person who is not 'dependent' and gives up or reduces drug use as s/he sees fit and does not come in contact with the service system (including treatment), a person who has (more) money and would prefer or seek service provision in the private sector does *not* belong in my purview. Human service workers work in particular places - community (welfare) agencies - and *therefore* often encounter 'drug-users-made-clients' who may experience some kind of hardship, temporary difficulty or who are, at least, problematised in some way,

shape or form and/or do not have the means to escape this problematisation. Whilst we cannot and should not generalise the 'drug user' as a 'poor' person in any circumstance, we can safely assume that people who use emergency relief, financial counselling, public housing or residential care services, etc. are not well-off.

**Writing an historical account of the drug user**

I will study how we have come to speak about particular people as 'drug users' and why these understandings necessarily changed over time through the genesis and history of Australian - and especially Victorian - drug '*problems*'[10]. The history of the '*drug using client*' in Victoria, or indeed Australia, has not yet been written and neither oral nor archival research has been published to-date. This chapter will, therefore, necessarily remain brief, a sketching and a signposting of a historiographic task still ahead.

History should not be understood as a logically coherent periodization of emerging and established regulations and rationalities, but rather as a not-inevitable process, an interpenetration of random, contingent and necessary factors, engendering various possibilities and involving human acting or agency. History also leaves us with a set of *sedimented* meanings that overlap, contradict and co-exist – as Valverde suggests – a '*piling up of rationalities of governance on top of one another, rather than a shift from one to another*' (1998, p. 177).

Since time immemorial, people have used plants as drugs and as problem solvers, the Greek *pharmakos* signifying *both* poison *and* remedy. Just how intertwined the fashions of drug

[10] In the following I am drawing on Foucauldian insights into historicity and problematisation. He asserts: '*Problematization doesn't mean representation of a pre-existing object, nor the creation by discourse of an object that doesn't exist. It is the totality of discursive or non-discursive practices that introduces something into the play of true and false and constitutes it an object for thought (whether in the form of moral reflection, scientific knowledge, political analysis, etc.).*' (Foucault 1988, p. 257) Foucault has argued that '*a profound historicity penetrates into the heart of things, isolates and defines them in their own coherence, imposes upon them the forms of order implied by the continuity of time*' (1973, p. xxiii). An important addition to a historicised approach is the thinking of 'layering simultaneity', as Jan Blommaert points out when he defines: '*we have to conceive of discourse as subject to* layered simultaneity. *It occurs in a real-time, synchronic event, but it is simultaneously encapsulated in several layers of historicity, some of which are within the grasp of the participants while others remain invisible but are nevertheless present. It is overdetermined, so to speak, by sometimes conflicting influences from different levels of historical context. The different layers are important: not everything in this form of overdetermination is of the same order; there are important differences between the different levels and degrees of historicity.*' (2005, p. 130-131 his emphasis) For example, the struggle of harm reduction – as a social movement – to keep services drug user-focused is co-occuring with the public health dominated harm minimisation – as a policy approach – to manage the drug user. These two elements of policy action overlap and inform each other but both vary substantially in different spheres of influence and are interpreted differently within policy texts and actions. I will take this up further in Chapter Three.

use were with various historical forms of empire, economy, trade and government is documented by Wolfgang Schivelbusch (1992). An historical investigation of drug use practices must entail an understanding of the differences between pre-modern, pre-industrial, early- and late-modern use and portray it as an intensely social and inter-subjective activity, influenced by time, place, culture and socio-political-economic context.

The *Merriam-Webster's Collegiate Dictionary* (1995) offers a superficial, yet useful illustration through the various words which were used to imagine the co-existence and eventual intersection of (antecedents of) human service work and drug use before and after the respective subject positions had been constituted as we now know them. Words or notions our (Western) public imaginary gained over time to describe drug use and (possible) welfare interventions include:

> charity, medicine and liquor (13th century), welfare, reform(ing), drug, abstinence, narcotic and prohibition (14th century), policy, intoxication, drunkard, habituation and almoner (15th century), aetiology (1555), treatment (1560), tobacco (1565), disability (1580), addiction and smoker (1599), philanthropy (1623), hubble-bubble (1634) [hookah 1763, chillum 1781, roach 1848, bong 1971], pharmacy (1651), psychology (1653), rum (1654), alcohol (1672), overdose (1700), police (1716), stimulant (1728), withdrawal (1749), intolerance (1765), patent medicine (1770), inebriate (ca. 1796), tranquilizer (1800), drugstore (1810), cigarette (1835), therapy and psychiatry (1846), alcoholism (1860), institutionalisation (1865), pharmaceutical (1881), morphinism (1882), casework (1886), urinalysis and doping (1889), alcoholic and social work (1890), social psychology (1891), hypodermic syringe (1893), detoxification (ca. 1905), police dog (1908), addict and pharmacotherapy (ca. 1909), cold turkey (1921), junkie and psychopathic personality (1923), nonuser and therapeutic index (1926), welfare state (1941), deviance (1944), methadone (1947), policy science, miracle drug and neuropharmacology (1950), prescription drug (1951), stoned (1952), de-institutionalisation (1955), parenting (1958), drugmaker (1964), timed-release (1966), druggie (1967), workfare (1968), orphan drug (1981), substance abuse (1982), designer drug (1983), co-dependency (1987).

One could, therefore, be thought of as *intoxicated* in the 15th century but not as *detoxified* until the beginning at the 20th century. The list does, of course, not imply that the notions have been applied with congruent or consistent meanings over the years and centuries, but it does suggest that they signify ways of thinking about intervention in human lives and are connected in multifarious ways.

When did drug use of any kind start to be considered as something needing 'identifying', 'treating', 'curing', 'servicing' or 'intervening' into? Obviously, the idiosyncrasies of quackery, alchemy or the centuries-old traditions of informal drug treatment and intoxication – whilst interesting – will not be discussed here; rather, my interest is *in how the drug user was 'made'* –

particularly, made a *client*? It can be reasonably suggested that, as soon as the first charities, reform societies and poor boxes were set up, 'drug users' received *help*, turning them into '*clients*'; the notion of the client as someone receiving *assessment*, *assistance* and *treatment* for drug use related '*conditions*' developed more slowly, as I shall show.

The following sections outline an historical journey illustrating how the 'drug user' was subjected to various cycles and conceptions of treatment *and* of welfare provision which had rather more to do with the politico-social fashions of the day than with his/her 'nominal' drug use or drug 'conditions'; in a sense, talking about *the drug users' historical march through the institutions* would more accurately describe the nature of the trajectory. That 'drug users' *learn to become* 'drug users' (learning/career model of drug use) was established by Howard S. Becker's pioneering work (1963), but my aim here is to '*de-centre*' the drug user *by showing how the different institutions and discourses imagined the drug user*. Indeed, it is more instructive to think of 'drug users' as *having been constituted differently* throughout history, rather than – more conventionally – having been *interpreted* differently, the latter unwittingly assuming the *a priori* of the drug user, a *given* to be simply *described* differently.

**Escaping institutions: The pre-modern drug user**

Drug use on the Australian island did not commence with invasion and colonisation; evidence dating back to the early 17th century shows Aborigines obtaining and using drugs '*during seasonal contact with Macassan seamen*' (Hunter 1994, p. 58); furthermore:

> There is good evidence that Aborigines harvested, prepared and ingested various mood-modifying substances made from naturally occurring flora. These included the potent indigenous tobaccos (*Nicotiniana* species), the psychoactive drug pituri (made from dried and macerated leaves of *Duboisia hopwoodii*), and stupefying beverages. Aboriginals are believed to have prepared and drunk intoxicating beverages; the sap of the "cider tree", *Eucalyptus gunnii*, in Tasmania was said to make people intoxicated. Bauhinia blossom and wild honey in northern parts of Australia, the soaked cones of the *Xanthorrhoea* (black boy trees or grass trees) in south-western Western Australia and of the corkscrew palm (in northern Australia) were used to prepare fermented beverages. (Gracey 1998, p. 30)

Aboriginal drug using practices were not commoditised; as drugs were 'found' and 'gathered', the 'drug user' could not be instituted/institutionalised, maybe not even conceived of, because only *intoxicating practices* existed. Colonisation, however, did change Aboriginal drug use patterns drastically; we do not know whether Aboriginal tribal/clan languages have a word or

description for ‘drug user’ and, if so, when such a word was introduced and what its meaning would have been. From a cross-cultural perspective, for many countries/cultures ‘*drugs are not a problem but a long-established socio-cultural asset*,’ whilst in others, ‘*where drugs* have *become a destructive force this has followed from western influences*.’ (Coomber & South 2004, p. 15)

‘Substance use’ in Australian Aboriginal communities has followed exactly this pattern, as cultural change or disruption in matters of drug use affects its social acceptability. The cross-cultural association between smoking marijuana (called yarndi) and smoking native tobacco or pituri was made explicit by an Indigenous interviewee who stated that:

> [Doris] Yarndi has touched their lives and it doesn't seem to worry us as much as the alcohol and that does. […] traditionally, we did have the bush that we used to smoke like yarndi so it's part of our tradition anyway... part of our dreamtime to smoke and go into the dreamtime dreams... […] it's a bush weed that you can get walking down the street... yeah, it's smoked in the same way... you know, dried and smoked the same way but it was actually pituri that was used to smoke and you will go into your dreamtime. […] so that's why I think why yarndi’s more acceptable because we've got that pituri background to get into our dreamtime …

The social-cultural asset of using pituri to go into dreamtime appears distant now, as institutional processes associated with the (capitalist) economy and trade have acculturated into thinking about drugs as commodities (and utilitarian devices), as the next section will illustrate.

## Drug users’ historical march through the institutions

I will now describe the ‘making’ of the drug user through the dialectics of (institutionalised) ‘helping’ and ‘drug use’ and the impact of the discourses of race, empire, prohibition and welfare, the evolving (natural and human) sciences shaping our understanding of drug users and the ways in which different institutional sectors shaped – and claimed their stakes in – what is known today as the ‘drug problem’.

### Helping and drug using practices are transformed into subject positions by institutions

In the wake of industrialisation processes, newly-urbanised people in their new socio-spatial arrangements were met by new governmental regimes, seeking to create new practices of sanitary, hygienic and moral ‘conduct’. The ‘mob’ or the ‘dangerous classes’ - and everyone else

- had to be *governed*. As Nikolas Rose describes it - for schools, but arguably other institutions – the project was the '*shaping of character* en masse *with the aim that the corporeal and moral habits of industriousness and obedience would be inculcated into the members of the labouring classes*' (1999a, p. 104). Temperance, sobriety and drunkenness were now subjected to the requirements of 'healthy' (and sober) workplaces and workforces and 'social' projects actively inculcated moral character in the new subjects (Rose 1999a, p. 104-5). In fact, it was the police, reformed in 1862, that fulfilled the functions that later on – through division of labour and rationalities of specialisation – were maintained by truancy officers, social and emergency relief workers and statisticians (Kendall 1997, p. 230-1).

The idea of *classifying* people is old, but the formal development of a classificatory scheme became possible through the invention of statistics, imbuing a whole new quality onto the activities of naming and counting people. Ian Hacking traced the '*statistics of deviance*' back to around 1820, defining them as '*the numerical analysis of suicide, prostitution, drunkenness, vagrancy, madness, crime,* les misérables.' (2002, p. 100) Whilst people might previously have thought of other people as different, drinking and drug using, the statistics of deviance created the possibility to think of '*them*' as '*other*' and constituted different ways of thinking about human practices: '*Social change creates new categories of people, but the counting is no mere report of developments. It elaborately, often philanthropically, creates new ways for people to be*.' (2002, p. 100). Once people who consume drugs are thought of and can be classified (or grouped) as 'drug users' – as noted, the construction of the 'drug using *client*' *rests* on the construction of the 'drug user' – we can 'treat', 'manage' and 'intervene' because we can now plan for and address 'them' as a 'population'.

Whilst Reinarman argues that, in Western societies, '*drug users as a group are defined by their relationship to the state*' (2001, p. 20), I hope to show that the construction of the drug user by the state is certainly dominant, but that it is not the only institution through which the drug user came and comes to be.

The division between 'public' and 'private' space is an early modern invention and it has an impact on the constitution of the drug user. People who use drugs were (and are) socially distinguished based on the practices associated with the various substances ingested and consumed (alcoholic, smoker, etc). It is a modern phenomenon to group people into 'populations' according to the substance(s) they prefer to use; in the Victorian context, people who used drugs became conceivable as a group within the modernist project of *public* health (Petersen & Lupton

1996, p. 6) and the state's social gaze started to scrutinise their capacity to parent. The 1864[11] Neglected and Criminal Children's Act in Victoria included in its target populations children of drunkards (Twomey 1997, p. 178), a decade after Victoria had passed its first 'public health' act (Lonie 1979). 'Impoverished' and 'destitute' mothers lobbied magistrates for help and access to other services and women used their husbands' drunkenness as an argument to elicit support (Twomey 1997, p. 174). The 'drug user' was thus conceived of as a subject position at the unique intersection between child protection, public health, prohibition and treatment legislations and instituted primarily through the state's legislative capacity; however, we do not know exactly how this occurred and in which way the 'drug user' came to be named the 'drug user'. In the late 1800s, craft and benefit societies (later called unions) refused to provide assistance and benefits for people whose illness was '*occasioned by drunkenness or fighting or any disease improperly contracted*.'(McQueen 2004, p. 210) Early forms of social insurance schemes thus also contributed to shaping drug using subjects, making drug use a practice enabling 'public' discrimination. By the end of the 19th Century, charitable organisations were testing *desert*:

> Moralism imposed tests of 'character'. At the slightest suggestion of 'drink', help usually was withdrawn. The Queen's Fund, established to celebrate the 1887 Jubilee, refused to assist women supporting drunken husbands. The story of how the families of alcoholics coped last century has yet to be told' (Kennedy 1982, p. 65)

Whilst the Queen's Fund '*would not help victims of male intemperance or criminality*' (Dickey 1980, p. 91), other benevolent societies and (less prestigious) helping organisations were already contesting such ideas, arguing, as the Salvation Army did, that '*the search for profit in society inevitably produced victims whose first need was physical assistance, whether 'deserving' it or not*' (Dickey 1980. p. 90). In this interpretation, women and children of alcoholics would have sometimes received assistance but the 'drug user' subject position began to be brought into the welfare discourse as 'other' and, by singling it out, the discourse was challenged to create rationalities upon which help could or could not be extended to the 'subject position' occupied by the 'drug user'.

In the mid- to late-1800s, the diffuse ways of helping and volunteering in hospitals, reform societies and charities became subjected to more organisational scrutiny and informal ways of supervising, providing welfare assistance and relief work started to be formalised. The practice of *helping* entered the (professional) discourse, with women assuming a leading role in

[11] Victoria was settled in 1836 and separated from New South Wales in 1851. Privately initiated , 'child saving' efforts started in 1842, although official legislation had only been enacted in 1864 (Gaffney 2003, p. 13)

the professionalisation of helping. Australia's first professional social worker, trained in the U.S. and in Australia in the 1920s and 1930s, was Norma Alice Parker Brown, who carefully started the discursive work of separating and distinguishing social work from religious and medical practices (Gleeson, 2004, p. 5-7), carving out the domain of the helping professions.

**The 'drug user' produced by the realities and discourses of race, empire and prohibition**

The notion that drug use is associated with questions of race and mental illness was inculcated in various State Acts from the late-1860s onwards, even though these Acts were seldom used:

> This last provision, known colloquially as the 'dog act' or 'blackfellows' act', under which courts could forbid supply of liquor to particular individuals who had wasted their estates or injured their health through drinking, was little used. (Jordan 1994, p. 3)

One of the best known images and an explicitly racial characterisation of 'drug users' appeared in the Bulletin in 1886: Phil May's '*The Mongolian Octopus - his grip on Australia*'. Here, a semi-toothless, older man of Asian appearance is portrayed with tentacles 'introducing evils' into Australian society, spreading immorality to white women, offering cheap labour (thereby competing for income with the white male family provider), being a source of corruption and, of course, last but not least, smoking opium. The Bulletin's association of opium smoking with the Chinese excludes from view the originator of larger scale opium use in China, namely the British who were '*distributing free pipes and selling the drug to new users at very low prices*' (Marks 2002, p. 114) from the late-1700s – all in the name of free trade - a legacy that is still with us. Indeed, North-Americans '*too had been bringing opium from Turkey to China*' and with British (and US) drug dealers furthering their activities, the Opium Wars (1839-1842 and 1858-1860) between Britain and China erupted (Marks 2002, p. 115), as the '*British colonial government in India and the EIC [East India Company] depended on opium for revenue*' (Marks 2002, p. 117)[12].

After 50 years of '*debate and continuing pressure from the Chinese business community, Christian groups and the temperance movement, the importation of smoking opium into Australia was banned in 1905*.' (Lang 2004, p. 6) It is worthwhile to note that opium had been used widely

[12] Not only was the trade with drugs an empire building scheme, but US profits of opium sales were used to finance East Coast universities and infrastructure, such as Bell's telephone (Marks 2002, p. 127/128) – universities and infrastructure being one of the hallmarks of modernity.

for many ailments, yet the '*belief in the wholesome properties [...] was only shaken with the emergence of medical science around the end of the nineteenth century*.' (Dikötter, Laamann & Xun 2004, p. 17)

*Addiction* is a modern concept and could be described as one way of coping with capitalist modernity; the addict '*who is defined by his endless and exaggerated desires, has become emblematic not only of the consumer but of the modern subject in general*' (Margolis 2002, p. 23). The 'drug user' gradually became – simultaneously - '*othered*' and '*samed*' through social processes marking the absence and the presence of desire, time and status and their collective consumptive achievement (for example through taste marketing, social groups taking different drugs or better quality drugs, the 'spirit' of hospitality, etc). At the turn of the century, the medical sciences had claimed definitional authority over the '*addict*', but there would have been nothing and no one to claim authority 'over' if *technologies* of practice (the idea of *treating* people), identifiable *places* (asylums, retreats, hospitals, medical practices) and social *relationships* were not (already or in the process of being) established. For example, the hypodermic syringe was invented and improved between the 1850s and 1860s (Davenport-Hines 2004, p. 67-68), signifying a precondition for the possibility of conceiving of '*injecting drug users*' (and the establishment of needle and syringe exchange programs in Australia in 1986). Ironically, but not surprisingly, it was the championing of *prohibition* in the US that sparked and entrenched a new administrative route, *producing the subject position of* '*intravenous drug users*': '*No one seems to have injected morphine intravenously until the twentieth century, when American drug-users were turned by prohibition legislation from opium-smoking to heroin injections in the period after 1910*.' (Davenport-Hines 2004, p. 68)

**Gold, McCarthy and 'the social': medical and welfare discourses institute the drug user**

As early as 1864, '*some ascribed [the] 'softening of the stomach' in infants to maternal alcohol abuse*' (McCalman & Morley 2003, p. 41), paving the way for the long history of the modern problematisation of maternal drug use and infant health – culminating in today's *Fetal Alcohol Syndrom* (for a critical discussion, see Armstrong 2003). This period marked the beginning conception of the use of particular substances as '*social problems*': '*Philanthropists, clergy and reformers blamed drink for inebriety, poverty, family violence, insanity, crime, delinquency and illness*.' (Garton 1990, p. 103) The use of substances began to 'assemble' and arrange social

practices in new ways, their 'problematic' use suggesting moral and therapeutic reform, chiefly implemented through the asylum, in which drunkards' '*weakened will*' could be '*strengthened by the reformative regime of institutional life*.' (Garton 1990, p. 103)

In 1843, Australian colonies established various versions of the Dangerous Lunatic Act (Coleborne & MacKinnon 2006, p. 372), Victoria following with the Lunacy Act of 1867, the Inebriates Act of 1872 and the establishment of short lived '*retreats*' for male and female inebriates, closed in 1891 because of limited uptake (Jordan 1994, p. 3). Public treatment provision was available from the 1860s and 1870s onwards in metropolitan (Yarra Bend and Kew Metropolitan Asylum) and rural (Goulbourn, Beechworth and Ararat) institutions (Coleborne & MacKinnon 2006, p. 372), possibly representing the first '*state drug treatment*'. The distinction between psychiatric and inebriate treatment was being drawn and, in 1872,

> 'an Act was passed to provide for the care and treatment of inebriates. This was brought about when the Lunacy Statute, under which the Master-in-Lunacy was empowered to order the detention of habitual inebriates in a lunatic asylum for one year, was repealed. As the result, a private retreat for inebriates under the superintendency of a Dr McCarthy was opened in Northcote. This was the first institution of its kind *in the whole world* and was made possible because power had been granted by Act of Parliament to compel inebriates to enter for treatment. (Brothers' Beattie-Smith Lectures cited in Dax 1961, p. 130, my emphasis)

The Irish doctor, Charles McCarthy, had started to lobby for special treatment to save inebriates in 1859 and supported the disease concept of inebriety, making him temporarily the owner of the Northcote site (Lewis 1992, p. 77). The Victorian Royal Commission on Asylums for the Insane and Inebriate of 1884-86 had reported '*on the need for an asylum for the insane and the inebriates*' (Lonie 1979, p. 26) and agreed that '*prison and fines were useless in stopping habitual drunkards from drinking …and that compulsory seclusion was essential to successful treatment*' (Lewis 1992, p. 77). According to Lonie (1979), private nursing homes were available for the well-off people and the state assumed its responsibility in Victoria's Inebriate Asylums Act (1888) by widening the access to treatment. The 1904 Act modified the term 'inebriate,' broadening it to '*a person who habitually uses alcoholic liquors or intoxicating or narcotic drugs to excess*' (Lonie 1979, p. 27). The two state institutions, Beaconsfield and Northcote Retreats, had been closed by 1892, but Lara was set up instead for inebriate men and the Salvation Army ran a women's institution with state subsidies (Lonie 1979). An explicit '*cure*' of alcoholism was promised by the *Bichloride of Gold Institute of Victoria*, under the auspices of Wesley Central Mission in 1893, catering for middle class 'addicts' (McFarlane 2000), who could afford '*the*

*Keeley cure, using injections of bichloride of gold*' (Lewis 1992, p. 80). Records of the mid-1880s already show medical and moral discourses diverging, with churches and medical establishment promoting different explanations of '*habitual drunkenness*', in practice, however, 'the medical perspective never entirely supplanted the religious-cum-moral, or the criminal, one.' (Lewis 1992, p. 79) Lewis calls the early period of medicalisation of alcoholism and inebriety the '*treatment movement*':

> The nineteenth and early twentieth century treatment movement relied heavily on the disease concept of alcoholism, itself related to the rise of modern medicine, to support its case, and it sought to engage the state's growing willingness to intervene in social problems to obtain legislation and establish new institutions. By the later 1920s the movement was in decline. (1992, p. 75) There are a number of reasons: (1) per capita consumption of alcohol was falling markedly by the early twentieth century; (2) the Temperance movement's basic orientation towards prevention; (3) the ethic of individual responsibility in health and welfare matters; (4) the long-established connection between inebriety and lunacy administration; and (5) the shaky status of inebriety as a disease, and closely associated, the relative ineffectiveness of treatment. (1992, p. 82)

The medicalisation of alcohol use, at least temporarily, was in decline but the charity and religious discourses had increasingly differentiated themselves; the denominational framings of a 'drug using client' differed in their understanding of charity and of drunkenness:

> Catholics tended to see charitable giving as part of the vocation of the Christian, pleasing to God in itself, Protestants to use relief as a means of saving souls and promoting social conformity. Catholic moralism tended to be aroused by sexuality, Protestant moralism by idleness and drinking. ... Protestant agencies often required attendance at religious services as a condition of whatever material help they gave. Catholic agencies usually did not. (Jordan 1994, p. 7-9)

Utterances of the still fashionable dichotomy between deserving and undeserving poor were already found in 1851 (Beilharz, Considine & Watts 1992, pp. 62-63) and forms of spatial '*social exclusion*' started to become more obvious: '*By the 1870s, most gold towns appeared to have an outsiders' camp where the Chinese miners who had stayed were relegated, along with prostitutes and alcoholics.*' McCalman & Morley 2003, p. 53) Between 1850 and 1900, Victoria's old and current large providers of welfare had opened their doors: Wesley Mission, Salvation Army, St Vincent de Paul and the Mission to Melbourne's Streets and Lanes (Challen 1996). Melbourne experienced rapid economic and 'social' growth and, after the Gold Rush, had no less than '*20 sizeable 'bastilles' administered by philanthropic bodies*' (Gleeson 1999, p. 119) including inebriate homes and, by the 1880s, the first branches of the Charity Organisation Society (COS) (Beilharz, Considine & Watts 1992) had opened. The COS constituted itself as a governance

body to '*organise existing charities into a more efficient system*' (Jordan 1994, p. 7), one of the first institutions to approach welfare in a more 'systematic' way, for example, through pioneering case work practices (Garton 1990, p. 142). The COS was also committed to scrutinise and assess every application for assistance and the Melbourne Charity Organisation Society aimed to eradicate '*two evils, 'indiscriminate giving' and 'imposition on charity*' (an 'authority' quoted in Dickey 1980, p. 89). In other words, the conservative part of the welfare lobby already intended to discover '*welfare cheats*' – a remarkably similar language to Australian Centrelink operations of the 2000s:

> It added searching enquiry into the bona fides of the applicant for relief to the *labour test* and the relief card, offering to carry out such enquiries on behalf of existing charities, and in 1891 was able to assure the Government that two-thirds of applicants for relief work were undeserving of help. (Jordan 1994, p. 7, my emphasis)

As mentioned earlier, both worker and client are co-dependent social constructions and both roles are preceded by an instituting and instituted process that requires the two subject positions to be inhabited and operationalised. Beilharz, Considine and Watts (1992) locate the transformation of 'the pauper' into 'the client' and the establishment of the welfare *relationship* in the latter half of the nineteenth century. Arguably, the birth of the 'human service worker' coincided with the birth of '*the social*'. *The social* takes form

> 'beginning in the late eighteenth and early nineteenth centuries, by the way it sketches out its own originality in relation to older sectors, so that it is able to react on them and effect a new distribution of their functions.' (Deleuze 1979, p. ix)

Gilles Deleuze has contemplated how we came to consider something as social, more precisely as *the social*:

> *the social* refers to a particular sector … The social 'leads to a new hybrid form of the public and the private', 'the social takes form, reacting on other sectors, inducing new relationships between the public and the private; the judicial, the administrative, and the customary; wealth and poverty; the city and the country; medicine, the school, and the family; and so on.' Deleuze 1979, p. ix-x)

It is at the unique intersection of all these previously established sectors and regulatory regimes, including business, law and (internal) order, morality, police (law enforcement), poverty laws, (public) health and the human sciences that the *human service worker* came to exist. The human service worker '*works on the social*,' which requires particular types of knowledges of human conduct, motivation, intentionalities, etc., to make such work conceivable and implementable. Interestingly but not surprisingly, the sphere of human service work was not only largely created

by women but, from its inception, had a class dimension. Thinking about the origins of feminism and the '*feminisation*' of human service work, Barbara Cruikshank says:

> Denise Riley […] suggests that middle-class women emerged as collective subjects of politics alongside the invention of the social as a field of intervention into the lives of poor women. It was not only because women (meaning middle-class women) were excluded from the political that they acted within the social. It was also the case that middle-class women and other excluded populations "lacked a stake in maintaining the status quo." Among the excluded, however, the stakes of middle-class women were uniquely invested in the will to empower. Feminist and social historians have documented middle-class women's entry into public-political life as social reformers, philanthropists, and charity workers. […] the social enabled women's activism even as it limited the political solidarity of "women" to the claim that women are naturally more benevolent helpers than men. What is of significance here is that feminism was caught up at the outset in the development of the liberal arts of government. (1999, p. 59)

In Australia too, upper- and middle-class women were at the forefront of charitable and hospital work (Dickey 1980, p. 75, 92-3), the '*distinction being increasingly drawn between medical need and pauper status*' (Dickey 1980, p. 75). Colonial alcohol consumption was also deeply gendered, the paradox being that, '*while women were prevented from drinking in the public bars, they had always been there as workers*.' (Kirkby 2006, p. 209) The gendered nature of drinking habits was given political prominence by the temperance movement, one of the largest international mobilisations of women [13] (Pixley 1998, p. 501). The Women's Christian Temperance Union (WCTU) sought women's vote against alcohol when it campaigned for suffrage in the 1880s (O'Lincoln 2005, p. 77). Ian Tyrell (1998, p. 11) demonstrates the links between the temperance movement and anti-tobacco agitation, its earliest activities tracing back to the 1840s. The temperance movement existed in Australia, intimately linked to religious principles of abstinence, as Humphrey McQueen states:

> Temperance played an important role in the social fabric of nineteenth-century Australia, and not without results; although the population doubled in the last thirty years of the century, the consumption of spirituous beverages in New South Wales went up by only 25 per cent. Early radicals such as Charles Harpur were lifelong campaigners for total abstinence, gaining the support of both the Protestant and the Catholic clergy. (2004, p. 211)

[13] The accomplishment of the temperance movement in politicising home life and demanding protection from male aggression needs to be seen in the context of the gendered industrial relations and the patriarchal establishment of the welfare state, argues Pixley (1991), concluding that women's engagement in defending the family was perhaps simply the most pragmatic choice for women to claim their needs in the male dominated world of that time.

The WCTU had brought 'women's issues' to the political stage and indeed to the parliament, but its work of raising awareness about male/domestic violence did not bear fruit institutionally until the establishment of Australia's first women's refuges in 1974 (Mason 1998, p. 339). For the creation of the future domestic violence service system, however, the link between domestic conflict and drug and alcohol use had been made, even though alcohol was such an integral part of colonial culture; but whilst the changing social conditions of its use sparked the activist temperance movement, it still remains the least regulated of all drugs used in Australia (Reynolds & Howse 2004, p. 260).

Not only were forms of helping debated among the different 'helping organisations', '*clienthood*' was equally contested by different political philosophies and in the various interactions between the state, charity and reform societies and the churches[14] as welfare 'providers'. Christian values influenced and motivated almoners; charity workers and their clients were imagined in the moral and denominational discourses; and it was clergymen who started to take interest in young people using drugs, in the late-1960s turning drug users *into clients in a sector* named after the substances that were used: '*drug and alcohol work*' was initiated by priests and ministers across Australia (for example Rev. Ted Noffs in Sydney and Father James Armstrong for the Buoyancy Foundation of Victoria). 'Drug users' were on the way to become 'drug users' in their *own right*, to be addressed with their own technologies of engagement, assessment and treatment – a process that eventually would pave the way for people publicly identifying themselves as 'drug users', fighting for '*drug user rights*'.

More historical research is needed to determine more precisely when '*welfare client*' and '*drug using client*' were produced as separate and differentiated subject positions and how welfare and drug discourses (in conjunction with medical discourses) operated to produce them. It could be suggested that they were not considered separate until '*the alcohol and other drug sector*' and the law enforcement response were produced by drug policy processes, whereby the distinction between social and drug policy would have resulted in this 'split'.

[14] The state-church interaction has become a defining feature of the Australian welfare state thenceforward. Paul Smyth claims the Vatican's *Rerum Novarum* (1891) suggested a 'just wage' for the first time and that the notion of the 'welfare state' was therefore a contradiction in terms since the church suggested the wage as a protection from state capitalism (2003, p. 18).

**The 'scientific' inebriate: drug users mean business**

The decades between 1900 and 1940 could be described as Australian drug policy's age of imports: new drugs were imported (instead of 'Chinese' opium, cocaine) and US imports, such as the temperance and prohibition movements, gained momentum in Australia, despite having less legislative 'success' than its US counterparts (Lonie 1979, p. 38ff). The *governing mentalities* (Campbell 1999) shifted to ideas of social purity and (racial) hygiene, as temperance activists started to look for and argue with 'scientific' findings of 'inebriety' (Rodwell 2000, p. 63). Eugenics gynaecologist Saleeby viewed alcohol as 'race poison' (Rodwell 2000, p. 64) and proposed legislative changes to forbid parenthood for 'chronic' inebriates (Rodwell 2000, pp. 64-65). The Eugenics Society of Victoria was established in 1936, well after Australian state schools had started to deliver educational temperance messages informed by eugenics (Rodwell 2000, p. 66). Drunkenness was now portrayed as a threat to the nation (Rodwell 2000, p. 72) and to the productivity of industrial society (Davenport-Hines 2004, p. 293). The prevailing social attitude until the late-19th century had been characterised by understanding inebriety as a condition requiring treatment:

> But, through its rulers, society was pained rather than angry with the addict who was a person to be pitied and forced into good health rather than imprisoned as a criminal. (Lonie 1979, p. 30)

At the beginning of the 20th century, however, a text by the Victorian Foundation on Alcoholism and Drug Dependence describes a significant attitudinal change:

> Before, addiction was regarded as a bizarre personal aberration, like eating a broken glass. Now it was seen more as yielding to temptation – all too understandable because of human weakness - and a pursuit of forbidden pleasures. ... [A]ddiction was regarded with a mixture of pity, envy and fear. (Cheetham & Travers 1979, p. 2)

Why had social attitudes towards 'addiction' changed at the turn of the century? The answer might well lie in the growing influence of a profession: doctors. Doctors 'discovered' that drug addiction was not only a doctor's habit but also a doctor's *business*. Acker argues that the 1920s' and 1930s' construction of addiction in the US was by and large influenced by professional interests of psychiatrists, pharmacologists and the American Medical Association in the '*criminalisation of non-medical opiate use*' (2002, p. 10), the term 'non-*medical*' being highly

significant. Victorian qualified medical practitioners (and chemists) equally gained the monopoly to distribute some drugs (such as cocaine, heroin and morphine) via prescription methods in 1913 (Manderson 1993, p. 63). The discovery of '*addicts as clinical material*' (Acker 2002, p. 17) occurred in Australia with the rise of anthropometrics and studies of public health and the opening of the Victorian school medical service in 1909 (Kirk & Twigg 1994, p. 25); the medical establishment felt committed to fight all social 'evils', deformity, mental and physical 'defects'. Seeking treatment was now the *responsibility* of the citizen - not just for him/her but for the wellbeing of 'the race' (Kirk & Twigg 1994, p. 30); ironically most cases of '*...addiction in Australia had been caused therapeutically*' (Lonie 1979, p. 64).

Recreational drug use was increasing in Victoria as was the number of convicted drunkards in the 1920s (Lonie 1979, pp. 64-65), whilst treatment was somewhat unregulated and a 'cure' still basically understood as achieving abstinence. The training of medical staff in drug treatment coincided with the first social work courses opening in Australia's universities of the 1920s and 1930s, including Melbourne (Beilharz, Considine & Watts 1992, p. 65), and the establishment of the first professional body, the Victorian Association of Social Workers, in 1935 (Mendes 2003, p. 17). Charity organisations, like the COS, pressed for the need for social work training and, in 1933, a formal course at the University of Melbourne began although '*[t]he establishment in 1929 of the Victorian Institute of Hospital Almoners is generally regarded as the beginning of Victorian social work education*.' (University of Melbourne 2006)

Just as the drug user had been medicalised and become 'clinical material', social work became '*professional*' and '*scientific*'. '*Helping*' had started to become linked with '*the social question*' and '*social preservation*' and the '*central ambition of the nineteenth century positivism, the desire to ground ethics on a 'scientific*' basis' (Kennedy 1985, p. 60). Australian social work courses, based on the British model, '*focused on the social aspects of poverty in contrast to the American emphasis on psychology*.' (Garton 1990, p. 142) The COS and professional social work were historically inseparable and the helping culture in Australia was informed and institutionally linked to British and American ways of 'helping' (Kennedy 1982, p. 72-73).

The professionalisation of charity and medicine coincided in Australia, primarily because it was colonised at the time of industrialisation associated with an established mode of state intervention. As well, Australia never had a strong presence of private psychiatric institutions (Coleborne & MacKinnon 2006, p. 371) and the '*in and out of (state) institutions*' for '*inebriates*' continued into the 20th century, when 'drug users' had become linked with the institutions of mental health and the law more generally:

> In fact, Northcote closed in 1892, Lara, near Geelong, functioned from 1907 until 1937 and the Salvation Army ran an institution for females from 1910 to 1945, then between 1937 and 1947 a benevolent home took the male patients. After that, in 1947 and 1952, two of the mental hospitals were used for inebriates, but a Crown solicitor's ruling in 1954 showed that they could not legally be used as such, so since that time there have been no inebriates' institutions. (Dax 1961, p. 131)

From the 19th century until the 1960s, the average 'dependent user' was '*a middle-class, middle-aged woman or health professional*' (Norberry 1997), resulting from '*medicinal use*'. The notion of the drug user as an addicted doctor, by contrast, has not had a lasting effect on the public social imaginary and it took until November 2000 to establish the Victorian Doctors Health Program (VDHP), in which service provision was extended to medical practitioners and medical students with drug and alcohol problems (Warhaft 2004). Particularly noteworthy is that Warhaft describes that this program was modelled on North American examples but that it needed to be adapted to the *Australian* culture:

> [T]he North American culture for managing substance use disorders is largely abstinence-based, and there is much medical and community support for abstinence from all drugs, including alcohol, and for self-help group programs such as Alcoholics Anonymous and Narcotics Anonymous. This is not generally the case in Australia. (Warhaft 2004, p. 376)

The regulation and scheduling of substances and the prescription of drug use (and the differentiation between legal and illegal use) through legislation happened gradually. With the assistance of the pharmaceutical industry, the notions of treatment *options* or treatment *modalities* became instituted. The Pharmacy Guild of Australia (n.d.), established in 1928, is now the representative of roughly 4,500 pharmacies across Australia. The National Health and Medical Research Council (NHMRC) was established in 1936, though its precursor, the Federal Health Council, had operated since 1926 (NHMRC 2006). Public health and welfare statistics now became planning instruments for all kinds of interventions. By constituting health and welfare as a public discourse, they became and had to be addressed as public matters, worthy of state intervention and regulation:

> For the creators of nuisances, the strategy was to evade costs of reform by making them *public* responsibilities and thus shared, while for the middle class, public health was to be supported provided it created an urban environment that was liveable and sought to wean the working classes away from their bad habits and malodorous practices. For the doctors, it represented 'reason in action', a happy marriage of the power of the state and rational reform, a testament to the power of the *scientific* planning of life. The gains for the poor were more ambiguous, as cheap housing had to come down, lodgings were regulated and rents increased to pay for these changes. (George & Davis 1998, p. 144)

Exactly how the drug user was regulated *non-criminally* (i.e. through public health, industrial relations, etc.) is difficult to establish and Swensen (1994) points out that there is a real lack of research into this area. The major state legislations in Australia were modelled after the British Public Health Act 1848 (Reynolds & Howse 2004, p. 73), with Victoria currently reviewing its Health Act 1958 and the Victorian Alcohol and Drug Association recommending:

> That other legislation such as the *Drugs, Poisons and Controlled Substances Act 1981* and the *Alcoholics an Drug-dependant [sic] Persons Act 1968* also be reviewed to ensure these Acts are consistent with the objectives and principles of the Public Health Act. (VAADA 2006a, p. 8)

This *coordination* of the regulatory approach might very well produce new cross-paths in the construction of the 'drug user', where *nuisance regulation* meets *infectious disease control* and where *community treatment orders* meet *public drinking and public begging prohibition* (Victoria being the only Australian state where public drunkenness is outlawed).

The 'drug user' of *medicinal* opiate provided the State of Tasmania with a successful manufacturing venture, initiated by morphine demand during World War Two, when the Commonwealth Scientific and Industrial Research Organisation (CSIRO) started to cultivate poppies (first across several states, then settling for Tasmanian sites) (Davies 1986, p. 33-34). Temporarily ceasing production after the war, the poppy industry was taken up again by the British company Macfarlane Smith in 1964 (Davies 1986, p. 34) and today, with an '*an annual average crop yield of around 2.5 tonnes per hectare, Tasmania supplies about half of the world's medicinal opiate market*.' (Poppy Advisory & Control Board 2005) In 2006, GlaxoSmithKline (GSK), founded in 1886, boasted on its website: '*Tassie poppies – helping the world*: *Founded with the objective of providing a reliable and secure source of opiate alkaloids, GlaxoSmithKline has grown to become one of the world's major suppliers, with an international reputation for security, reliability and quality*.' (GSK Australia 2006)

Gradually, drug taking and helping became social practices which generated an income and profits: drug use became a *commoditised activity*. With the help of state regulatory regimes, his or her '*habits*' can now be thought of in terms of *consumption* and they are regulated in space and time and linked with other socially meaningful practices. A web of governance and networks has been developed, closing the 'gaps' and 'lapses' in legislative control over the 'drug user' so as to establish 'congruency' of practices and safeguarding 'discretionary interpretations' of legislative chemical intent.

**The biggest stimulant for drug consumption in the *illegal* drug economies** (and the basis for an entire ancillary industry) **is but one institution: *prohibition***.

**Prohibition criminalises some 'drug users' and functions as a work creation scheme**

Having described the construction of the drug user in moral, medical and religious discourses, an even more potent construction of the drug user is achieved by the *legal discourse*.

As stated earlier, historical accounts should not start with the invasion of the Australian mainland and associated islands; Manderson (1993) starts his history of Australian drug *laws* in a purely Anglo-Saxon context; yet, we know that Aboriginal cultures have laws too and that drug use did not start with Captain Cook's arrival. Dé Ishtar describes Kapululangu Women's Law (yawulyu) as an intersection of culture and law, the terms being used interchangeably; law '*translates as the rules which govern all behaviour and hold the meaning of life*' (2005, p. 26). Law has a relationship to cosmology and morality and is, therefore, more broadly applied to '*knowledge, wisdom, learning and science*' (dé Ishtar 2005, p. 26). What applies to a cultural reading of 'the law' equally applies to the cultural reading of drug and alcohol '*diagnosis*': Room problematises the cross-cultural '*meaning and meaningfulness of five different diagnostic categories in the substance use disorders: dependence, abuse, harmful use, intoxication and withdrawal*.' (2006a, p. 39) By adopting a culturally-specific understanding of Western drug consumption practices and Western scientific 'definitions' of drug use 'pathologies,' 'self-control' and, to some degree, 'self-consciousness' are in themselves Western ideas (see Valverde 1998, p. 18).

The relationship between indigenous alcohol use, ('white') law and (male) violence is actively debated among Indigenous commentators (Behrendt 2004), but the effects of colonisation were nonetheless deep and immediate:

> The image of the drunken Aboriginal is a colonial construction, predating the ready availability of alcohol to Indigenous people. Alcohol was used to engage Indigenous Australians in discourse, to pay for labour, to attract people into settlements and to lure people into assimilation. Indigenous Australian women were encouraged to consume alcohol, which was used by white men to barter for sex. Young girls and boys, well under the age of puberty, were fed alcohol and used for sexual gratification. This abhorrent type of behaviour was unheard of among Aboriginal people prior to invasion. (The Aboriginal and Torres Strait Islander Women's Task Force on Violence 1999, p. 66)

Reynolds and Howse show how crime, poverty and alcohol consumption started to be linked in legislation:

> Drunkenness as a crime was placed by the Colonial statutes into the context of street crime, together with offences such as begging alms, frequenting with prostitutes, being without visible means of support, and wandering in the company of Aborigines. People who committed these offences threatened the logic and orderliness of Victorian society. (2004, p. 262)

Apart from duty impositions and poison acts, the Commonwealth 1901 Customs Act was the first serious step towards prohibition. Victoria followed with two 'waves' of incremental drug legislation, the first starting in 1905, with a comprehensive amendment including the granting of police powers in 1906 (Lonie 1979, p. 14) and '*a 'catch-all' clause*' (Lonie 1979, p. 19) covering possession, and the second during the 1920s and 1930s, when international treaties, conventions and other pressure groups came to the fore and influenced models of drug legislation. The influence of British and US legislative and policy frameworks is particularly visible in the law-making processes of Australia (Manderson talks of the 'British System' between 1922-1939 (1993, p. 105) and of the international and US Power influence 1940-1961 (1993, p. 115) and arguably beyond). It is also in the law-making act that we start to see a distinctly *Australian* approach to drug law emerging. Exactly why drug laws came into existence is summarised by Manderson:

> [D]rug laws have *not* been about health or addiction at all. They have been an expression of bigotry, class, and deep-rooted social fears, a function of Australia's international subservience to other powers, and a field in which politicians and bureaucrats have sought power. (1993, p. 12)

In 1952, Victoria Police (2005) set up its first drug squad (renamed Major Drug Investigation Division in 2002), almost 100 years after Victoria Police had started to operate in 1853 (Victoria Police 2005a). From two officers in 1967, the drug squad grew to 39 officers in 1985 (McKoy 2002, p. 75).

Heroin was meant to be an '*addiction-free substitute for morphine dependency*' (Davies 1986, p. 144), but the height of Australia's prohibition was reached when it was banned in 1953, both its manufacture and import and its therapeutic use (Lonie 1979, p. 82), in spite of some medical opposition (Wodak & Moore 2002, p. 14/15). By the 1960s, Australia was 'stuck' with or committed to the '*international prohibition juggernaut*' (Wodak & Moore 2002, p. 12) and became signatory to the *Single Convention on Narcotic Drugs* in 1961 (Manderson 1993, p. 137).

Being a signatory did not prevent the ratification processes itself from becoming contested, though,[15]

> Faced with State laws which had been subject to only piecemeal reform over the years, the Commonwealth refused to ratify the Convention until the drug legislation of the States complied with it. (Manderson 1993, p. 141)

Yet, drug policy began to be more carefully deliberated on the domestic front (Brereton 2000, p. 91) and understood in wielding considerable influence: '*politicians saw votes in it, bureaucracies saw power and prestige in its administration*' (Manderson 1993, p. 141); in short: '*Drugs have been the subject of our laws, but not their object*.' (Manderson 1993, p. 12) Similarly, Valverde argues that alcohol was historically linked with the governance of individuals, health and the nation's morals and that liquor regulation was about regulating consumption not improving health (1998, p. 144).

Whatever the intentions and effects of prohibition, as a product of international and 'homogenising' national pressure and the cultural influences of '*narcophobia*' (Dikötter, Laamann & Xun 2004, p. 93 ff), the user of now *illicit* substances was criminalised and, therefore, easily victimised and stigmatised – images of the 'addict' detracting from the very institutional, bureaucratic, professional and political process that had made the 'drug user' a 'drug user'. As mentioned at the beginning of this chapter, 'drug user' is to mean any person who uses substances, whether legal or illegal; this becomes problematic, however, because in everyday language, the 'drug user' does *not* refer to *any* substance user but only to people who use *illegal substances*, leading me to argue that it is the *productive power*[16] of prohibition that has constituted the 'drug user' as referring exclusively to people using *illegal* substances.

Prohibition also gave prominent status to the ideas of *substitution* and *drug testing*. In fact, the idea of substitution can only be thought of if there's a perceived need to substitute a

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[15] Australia has a dualist system, contending that domestic and international law are two distinct systems of law. For the ratification of international treaties, the executive branch of the government ratifies a treaty but the (federal or state) parliament needs to enact and implement this legislation. There was a perception that before conventions are ratified the states should show their commitment to the convention; however, compliance to particular conventions can exist prior to or after ratification.

[16] I am drawing here on a Foucaultian power concept. When Foucault urged us to study (the knowledge of) sexuality in its historicity, he clearly expressed his research interest as one of moving the analysis of power, knowledge and truth from a 'repression thesis' to a 'productive/positive thesis': '*But the postulate I started out with [..] is that these deployments of power and knowledge, of truth and pleasures, so unlike those of repression, are not necessarily secondary and derivative; and further, that repression is not in any case fundamental and overriding. We need to take these mechanisms seriously, therefore, and reverse the direction of our analysis: rather than assuming a generally acknowledged repression, and an ignorance measured against what we are supposed to know, we must begin with these positive mechanisms, insofar as they produce knowledge, multiply discourse, induce pleasure, and generate power*' (Foucault 1998, p. 72/3)

substance in the first place. Prohibition is the power restricting access to certain drugs, subsequently *producing a substitution logic* (others include inability of access due to scarcity, expense, etc). As often the case, two inventions were initiated by their military use: methadone and the ERS urine-screening machine. Methadone was thought of as a morphine substitute and developed by IG Farben following opiate supply problems during World War Two, when '*Hitler gave orders for the development of a substitute drug for the relief of pain on the battlefield*.' (Davies 1986, p. 144) *Different drug scheduling* of methadone enabled Dole and Nyswander to transform methadone into a treatment drug and, in Australia, the first pilot program of methadone 'treatment' opened in 1970 at Sydney's Wisteria House (Davies 1986, p. 145-147), the first rural methadone provision commencing in 1975 at the far North Coast of New South Wales (Reilly & Miles n.d.).

The Vietnam War and the anticipated return of 'clean' American soldiers (who had used heroin and other drugs) made the Nixon administration enlist the help of psychiatrist Jerome Jaffe[17] who '*decided to employ a recent invention of Avram Goldstein: the ERS urine-screening machine*.' (Carnwath & Smith 2002, p. 87) Soldiers could not be repatriated until they provided consistently clean urine samples (Carnwath & Smith 2002, p. 87). Vietnam War soldiers on rest and recreational leave sparked a rise in heroin use and dealing in Australia, particularly in Kings Cross, Sydney (Davies 1986, p. 47) With drug testing/urine screening and methadone programs in place, two important technologies, arguably effects of and being brought into prominence by prohibition, were on their way to global reach.

Victoria's Poison Act of 1962 produced the '*drug trafficker*' (or 'drug dealer') as distinct from the 'drug user', imposing special punishment and penalties higher than for the drug user/drug possessor (Manderson 1993, p. 142/143). While in actuality quite often the very same person engages in 'using' and 'trafficking', in populist and popular discourses (heavily supported by the media machinery), the drug trafficker is still constructed as much more responsible for his or her actions than an 'ordinary' drug user: everything hinges on the choice that a 'drug trafficker' (allegedly) has. In the very public debate over the execution of Australian-Vietnamese Van Tuong Nguyen in December 2005, the *deterrence narrative* was deployed eagerly by politicians and journalists in association with the moral repulsion at drug trafficking *and* with efforts to gain clemency from the Singaporean government. To this day, racism and drug use are

[17] Jerome Jaffe, '*President Nixon's 'drug czar' made methadone maintenance the corner stone of his national treatment programme*' (Carnwath & Smith 2002, p. 174).

linked; when describing the police and media hype around Vietnamese/Asian drug dealing, Dale (1999) argues that

> It is nothing short of miraculous the way the British introduced opium use in China in order to cultivate it for its own supply, then when it became troublesome, turned the picture around so that now you have America, Britain and its colonies acting victim to Asian suppliers.' (p. 131)

The subject position of the '*drug trafficker*' also meant that drug 'supply' was (and is) mostly problematised at, or at least mostly reaches the lowest level of the chain of supplier – distributors – transporters – dealer, whilst manufacturing and growing drugs only later entered the discourse as worthy of intervention.

The apparatus necessary to uphold and enforce the prohibition system is wide-ranging: from customs and police officers, magistrates, lawyers, social workers, pharmacists, drug testing companies, prison staff, probation officers, researchers, school drug educators and sniffer-dog breeders and trainers. The technology and professional skills required to enact prohibition are immense too: from hypodermic syringes, sharp disposal bins, (random) urinalysis (UA), breath analysis (BA), saliva testing, hair, blood and sweat drug screens, pre-employment and post-incident drug testing to the endless list of drug and alcohol screening and assessment technologies without which no one could be officially identified as drug user and put on record. The assumption is that the 'drug user' is everywhere, but rather than being 'normalising', it increases vigilance towards governing everybody (to monitor, control and discipline actual and potential drug users; to deter drug use using unsafe blue light public toilets; etc.), with the help of governmental mandates, employer initiatives and the formal and informal social controls by citizens, neighbours, security guards and families, watching each other and governing themselves (Dawn & Haggerty 2001). Drug testing and detox involve large businesses with ever-increasing profits (Zimmer & Jacobs 1992, Tunnell 2004) and the ethical, legal and civil rights dilemmas of (mandatory) drug testing, particularly given the possibility of inaccurate results, are ever-present. Drug testing procedures also constitute a 'drug user,' skilled in inventing ever novel ways of 'cheating', choosing and experimenting with drugs which are less detectable or in using different roads to drive home to avoid police checks.

Prohibition ensures demand: '*[T]here is no such thing as trying to sell heroin*.' (Dale 1999, p. 129); it brings into existence a whole new array of phenomena: it can be convincingly argued that (police) corruption, (pharmacy) burglaries, doctor shopping (the 'drug seeker'), drug dealing, trafficking as well as diversion – to a larger or smaller degree – *exist* because the drugs

they relate to have been prohibited. Whilst they are called 'drug-related,' they should rather be referred to as *prohibition-related* and *prohibition-created* crimes; *without* prohibition, the institution of the 'drug squad' would not have existed and *with* prohibition, the English cannon boats steaming up the Pearl River in the 1850s, to enforce free-trade and Chinese opium consumption would have cut a rather contradictory spectacle!

Prohibition has been a product of the 'social-historical imaginary,' (Castoriadis 1997) emphasising the *materiality* and *praxis* of collective ideas (not simply human intentions) and processes. Deleuze's (1979) argument about the rise of '*the social*' (as the 'social sector', a particular social-historical institution and formation of acting *on* the social), should not be mistaken for or 'collapsed' with 'the social' per-se, as this could obscure the self-instituting nature of society which Castoriadis[18] has been at pains to demonstrate (1997, p. 369 ff):

> As instituting as well as instituted, society is intrinsically history – namely, self-alteration. Instituted society is not opposed to instituting society as a lifeless product to an activity which brought it into being; it represents the relative and transitory fixity/stability of the instituted forms-figures in and through which the radical imaginary can alone exist and make itself exist as social-historical. […] Society is, therefore, always the self-institution of the social-historical. But this self-institution generally is not known as such (which has led people to believe that it can not be known as such). (Castoriadis 1997, p. 371-372)

Obviously, prohibition can only be enacted by state legislation if the state exists, drug squads only operate within an institutional context called 'police', welfare workers can only be mandated by a welfare state, sniffer dogs have to become domesticated animals before any 'sniffing knowledge' can be imparted and drugs need to be plantable and/or manufacturable in order to be supplied and eventually consumed. Practices and institutions thus have their own history (without any implied intentionality or rationality) and nothing new is being invented and imagined that does not relate to (rejects, enables, enforces or resists) what is already in place and already done. Prohibition *produced* the subject position 'drug user,' referring to someone taking *illicit* substances and the existence of the 'drug user' and 'trafficker,' in turn, brought about a variety of professions, creating new cultural practices in how we imagine prohibition in our workplaces, in our 'public' and 'private' lives. It should be added, though, that also legal drugs are regulated through prohibitions, for example by smoking bans, not to serve intoxicated people in bars and pubs, public drinking and drunkenness in Victoria, under-age drinking, etc.

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[18] Latour criticises Castoriadis, claiming he commits a fallacy and a contradiction when talking of the self-production of society (2005, p. 67); I would argue that Latour's discussion of what exactly is meant when we invoke the word 'social' is compatible with Castoriadis' approach. An analysis of the differences and commonalities between the two approaches and their interpretation of the social (imaginary) is yet to be made and would be worthwhile.

**Creating a split personality[19]: drug users 'belong' to different sectors**

In the following, I will briefly outline the emergence of '*the alcohol and other drug sector*' within the developing post-war welfare state in Australia, problematising how the inception of various 'sectors' (health, welfare, education, mental health, drug and alcohol, police) – thus institutionalising the growing division of labour of 'helping' and 'controlling' – created the drug user as 'belonging' to different sectors.

> Dax, already in 1961, described the start of a multi-pronged effort to 'treat' alcoholics:
>
> …the newly formed Alcoholism Foundation will undertake the work of *education* and *prevention*, the Mental Hygiene Department the *treatment* of the alcoholics, and Alcoholics Anonymous and the church groups their *after-care*,' (1961, p. 131 my emphasis)

locating alcoholism within psychiatric knowledge and demanding coordination with other institutions for '*complete care*':

> Alcoholism is the branch of psychiatric study which perhaps needs more co-operation by the various social organizations *than any other*. A close relationship is especially needed with the police who will always welcome and participate in a *complete service* for the care and treatment of alcoholics. (1961, p. 132-133, my emphasis)

The ideas of service *coordination* and *complete service* are, of course, not problematic as such, often invoked as 'solutions' to fragmentation (although their 'execution' and praxis often become problematic, relying as they do on technologies carrying their own inherent logic). What Dax described, however, represents institutional 'sub-systems' that practically and discursively address 'aspects' of the drug user, which are not necessarily 'held together' within the '*situated contexts*' of the (inter-) acting individuals. During the last few decades, then, 'drug users' have been increasingly subjected to an institutional dichotomy: social and welfare aspects of life where drug use remained relatively 'hidden' and therapeutic aspects of life '*in which drug use was central*.' (Acker 2002, p. 120)

The construction of the 'aspirational' universal welfare state (universalism '*of such mentalities was an ideal rather than an operational reality,*' Rose 1999a, p. 255) in many

[19] Manderson uses the idea of split personality with regards to the inextricably linked '*distinction between users and big-time traffickers*' (1993, p. 184)

Western countries during the post-war years led to unprecedented institutional growth. Steadily expanding, the Victorian 'community sector' became more organised through the 1946 creation of a 'peak body', the Victorian Council of Social Service (VCOSS; n.d.), starting a tradition of advocacy for disadvantaged groups and directed social policy analysis. In the 1960s, the welfare *sector* of non-government organisations (NGOs) as we now know it was established, setting up community-based services and growing extraordinarily: 41.1% of all NGOs existing in 1992 were founded between 1960-1979; another 43% of services started between 1980-1990 (Community Services Victoria (CSV) 1992, p. 1). The Social Welfare Act 1960 introduced the notion of *prevention* of social problems (CSV 1992, p. 9) and the Community Welfare Services Act 1978 reflected '*a new emphasis upon community services alongside correctional and welfare functions*.' (CSV 1992, p. 11) Child abuse was 're-discovered' in Australia in the mid-1960s (Goddard 1988, p. 15) as was poverty towards the end-1960s – a decade of '*professionalising through the employment of trained social workers*'(Markiewicz 1996, p. 27). Official recognition of continuing deprivation and its first authoritative estimate occurred through the '*Henderson poverty line*' in 1972-73[20].

In the context of the increasing recognition of 'social and state responsibility' and the shaping of distinct 'social problem' representations, the social-historical imaginary created a '*drug and alcohol secto*r'. Whilst Senior Detective and head of the Victorian drug squad, Kyte-Powell, argues that the *modern* drug problem started with long-distance truck drivers' amphetamine use in the early fifties (1977, p. 333), other authors locate the significant change in the 1960s. Davies claims that 1966-7 marked the birth of the '*drug welfare*' sector (1986, p. 47), whilst Manderson found significant changes in the portrayal of Australian 'drug users' during the late-60s, shifting from the housewife and health professional (with most legally dealt-with people being middle-class and middle-aged) to the 'recreational rebels', heroin and/or cannabis using young people, students and the unemployed (1993, p. 144-145), their drug use now challenging the '*medico-legal drug control as the morphine-dependence of their parents never had*.' (Manderson 1993, p. 145)

[20] '*The poverty line developed by Professor Henderson is referred to as the 'Henderson poverty line'. Professor Henderson was Chairman of the Commission of Inquiry into Poverty that was established in 1972*' (Senate Community Affairs References Committee 2004a, p. 13)

Davies claims that the 'discovery' of 'youth drug abuse' was shaped by churches (for example, the Salvation Army), the media[21] and the courts and that they, rather than the traditional welfare sector, were 'keen' to address it:

> Youth drug abuse was a relatively new field for social work and the church, and while the media was anxious to establish that teenagers were experiencing drug problems, traditional welfare agencies had no such desire. […] The social workers may not have freely acknowledged the spread of opiate use, but the courts, faced by increasing pressure from cases, had no alternative but to seek answers. (1986, p. 45)

Exactly why and how the distinction between a 'drug-using client' and a 'welfare client' was made is unclear to-date; on the other hand, institutions specifically servicing the 'drug user' began to proliferate. The Buoyancy Foundation of Victoria was set up in 1967 (operating with notions of 'self care' and using non-pharmacotherapy-based approaches to drug use; Homburg 2003). The first peak-body of the burgeoning sector, the Alcoholism Foundation of Victoria, was established in 1959. Eventually, the Victorian Foundation for Alcohol and Drug Dependence, by then broadening its scope to various drugs 'of dependence,' became what is now known as the *Australian Drug Foundation* (ADF; n.d.). Initially, the peak-body was connected to direct service delivery, but as other institutions assumed these tasks, the ADF adopted research, education and prevention roles.

It is noticeable that '*drug use problems*' are often implicitly or explicitly represented as 'belonging' to either psychiatry, social work or the churches (or at least that they are legitimate '*stakeholders*'). Increasingly, such claims have also been taken up by research, education and prevention discourses and once NGOs started to provide services for (illicit) drug users, government departments were compelled to partake in this newly discovered, 'unmet' service need area, probably sensing their own growth opportunities. In 1960, one of the influential texts of modern alcohol studies was published, Jellinek's *The Disease Concept of Alcoholism*. The *definition* of alcoholism treatment became more 'serious' and more contested: treatment 'options' diversified and turned into 'scientific responsibility'; they were increasingly subject to research, training and lobbying to establish claims on how to properly treat 'drug dependence' medically, therapeutically and socially. The 'drug user' was considered to be and addressed as '*dependent*'. In 1968, the Alcoholics and Drug Dependent Persons Act was issued in the state of Victoria:

[21] With the advent of brand name management of a Government's reputation, the media's moral panics and outrage at certain drug use practices, numbers of drug users or high incidence of overdose can conjure (or at least help to bring along) changes in drug service provision. For example, the establishment of the Youth Substance Abuse Service in Victoria or the cessation of supervised volatile substance use in residential settings by Berry Street (Bessant 2003).

> Clients are usually referred as voluntary admissions under the Victorian Alcoholics and Drug-Dependent Person Act, 1968, No. 7772. The act also provides for compulsory admission to assessment, treatment or detention centres, in cases of a substantiated complaint against a person by a close relative for example, or in connection with criminal proceedings in the courts. The overwhelming majority of clients are voluntary admissions. (Travers 1976, p. E.2.1.)

Procedural and discursive constructions were inscribed in this Act and continued to be contested along several dichotomies: detention vs. non-detention, involuntary vs. voluntary, substantiated vs. unsubstantiated cases, 'criminal' vs. 'social' responses to drug use. Davies claims that, since the 1970s, the *socio-cultural* model of drug use dominated in the community sector, whereas the *public health* model of drug use dominated in government departments (1986, p. 55). Whether such distinct bifurcation of approaches indeed existed still needs to be established; it seems unlikely, given the fact that *addicts* and *alcoholics* continued to form part of the *psychiatric* discourse and were serviced by *psychiatric* institutions till the 1980s (and some still to this day). For the '*drug user*,' the predominance of psychiatry, however, was in decline.

Davies calls the 1970s a '*time of maturation*': numerous health and social services personnel now planned drug *interventions* and government funding for treatment services increased, partly due to lobbying and active surveying of the drug-using population by peak-bodies (1986, p. 49). The growth of welfare expenditure (Crisp 2000, p. 186) and of the drug and alcohol treatment sector culminated in the establishment of its new peak-body – the *Victorian Association Of Alcohol And Drug Agencies* (VAADA; n.d.) in 1981, a year also witnessing the birth of the *Australasian Professional Society on Alcohol and other Drugs* (APSAD), defined as '*Australia's leading multidisciplinary organisation for professionals involved in the drug and alcohol field*.' (APSAD 2006) Professionals and institutions constituted and spoke of themselves as '*belonging*' to the *AOD sector*.

'*Clients*', the temporary or prolonged status of 'drug users' seeking or being made to seek treatment, are now serviced by governments, non-governmental, privately or church-run institutions and so-called therapeutic communities. Uniting Care Moreland Hall Alcoholism Treatment Centre was established in 1970 with a methadone program commencing in 1972-3 and an 'outreach' component from 1994-5 (2006). Odyssey House Victoria was established in 1977, opening in Melbourne in 1979 (n.d.).

In a statement in a Manual issued by the Department of Social Security in 1979, the subject position of '*alcoholic*' is merged with a whole array of other welfare subject positions:

> Most homeless and destitute people are called 'alcoholics' by state welfare and charitable organizations, and it appears that the Department of Social Security has in this instance used 'alcoholic' as a synonym for unemployable, destitute and homeless persons (Conley 1982, p. 302)

This is peculiar and invites the question as to whether drug-using practices had already become an overarching characteristic by which to identify and subsequently subsume 'multi-problem' scenarios. Further research is needed to ascertain which historic rationalities and practices brought about the use of these terms to differentiate and/or merge the people thus signified: a 'drug user', an 'alcoholic', a 'poor' and an 'unemployed person'.

Whilst these institutions and organisations were established, new calls for coordination and a uniform approach emerged; Kyte-Powell describes the systemic response he envisages for servicing and dealing with the 'drug user':

> Drug dependent persons taken into *custody* are provided with the *medical treatment* if they need it. In such a case a doctor is called and if he deems it necessary he directs that contact is made with the Alcoholics and Drug Dependent Persons Services Branch for the appropriate assistance. […] The time is ripe for the introduction of a permanent *drug control authority*, consisting of *health, law and education* – divorced from 'empire building' and working as one against the common target. (Kyte-Powell 1977, p. 337, my emphasis)

These sectors – custody, medical treatment, drug control, health, law and education – are deployed by and within different occupational and professional discourses, contexts and cultures and their operating assumptions and technologies produce a *divided* if not *fragmented* 'drug user' – a split personality whose 'characteristics' are differently problematised in each sector. The more diverse drug treatment and the more 'streamlined' community service provision became and the more professional groups came to define or co-define the drug 'problem,' the more *fragmented* the drug-user-as-client became.

Clienthood of the 'drug user' is now constructed not only by different '*scientific*' disciplines, but by different *institutions*, different (professional) *approaches*, *funding regimes*, state *regulatory systems*, *policies* and *strategies* and definite *hierarchies* (of desert). An alcoholic Vietnam veteran can claim lifelong free counselling with a white or a gold card and a beer-drinking gambler is a welcome patron, offered free gambling counselling; a heroin-using emergency relief client might be able to get a once-off supermarket voucher or cash, whilst a person who has just overdosed gets a few days in a public hospital; an alcoholic mother might be evicted from a refuge for having consumed drugs on the premises and a methadone client has to

sign a contract to comply with the program's requirements and not disturb the pharmacy's business: just some of the '*clienthoods*' available to the 'drug user'. Additionally, 'drug users' can be '*dual diagnosis*' and '*complex needs*' clients - terms which are more expressive of a segregated service system and not of inherent or individual characteristics of a 'drug user'. The service system *constitutes* 'complex clients' because of its strict division of labour and 'specialised culture. The drug-using client is diagnosed with a 'dual diagnosis' not because s/he has two 'problems,' but because s/he endeavours to use two service systems.

Obviously, that many sectors 'help' or at least intend to help the 'drug user' is also due to the fact that drug and alcohol issues *are* complex (whether 'problematic' or not) and *do* require an understanding of this complexity, not only pertaining to individuals using drugs but equally to the multiple societal and social relationships they find themselves in.

Summarising, trying to bring about a way of helping the 'drug user' that recognises and values expertise and experience across different branches of the service sector, one becomes aware of their lack of cooperation, their prevailing segregated logics and cultures and different knowledge systems, producing as 'by-products' drug users as divided 'personalities', constituting them within a *deficit* model, lacking education, morality, willpower, skills, employment, health, resources, etc. Similarly, in the process of prohibition, 'drug users' became the '*by-products or victims of the traffickers' business*' (Manderson 1993, p. 185), by the very existence of drug legislations focusing on global drug control, curbing drug trade and punishing traffickers.

The more institutions were historically imagined, the more the 'drug user' became subjected to different, often contradictory[22] discourses and practices and whilst it is helpful to think the complexity of drug using practices in a '*multi-relational institution*', ongoing social struggles necessarily *contest* the appropriation of the 'drug user' by certain institutions or sectors.

**'Treatment opens its doors': the drug user is made treatable**

I will now focus on *drug treatment services*, one of the sectors '*helping*' the 'drug user', problematising our taken-for-granted notions of '*drug treatment*' and '*drug services*' and outlining some of the historical changes in our understanding. I use the term '*drug treatment*' for the provision of 'treatment with drugs' and/or 'treatment for 'drug 'problems',' but also in its

[22] For example, a person who uses drugs who is diagnosed as intellectually disabled may be at odds with the cognitive-behavioural approaches the Alcohol and Other Drug (AOD) field favours. Contradictions are not only observable within different service fields, but within the same service field as well.

wider application to services and institutions assuming a role in making the drug user 'serviceable' and 'treatable', as it is here that the 'drug user' is *made* a client/patient/customer/prisoner, etc.

Walking by a large treatment agency, *Turning Point Alcohol and Drug Centre*, in the Melbourne suburb of Fitzroy, I noticed a large sign on its sliding doors: '*treatment opens doors*' and I wondered… does one not have life opportunities as a person who uses substances 'problematically' *until* receiving treatment or does one's life begin (or 'restart') with treatment? Is this a statement of 'fact' about the 'value' of treatment, or does it intend to reinforce the social acceptability of undergoing treatment or simply a pun stuck on a sliding set of doors? Windana, the name of a Melbourne-based '*Drug and Alcohol Recovery*' agency, is a Koori (Aboriginal) word meaning '*which way?*' – Whatever the interpretation or meaning-making of this phrase, 'treatment' is obviously deeply bound-up with social significations of the '*turning point*' and the 'crossroads' of life. Treatment is always imagined within 'treatment modalities,' bringing forth particular views about human life, subjectivity and drug use.

From the early days – when social workers were 'friendly visitors' to poor people's homes – clienthood of the 'drug user' was *conditional* and did not eventuate when the drug user was considered unworthy – 'undeserving' – of help. As well, 'drug treatment' in Victoria began with the Lunacy Acts, drug treatment and psychiatry being intertwined and inseparable. On the other hand, early on, 'drug treatment' was already linked with ideas about social control, surveillance and the management of 'risky populations', as Rose describes:

> Psychiatry has long been as much an administrative as a clinical science. One only has to recall its role in relation to concerns about degeneration in the late nineteenth century, in eugenic strategies over the first half of the twentieth century, in the programmes of mental hygiene in the 1930s and in the plans for a comprehensive, preventative health service in the 1950s and 1960s under the sign of community psychiatry. (1999a, p. 261-262)

Spencer argues that the French psychiatrist Philippe Pinel (1745-1826), pioneered a 'non-violent, non-medical' approach to psychiatry for hospitalised mental patients and developed a '*moral treatment*'[23] (Spencer 2005, p. 20), commencing "*open door*" and "fresh air" policies (Millon 1969, p. 9; 543), physical restraint still part of the repertoire of treatment techniques:

[23] Spencer cites work stating that Pinel's notion of 'moral' treatment might be more accurately translated as 'psychological' treatment (Spencer 2005, p. 20) and Zusman argues that 'moral' is not translatable other than as in opposition to physical, psychological, relationship and milieu treatments and it was associated with ideas of 'authority' and 'humaneness' (1966, p. 392).

> He removed the chains from his patients but took care to "render the effect of fear [in the patients] solid and durable," and noted that "straight waist coats, superior force and seclusion for a limited time are the only punishments inflicted [at The Bicêtre]." (Zusman 1966, p. 366)

Retreats and asylums appeared earlier in Australia than in the UK and almost simultaneously with the United States (Lewis 1992, p. 77). Early medical reformers had lobbied the colonial governments to recognise 'alcohol dependence was a treatable disease' (Lewis 1992, p. 75). Coleborne shows how, between the 1880s and 1910, different asylums for the 'insane' across Australia and New Zealand operated with the following 'treatments'[24]:

> Modelled on asylums in Britain, these institutions combined moral therapy with practices of restraint, solitary confinement and other treatments. They were regularly inspected by official visitors and asylum inspectors. (2006, p. 429)

Around the turn of the twentieth century, a gradual shift from the charity model of 'not alms but friends' to the model of '*neither alms nor friends nor neighbour*' but '*a professional service*' (Ehrenreich 1985, p. 62-64) occurred, a shift from Jane Addams' preventative social work to Mary Richmond's case work. Ehrenreich also argues that, in the 1920s, social work became more interested in psychiatric understandings and in 'personality,' coinciding '*with the new needs of capitalism for ensuring social peace and creating personalities congruent with the consumer society in the making*.' (1985, p. 76) The Australian Association of Social Work (AASW) was founded in 1946 (AASW 2002), during the post-war welfare state expansion and started to define the social worker – apart from being a developer, planner of services and information provider – as someone with therapeutic and clinical functions (AASW 2002a).

From the 1960s onwards, social movements - such as (second wave) feminism, recovery and anti-psychiatry movements, gay and lesbian, disability and holistic health care movements - created social change. Alcohol, prescribed barbiturates and over-the-counter sedatives had been the 'drugs of concern' until the 1960s, but drugs such as tobacco, licit and illicit substances started to gain attention (Rankin 2003) and entered into 'treatment speak'. From a total of 44 alcoholism treatment facilities (excluding private providers) in 1968, the number rose to 271 service providers for substance use problems in 2001 in Victoria (Rankin 2003, p. 260). Alcohol and drug treatment witnessed another development: the spread of therapeutic communities, self-

[24] Spencer claims that Dr Neville Yeoman (1928–2000) played a pivotal role 'in evolving social psychiatry, community psychiatry and clinical sociology in Australia […]Neville's role as a pioneering Australian innovator of therapeutic community, full family therapeutic community, mediation therapy, community mental health, and large group therapy.' (2005, p. 5)

help and mutual help, technologies of 'empowerment' and the rise of the [treatment] 'consumer perspective'. As part of a less-formal (i.e. less-professionalised) way of treating people, Alcoholics Anonymous (AA) was established in 1945 (AA Australia; n.d.), arguably the first 'peer' or 'mentoring' approach to alcoholism, using a disease model (without becoming a domain of doctors). AA invented the modern idea of the drug user being the expert of his or her own condition and it marked 'the democratization of pastoralism' (Valverde 1998, p. 19):

> …mutual help, as the gathering of a flock that refuses to be shepherded except by other sheep. …Whether or not it works to cure alcoholism, AA has certainly succeeded in developing a whole array of non-professionalized, low-cultural capital techniques for acting on oneself that have profoundly shaped our present. (Valverde 1998, p. 19)

Methadone maintenance, available in Victoria since 1972 (Department of Human Services (DHS) 2002, p. 78), continued to be available to a select few in the early 1980s (Davies 1986, p. 152/3), a policy shift occurring in the provision of methadone in 1985 (Ezard et al 1999, p. 417; Fitzgerald & Sewards 2002, p. 36). Victoria had 181 clients on methadone maintenance in 1985, 1164 in 1989 and 3694 in 1996 (DHS 2002, p. 70) and, by the same year, '*approximately 95 % of methadone clients were with community-based prescribers*;' the drug user was subjected to random urine testing to monitor 'compliance' and behaviour, being occasionally '*performed as a legal or child custody requirement*' (Ezard et al 1999, p. 418) and s/he had (and has) to pay for the dispensation costs with an '*estimated average of nearly one-fifth of clients' weekly income …taken up in methadone-related expenses*' (p. 422). The social-spatial arrangement of the methadone program was significant: prescriber and dispenser were at different locations, involving travelling time for clients, collection interfering with work requirements and women waiting longer for 'the dose' than male clients. Practices included the dispensing in exposed pharmacy settings which clients found '*too public*,' methadone clients generally served after non-methadone clients, demarcating hierarchies of desert even as and particularly because the drug user was made a '*customer*'. Clients were dissatisfied with the limited number of '*takeaway doses*' and found the daily collection of their dose a negative (Ezard at al 1999, p. 420-422). The very program design constituted the drug user as *transient, ephemeral* and in need of surveillance by regular monitoring and needing to obtain new scripts. Similarly, it is not uncommon that waiting lists to access any form of treatment are interpreted as (necessary for) testing the drug user's willingness, commitment and desert to 'change'. Whatever the specific conditions of clienthood – following the discovery of psychopharmacological methods in the 1950s (Millon 1969, p. 544) – the 'drug user' had arrived in the *age of pharmacotherapy*, but not without

contestation: McArthur shows the very cyclical nature of the methadone program's appeal to government and (health) professional communities (1999), but overall, the list of pharmacotherapy products (Buprenorphine, Methadone, Levoalphaacetylmethadol (LAAM), Naltrexone) is ever increasing and the search for non-addictive drug-based solutions to 'drug habits' is alive and well.

Governmental and non-governmental agencies deliver treatment programs, the responsibility for treatment being assumed by the states and territories. Over the last century, governments periodically took on the role of direct treatment provision or funding of treatment programs and (mental, child welfare, criminal justice) institutions. Institutionalisation and deinstitutionalisation were inconsistent and periodic processes: 'moral panics'[25] triggered the opening and/or reforming of some institutions whilst inappropriateness of settings or treatments or insufficiencies of funding closed others (see Gleeson 1999, p. 121 ff; Gaffney 2003). If it was not the 'drunkards' who were shifting between institutions and 'the community,' it was – and is, thanks to Child Protection legislations – their children[26]. Gaffney also points out that Victoria always had only a minority of government institutions and that non-government institutions even housed juvenile justice clients (2003, p. 14), the 1950s and 1960s marking the maximum involvement in institutional care for children (Gaffney 2003, p. 16).

In Australia, the legal 'drug user' in receipt of medicinal drug treatment(s), is subsidised by the Pharmaceutical Benefits System (PBS) and the number of drugs available has increased significantly since its inception:

> The number of drugs listed on the PBS has grown from 139 drugs in the first year of its operation in 1948 to 605 drug substances (generic drugs), available in 1581 forms and strengths (items) and marketed as 2703 products (brands). Of the 1581 items, 671 are unrestricted and 910 are restricted, of which 416 require an authority prescription and 494 do not require an authority prescription. (Medicine Australia 2005, p. 6)

Whilst the cost of the PBS is cause for continued discussion, Harvey argues in an ACOSS paper that it is '*rightly regarded, nationally and internationally, as one of the most effective national programs for providing drugs to an entire population in a cost effective and equitable*

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[25] The word 'moral panic' goes back to the seminal work of Stanley Cohen who brought prominence to the idea of producing 'moral panics' (1972).

[26] The report 'Forgotten Australian' demonstrates how traumatising the experiences, record receiving and record reading was and is for children who had been made wards of the state or of private institutions whose parents were deemed to be 'drunkards', 'alcoholic sluts' and the like in the 1940s, 1950s and 1960s (see Senate Community Affairs References Committee 2004b). Gaffney (2003) explains how colonial inspection of institutions took place but that the institution and its physical structure was scrutinised whilst (the suitability of) care was not.

*manner*.' (2002, p. 6) With an annual PBS cost of A$ 6 billion (Department of Health and Ageing 2007), the recipients of medicinal drug treatment enjoy considerable government expenditure on their behalf. Nonetheless, prescribers and recipients are strongly encouraged to use medications '*responsibly*' and to question their need for continued prescription and/or use of subsidised legal medicines constantly. Periodically, the parameters and the costs of the program are hotly contested by government, non-government and business interests.

Since the 1970s, treatment 'methods' for drug use have been widened and diversified:

> These changes have included shifting resources to provide broad community-based treatment, shifting the balance from residential to non-residential services, establishment of services in general hospitals and initiatives to increase the involvement of general practitioners. Programs and frameworks have been established for special groups. [..] New clinical methods have been developed and introduced, including those for general screening, diagnoses and assessment, ambulatory and non-ambulatory detoxification and pharmacological treatments of alcohol, nicotine and opiate dependence and the diagnosis, assessment and management of medical problems associated with substance use. (Rankin 2003, p. 260)

There has been a proliferation of treatment 'approaches' and (re-)conceptualisations for both legal and illegal drugs since the 1970s: intervention methods, controlled drinking, binge drinking, harm reduction, 'maturing out' and 'gateway' hypotheses, moderation in drug use, motivational interviewing, natural recovery, stages of change model, etc. Thinking of drug use as a *continuum* of problematic to non-use made it possible to rank 'drug users' and intervene with more subtlety and precision for different life and use patterns. Apart from the medicalisation, pharmaceuticalisation of drug treatment and the dominance of cognitive-behavioural approaches in Australia (Keene 2001, p. 190), there are 'alternative' responses such as meditation, massages, music and art therapies, recreational and yoga classes, herbal and homeopathic remedies and Reiki on offer. The number of different treatment approaches from therapeutic communities to pharmacotherapy and home-based withdrawal is equivalent to the number of different clienthoods which have been produced and, therefore, can be assumed by 'drug users'. Whilst there are some common denominators and assumptions underlying the different programs, a smoking cessation program and a youth drug use outreach program might have little in common. Similarly, *addiction-as-disease* concepts underpin medicalisation as much as some *self-help programs*. It is somewhat surprising that relatively little is known about the *situated context* and *parameters of clienthood* as governed by each program and treatment approach, particularly as experienced by clients in Australia.

Finally, a brief but illuminating description of how drug treatment clienthood is imagined in prison settings, the social-imaginary signification following prohibition logic being *incarceration*. This signification needs to distinguish between and somehow demarcate 'outside' and 'inside' drug users and one way of achieving this is through *governance*. As the person using particular substances had been criminalised, the 'drug user' would – if 'caught' and sentenced with a prison term – become a *prisoner*[27]. Prisoners can be governed through the specification of contrabands, sanctions, restrictions of access to Medicare and other outside 'privileges', severity of sentences and terms of imprisonment, types of programs on offer (no access to needle exchange programs), limited public scrutiny through privatising prisons, gender and age segregations and type of prison, etc. Additionally, classifications and differences in prohibition-related offences make hierarchies of desert for '*prisonerhood*' by prison staff and prisoners possible. For example, the Australian National Classification of Offences (ANCO) classifies 'drug offences' as '*61: Possession and/or use of drugs, 64: Importing and exporting drugs, 65: Dealing and trafficking in drugs, 66: Manufacture and growing drugs and 69: Other drug offences*' (Department of Justice 2006a, p. 79). Prohibition has a triple effect on the drug user: s/he uses illegal substances, s/he can therefore be imprisoned and prohibition-related offences can not only be committed outside but inside the prison system as well. In the last two decades, the institution of the prison has become a site for drug treatment as well:

> Drug and alcohol programs target prisoners with an identified drug problem and are run in all of Victoria's prisons. Specific programs include drug awareness, drug education, drug treatment and relapse prevention. (Department of Justice 2006)

The Victorian Prison Drug Strategy was introduced in 1992 and significantly updated in 2002 (Department of Justice 2002). In prison, the following 'clienthoods' of drug use can be assumed: "current Identified Drug User (IDU) status", "previous IDU status" and "not an IDU" (Department of Justice 2006, p. 65). Since 1991, Victorian prisoners are subjected to an urinalysis program involving random sampling and routine testing (Australian Bureau of Criminal Intelligence 2001, p. 97) and they are made identifiable as 'drug users':

> The Victorian Prison Drug Strategy makes provision for 'identified drug user' status to be imposed on a prisoner found guilty of committing a drug-related offence in prison. Sanctions on contact visits are imposed on such prisoners, who must participate in an approved education or treatment program if they are to have their identified drug user status removed. (Australian Bureau of Criminal Intelligence 2001, p. 98)

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[27] Hospitals and prisoners were arguably the first 'totalising' confining institutions in the ongoing drug users' *march through the institutions*.

Victorian prisoners must, therefore, (re)position themselves in relation to their 'identified drug user' status, with sanctions imposed or, at least, threatened. Prohibition and imprisonment, however, operate with the notion of *rehabilitation* just as much as treatment operates with notions of *care, enlightenment and humanitarianism*:

> Particular programmes and techniques are deployed not just because in some vague sense they are 'humane', 'enlightened' or 'democratic', but because of their evaluated effectiveness in preventing initial drug use and in drawing into treatment the maximum number of illicit drug users. Thus coercion, punishment and blame are displaced explicitly because current knowledge suggests them to be counterproductive. (O'Malley 2002, p. 215)

Victorian prisons offered methadone programs since the late 1980s '*but have been restricted to prisoners with a sentence of less than six months who were already on a community methadone program before they entered prison*.' (Department of Justice, 2003, p. 34) The drug using and incarcerated persons are asked for self-motivated performances of 'progress' and 'rehabilitation' in prison (and post-release), but the conditions of their confinement and treatment are restricted and pre-figured before and during incarceration.

In summary and moving back to the general landscape of drug use these are just some of the contextual '*parameters*' which play a role in how clienthood is assumed and played out: program eligibility (known as 'target group'), assumed client 'characteristics' (sociable, 'excluded', secluded, public, private, 'resistant,' etc), breaches of 'house rules', expulsions, clients' quality of life, average length of treatment/contact; (prohibition) policies and (overdose/referral) procedures; different treatment programs available to different clients in different cities and regions of the state (or country); differences in treatment 'populations', funding regimes, approving agencies, tendering conditions and professional/experience-based/training backgrounds of staff. For example, Fitzroy Legal Service's (2004) Services Directory lists the following differentiating program parameters: public transport (access, important for rural, regional and metropolitan clients), cost, hours, services, philosophy, eligibility (age, gender, ethnicity, geographic area, etc), exclusion criteria (for example (unstable) psychiatric conditions or above 20 mls of methadone), assessment, waiting period, special interest (sometimes 'target groups'), staffing (counsellors, former 'users'), admission, contracts (special conditions to admission and continuation of clienthood, i.e. obligations, expected conduct on premises), referral sources (self-referral or other type), length of stay, discharge

support and residential facilities. Paradoxically or logically, depending on one's view, a condition for 'drug treatment' can be to be drug *free* (or on certain drugs and doses *only*) *before* admission.

Treatment language is still centred around notions of *client compliance*, yet relapse is common: '*Despite advances in treatment, client compliance is generally poor, with relapse to problematic drug/alcohol use a common occurrence (Rotgers, Keller, & Morgenstern, 1996)*.' (Hammerbacher & Lyvers 2006, p. 387) Whilst all measures of client compliance are in place and readily expandable, there is no such thing as '*treatment compliance*' or *accountability towards the client*. In spite of the rise of the 'consumer perspective', *treatment compliance* is *in absentia* internationally; for example, a recent Scottish study found that a majority of people who commence drug treatment across all treatment types preferred to become *abstinent* (rather than *reducing harm*) (McKeganey, Morris, Neale & Robertson 2004), yet '*abstinence achievement*' is not an expected treatment outcome (sometimes it *aspirationally* is) and is not something treatment services are funded or accountable for.

How problematic (and sometimes even professionally damaging) it is to challenge the treatment dogma and to demand accountability of treatment services becomes clear from this US author's statement:

> I recently publicly defended a National Academy of Science critique of drug treatment research before an audience of angry treatment experts (see Horowitz, MacCoun, & Manski, 2001). Not one of them directly challenged our argument that treatment estimates were vulnerable to selection biases and regression to the mean; instead, they decried the patent unfairness of holding treatment to such a high standard when drug law enforcement is more generously funded without any evaluation. (MacCoun 2003, p. 17)

The juxtaposition of treatment and drug law enforcement is an effect of bias in many countries' drug policy budgets, but it should not prejudice or distract from questioning treatment *effectiveness* (including and beyond the 'evidence-base' of their 'effectiveness'). How treatment has become an unquestioned intervention becomes more obvious in this 'treatment expert' statement about amphetamine 'treatment':

> One really important piece of research that has not been done in Australia is looking at the engagement of users into treatment. What we do know is that they do not attend treatment easily, they do *not* find our treatment services particularly *suited to their needs*. Part of that is probably because there are *no specific* treatments for them, and treatment service staff are not very confident in dealing with amphetamine users. We certainly *do not know how to attract them* into treatment, how to keep them there, and what to do with them when we get them in there. (Drugs and Crime Prevention Committee, 2004 p. 572, my emphasis)

The question is: why should anyone – voluntarily, court-ordered or otherwise – attend treatment which cannot even pretend to know '*what to do with them when we get them in there*'?

In conclusion, the diversification and proliferation of therapeutic rationalities and practices constitutes very different clienthoods in which there is no *universal* '*nature of*' drug using practices, the disease, addiction or body politics. All clienthoods are subject to – more or less intense – administrative and therapeutic conditionalities and have depended as much on practices of freedom as on practices of confinement; as Lenson points out: '*sobriety is a cultural construction created for the furtherance of a political and economic agenda*' (1995, p. 6). Similarly and arguably, drug usage and drug treatment are cultural constructs for the furtherance of political and economic agendas. The social institution of 'therapy' was not only imagined in relation to itself as an institution, but became a *contextual element* of other institutions.

**Today's drug user is dispersed and unified[28]: a summary**

Whilst much more could be said, restrictions of time and word-count demand that the above historical and questioning 'meanderings' will have to suffice. From the historic journey it, hopefully, became clear how the drug user was constituted by different institutions, discourses and professions before, during and after the 'drug user' came in contact with any of them: the former 'made' the latter.

The last sections pointed to differences in various service systems' and drug treatments' conceptions of the 'drug user' as a client, but all are based on the presumption that the drug user is a *unified subject position*, 'deserving' to be addressed in a unified and congruent manner. The problem, of course, is that the 'drug user' is *at once* unified and dispersed, at once totalised and individualised. As Foucault expressed it, the dilemma we face is the '*simultaneous individualization and totalization of modern power structures*.' (2002a, p. 336) Arguably, prohibition and welfare discourses provide an inherently totalising dynamic for the poor 'drug user' whilst drug treatment discourses produce an individualising dynamic. It is not necessarily problematic or undesirable that treatment programs 'individualise' people per-se; the option to choose between different treatment modalities and options might be what people want. Coercive and voluntarist techniques of treatment, however, can be coexistent, if not co-extensive; Valverde

[28] I am drawing here on Nikolas Rose's (1999a, p. 258-259) discussion of the abjected person as dispersed and re-unified.

discusses the '*hybrid, semi-disciplinary, semi-liberal logic of most treatment programmes*' (1998, p. 177), and individualisation of the 'drug user' in treatment does not amount to '*treatment accountability*', bearing in mind that identifying and individualising 'drug users' *totalises them in political, administrative, moral and ethical regards*.

Claiming to not distinguish between people who take legal and/or illegal drugs when I employed the concept of the 'drug user'[29], I have myself 'unified' him/her, even though I noted that, in everyday language, s-he is clearly demarcated as an '*illegal* drug user'. The unification of 'the' drug *user* occurred by *reifying* particular substances as '*drugs*' (Moore 2004), perpetuating the social classificatory scheme of drugs as an umbrella term for substances of a '*certain kind*'. It is useful, then, to remain mindful of the fact that, whilst one reifies certain substances by calling them 'drugs', they are further specified *through their use* as resources, cures, therapies, pain-killing, commodities, 'mental' foods, means for profit-seeking, financing economies, trade or terrorism, ends for gratification, pleasure- and truth-seeking, etc. Using the word 'drug,' therefore, *one should bear in mind how the 'things' called drugs emerged and exist as* ***socially achieved significations***.

Professional services mostly take a 'drug *use* history' when admitting clients for assessment, referral and treatment, but this chapter attempted to sketch a *history of the drug user* as s/he was imagined by institutions, discourses, practices and technologies. Drug use is not a modern practice, but during modernity, the '*situated context*' of its practice 'created' a subject position called the 'drug user' through a variety of discourses (including welfare, medicine, race, empire and prohibition) and the state's legislative and enforcement capacities, mediating between dominant societal powers and influences and 'the people'. Developments in science and industry turned the drug user into a consumer and scientific object. Prohibition constituted the 'drug user' as a user of *illicit* substances and affected the very route of administration thereby making the 'injecting drug user' conceivable. Multiple institutions, technologies and practices came to exist due to the productive power of *prohibition* and rely on its continued existence. Subsequently and gradually, the 'drug user' was made serviceable and treatable and institutions and treatment modalities flourished '*for consumption*' by the drug user. The *human service worker* emerged as

[29] It may be just as problematic to identify all legal and illegal substances as drugs as to claim that there are substantial differences between legal and illegal substances. When forced to specify the *situated contexts* of these overall classifications, however, we will find that there is little use in identifying 'drug users' or 'drugs' per-se as the specificity of social encounters introduces more complexities than can be captured in such totalising overall subject positions and reifications.

a ‘partnered’ subject position to that of the drug user, evolving over time and expected to render the drug user serviceable.

Sometimes, ‘drug user’ is thought of as a more neutral term (compared to inebriate, addict, junkie), but it clearly is not, although it may be perceived as *normalising* drug use. Whilst academically produced texts regularly feature the ‘drug user’ as a noun, dictionaries have not admitted the term into their word lists, even today. My argument has simply been that we still *take the drug user for granted*; even when reading texts on the socio-historical construction of drug users (for example, Rowe 2005), the drug user is taken for granted by saying s/he has been *described or interpreted differently* throughout history, the point being *that s/he is constituted in a particular way and that it is important to detect the situated contexts of his/her constitution*. Discourses rely on the *a priori existence* of the ‘drug user’ when staking claims about him/her.

We can now start to question the underlying assumptions of all drug (use) *research*: *how has drug (use) research become part of the constitution of ‘drug users’ and which ways of knowing ‘drug users’ has it employed and deployed?* Chapters Two and Three will develop this question from a methodological and conceptual-analytic viewpoint respectively. Chapter Three elaborates how the ‘drug user went national’ when introducing the intricacies and complexities of what has come to be known as Australia’s *harm minimisation policy*. Chapter Two will outline my research journey when trying to understand the *socially constitutive nature* of the encounters between ‘human service workers’ and ‘drug using clients’.

# Chapter two

# The research journey

The research project I embarked on was named "*Community Services and Drug Dependent Client Groups. Are They Meeting the Needs?*" I found it important to study the *helping culture* and provided a brief historical account of the helper 'subject position,' 'creating' that of the 'drug user'. My growing understanding of the research task and how it had an impact on the development of the above research question is detailed in the following account of my research journey.

First, I describe the difficulties experienced when entering the 'official' drug research field; I then discuss the ontological and epistemological underpinnings of the research and, third, go on to explain how I collected primary data, explicating them using *discourse analysis*, which also informed my approach to the literature review and use of other data sources.

## Encountering official drug research

In the study's initial funding proposal, there were references to '*the increasing demand on [social] service providers*' made by '*drug-using clients*', which was '*complicated by changes in the profile of the typical drug user*'; that these demands were '*made by clients with profiles that are distinctively unlike those of traditional clients*' and that '*many of these clients are now addicted to hard drugs*'. The study was to engage in '*uncovering group norms and orientations in relation to issues of violence*' and it was anticipated to '*be difficult to access [clients] due to the transient nature of the population*'. The '*drug using clients*' were described as a '*drug dependent client group*'. The proposal, therefore, put people and practices into some kind of associative pattern: 'typical drug user', 'hard drugs', violence, dependence, addiction, group norms, population, 'client profiles' and service providers, making me wonder how they were related, why they were associated and by whom.

Reading drug policy and research literature and attending workshops and conferences, I acquainted myself with '*official drug research-speak*'. People spoke about the 'nature' of addiction - but is there '*a* nature of'? Is there *one truth* of addiction? Is it not as problematic to assume the experience of addiction to be the *same* for everybody as it is to assume it being

*different* for everybody? What does claiming a '*nature of addiction*' mean when different social and personal 'circumstances' may vary how this 'one' condition is experienced? What is the *rhetorical* use of stating that '*addiction can happen to everyone*'?

The more I read about drug 'issues,' the more I wondered about the seemingly unproblematic terminologies used; I encountered words such as 'substance abuse' and 'substance misuse' and found the very words 'drug abuse' making no sense. We cannot *abuse* a substance which is not alive and feels nothing; we can abuse our bodies or other people because we have collectively identified them as 'abusable'. To put it controversially: imagine calling *suicide* 'knife abuse' or 'rope abuse' – would we go out and investigate knives and ropes?[30] Unlikely; we would concentrate on the *human being* who attempted suicide! So why is drug use so often studied in a *drug-centric* manner, neglecting to studying it in a *people-centric* or *practice-centric* manner? Does drug-centricity allow us to speak in generalities, making the drugs the *agents* of the stories we tell? If we studied drug use differently, would we have to specify which 'abuse' we are talking about, who defines this abuse and why people are abusing and how (the very definition of) abuse is culturally and historically contingent? Of course, what we mean by 'drug abuse' implies that we *expect* a '*proper*' use of the substance (a *non-proper use* by default being *abuse*). '*Heretically*' challenging the applicability of 'drug abuse', would studies have to refocus the debate on the social practices and the meaning making processes that we have 'attached' to people and the substances they use?

Starting to engage with this topic, at least one hundred years of scholarship could be built on and I felt overwhelmed; the field of alcohol and drug studies has developed significantly, particularly in the last decades, not only due to the sheer and dizzying increase of publications in this area, but, more importantly, due to broader research perspectives. The field seems slow in adopting a more reflective or reflexive mode, however; only recently some Australian researchers have begun to explicitly problematise their own research conditions as impacting on their knowledge production and authors have critiqued the politics and ethics of drug research (Fry, Treloar, Maher 2005) and funding (Miller, Moore & Strang 2006) and attempted to rethink why *qualitative studies* have made little impact on drug policy development (Fitzgerald 2000).

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[30] I am not trying to downplay pharmacological or biological discourses that portray substances as acting on our bodies and in our bodies, but I am considering 'drugs' in a different way. One proposition would be to take up Actor-Network-Theory by Latour (2005) and consider drug problems both drug- and people-centric, by studying how substances bring actors and actors bring substances into a network of social meanings and practices. As an example, see Dawn Moore's article on *drugalities* (2004).

In academic research, 'drug users' are often recruited from service agencies (such as general practitioners, needle and syringe programs and treatment facilities), but we should be cautious about whom researchers access and where from, especially when claims are made that the research represents the 'drug user'. In fact, an existing study compares *visible* and *invisible* 'users', with 'visibility' defined according to their (non-)contact with service agencies, concluding that invisible drug users do not need help, whilst the visible ones should be sought out for service provision (Robson & Bruce 1997). Not only the type of research, its funding, approach and recruitment of participants can make drug research problematic, its very *content* can seem like entering a zone of perpetual conflict:

> Researching addictions and substance use is a contentious business. In addition to stakeholders such as the tobacco and alcohol industries, cancer charities, policy makers, treatment providers, self-help groups, and pro- and anti-drug legalisation pressure groups, addictions researchers also tend to hold beliefs on the subject area which we have acquired through the numerous influences that have had a bearing on our personal and professional development as well as, more generally, our socialisation. The knowledge we are attempting to accumulate is necessarily contested. (Heim 2006, p. 97)

Degkwitz suggests that different sciences privilege (or at least prefer) a *physical* phenomenon, a *psychological* structure or a *social* condition to explain addictive behaviours and, therefore, logically, do not even study the same '*object*' (2005, p. 67). In addition, we should also investigate how the various disciplines (and ways of studying) *constitute* their object and - thereby - often the 'problem' and how trans- or interdisciplinary approaches would be able to capture any *relational* qualities of drug 'problems', as I have shown that the 'drug problem' is *constituted by and in relationships* between drug using practices and institutions, between people and places, between organisations and states reveal. The drug field is ridden with specialisations, making it difficult to overcome the working and thinking processes along disciplinary lines:

> To complicate matters further, our discipline is fragmented to the extreme. Addictions research with its wide-reaching behavioural, social, political, economic, health, legal and cultural implications is conducted in a wide and diverse range of disciplines (e.g. anthropology, biology, chemistry, economics, history, law, medicine, neurology, psychology, sociology) with different epistemological traditions and further 'discipline-specific' divides. Given the complex nature of substance and addictions research, this fragmentation can perhaps be described as an inevitable consequence of unavoidable specialisation. (Heim 2006, p. 97)

The consequences of disciplinary divisions are felt across Australian drug research settings and proponents of quantitative and qualitative research approaches have been played out against each other (Walsh & Sanson-Fisher 1994, p. 82). The '*dominance of epidemiology in*

*appraising addiction and addiction policy*' in Australia tends to show drug problems devoid of their cultural, historic and social inequality context (Mooney 2005, p. 140). Whilst Australian qualitative drug research took its cue from North American 1960s and 1970s sociology, it is now emerging in its own right (Fitzgerald 2001, p. 309); still, '*coherent modelling of the wider structural context is mostly absent*' (Moore 2002, p. 281) and quantitative data '*is narrowly focused on individual 'decision-making' and 'risk behaviours"* (Moore 2002, p. 281).

David Moore and Tim Rhodes argue that '*innovation in drug research has tended to focus on method rather than theory*' (2004, p. 324); but even in the methods used - let alone developed - we have not come very far, Kippax and Van de Ven arguing against '*the prevailing orthodoxy of experimentation and controlled [trial] studies for the evaluation of health promotion*.' (1998, p. 383). David Moore further diagnoses '*emaciation, appropriation and multidisciplinary myopia*' in the Australian drug research field (2002, p. 271), largely having to do with the stability and availability of funding, the production of knowledge, the strategies of trying to obtain funds (the '*grant game*') within disciplinary boundaries or an incapacity to think outside them. Sociology is mostly absent from Australian drug research and has felt little impetus to contribute to drug policy debates (Zajdow 2005a).

I previously problematised the very existence of the two subject positions central to my research project and years of reading Australian and international drug research made me wonder which assumptions and practices are accepted as a given within drug research: How do we delineate what constitutes the Australian drug and alcohol research field? Which research 'methods' do we deploy? On which assumptions are our research questions based and how do our own socialisation and training affect how we read, what we read and the very questions we find ourselves asking? Why do we claim and how can we consider 'causation' of 'drug problems'? How do we come to know substances and the people using them?

These are questions about epistemological and ontological assumptions that scholars over many decades of work have attempted to answer and I will now detail my own explorations and how they have influenced the subsequent steps of data collection.

## Epistemology and ontology

Accepting that science constitutes a *social practice* means understanding that culture shapes how science is carried out; cross-culturally it is worthwhile to distinguish between the empiricist tradition of Anglo-Saxon countries and French rationalism, which links epistemology

to the history of science (Vadée 1988). Epistemology and historicity are inseparable concepts; in fact, Vadée talks of the '*double paradox of epistemology*', in that French epistemology turns the '*theory of science*' into a *theory of the history of science*, whereas empiricist, Anglo-Saxon epistemology largely ignores the '*historical character of science*', yet making it a vehicle of defending science in general (p. 442). Another epistemology, derived from the work of Karl Mannheim, Peter L. Berger and Thomas Luckmann and tracing back to the influential works of Marx, Hegel and the Phenomenologists, is '*social constructionism*' (Crotty 1998, p. 60).

There is not *a* social constructionism, it rather being an umbrella term (Burr 2003) and more appropriately presented as social constructionism*s*. Gergen and Gergen view social constructionism as a developing and unfolding dialogue by and among different authors and their respective positions (2003, p. 5), Burr locating it in opposition to essentialism, positivism and empiricism and emphasising '*the historical and cultural relativism of all forms of knowledge*' (2003, p. 6). It may have already have become obvious from the first Chapter that I adopt a social constructionist perspective for the study of 'drug problems', an epistemological stance most appropriate for this study as it is concerned with *the production of knowledge as a social process and a social action*. Adopting this stance allows this study to raise questions about how meanings are negotiated, communicatively produced from a pool of available meaning '*repertoires*' or '*significations*' and how struggles to '*fix*' meaning are expressions of ongoing processes of social construction.

Social constructionism views knowledge as historically and culturally specific and questions our taken-for-granted assumptions about knowledge, language and reality, in which language is a '*pre-condition of thought*' (Burr 2003, p. 7). Nikolas Rose cautions his readers to not (only) focus on '*what language **means** but on what it **does***' and not to '*accord too much to language as communication, and nothing at all to language as assemblage*.' (1998, p. 178) Rose thus seems to agree with social constructionists' view of language as action, but warns that when (psychologist) social constructionists regard the *self* as *dialogically produced and narratively achieved*, they inadvertently revert to a *humanist self* as language is reduced to talk and text (Rose 1998, p. 176-177).

When discussing how we come to know things and view language as constituted and constituting reality, we also have to account for the *materiality* of our encounters, the materiality and practices that are connected up (as well as brought into being) by language. The social constructionist epistemology assumes reciprocity between language and 'reality'; Berger and Luckmann contend that '*the sociology of knowledge is concerned with the analysis of the social*

*construction of reality*. (1967, p. 15) Social constructionism is *anti-foundationalist* in its view that *'all knowledge is discursively produced and therefore contingent, and that there is no possibility of achieving absolute or universal knowledge since there is no context-free, neutral base for truth claims.*' (Jørgensen & Phillips 2002, p. 175)

Confusion sometimes still reigns over the fact that, when one regards reality as socially constructed, one is saying things are 'less' or 'not real'; to which Burr counters:

> When used ontologically, the term social constructionism refers to the way that real phenomena, our perceptions and experiences, are brought into existence and take the particular form they do because of the language that we share. This does not make these phenomena or things unreal, fictitious or illusory; they are no less real for being the products of social construction. (2003, p. 92)

Williams warns that '*epistemological and ontological matters cannot and should not be collapsed or conflated*.' (2003, p. 51), yet they are intimately related. Skolimowski reminds us of the difficulty to define knowledge: '*It is through knowledge that we must define knowledge, even if we do it imperfectly ... We cannot define knowledge because knowledge is doing the defining*' (1994, p. 339), whilst Kvale talks about it in terms of the '*interdependence of human interaction and knowledge production*.' (1996, p. 14) Similarly, Fleck argues that cognition is not possible without a collective in which it can be thought '… *without social conditioning no cognition is even possible. Indeed, the very word "cognition" acquires meaning only in connection with a thought collective.*' (1981, p. 43 cited in Latour 2005, p. 113)

As we approach reality in thought, knowledge always has a vantage point in the subject, but there is a conundrum, identified by Castoriadis in that '*the distinction between the question of being and the question of beings, is impossible to maintain*' (1997, p. 182). What is subjective can be no less collective and vice-versa; indeed it is in language that subjectivity can be crystallised, articulated, stabilised and '*made real*' (Berger & Luckmann 1967, p. 53). Still, the dialectic of the constituted and constituting language produces a self that goes beyond mere communication:

> The self is produced in the practicing of it, hence produced as an interiority that is complex, contested, and fractures, through the intersection of the multitude of activities and judgements that one brings to bear upon oneself in the course of relating to one's existence under different descriptions and in relation to different images or models, the sanctions, seductions, and promises under which one accords these therapeutic ways of practicing subjectivity a value and an authority. (Rose 1998, p. 192/3)

I find it less productive, therefore, to debate which objects or subjects have ontological 'priority', but rather more productive to study praxis in Bourdieu's and Mol's sense; the former (1977) is concerned with how the *habitus* generates practices appropriate to the structure of the field and the situation, whereas Mol (2002) is concerned with how the social and the non-social are brought together in practices and depend on each other to bring about 'reality', to achieve 'diagnosis', etc. In her analysis of how atherosclerosis is practically achieved, Mol pushes epistemology one step further by arguing that practicalities need to be kept present and can only be found in *time-space coordinates*:

> But after the shift from an epistemological to a praxiographic appreciation of reality, telling about what atherosclerosis *is* isn't quite what it used to be. Somewhere along the way, the meaning of the word "is" has changed. Dramatically. This is what the change implies: the new "is" is one that is situated. It doesn't say what atherosclerosis is by nature, everywhere. It doesn't say what is is in and of itself, for nothing ever "is" alone. *To be is to be related*. The new talk about what is does not bracket the practicalities involved in enacting reality. It keeps them present. [..] The praxiographic "is" is not universal, it is local. It requires a spatial specification. In this ontological genre a sentence that tells what atherosclerosis is, is to be supplemented with another one that reveals where this is the case. (2002, p. 53/54)

Mol's point would suggest that it is not only the various disciplines that constitute and study the object differently, but the object varies according to its location and 'situative context', its practicalities. All the above has immediate repercussions for the theoretical stance one can adopt and they shift terminology from *knowledge* and *explanation* to *understanding* and *interpretation*, as Hoy explains: '*Both hermeneutics and poststructuralism are informed by Nietzsche's project of displacing the Platonic, Cartesian, and Kantian privilege given to knowledge and explanation over understanding and interpretation*.' (2005, p. 31) The move to an interpretative and relativist position of knowledge (production) is arguably a step forward to embrace plurality and multiplicity, in acknowledging and celebrating diversity in human meaning making. Hoy, in fact, argues that interpretation makes meaningfulness possible in the first place: '*How we interpret ourselves in the world is thus not meaningless; on the contrary, only in the context of interpretation is meaningfulness at all possible*.' (2005, p. 34)

For the research process, a social constructivist position implies that researchers inevitably engage in 'ontological politics', as defined by Law:

> If realities are enacted, then reality is not in principle fixed or singular, and truth is no longer the only ground for accepting or rejecting a representation. The implication is that there are various possible reasons, including the political, for enacting one kind of reality

> rather than another, and that these grounds can in some measure be debated. This is ontological politics. (Law 2004, p. 162)

By regarding knowledge as socially constructed, the researcher is seen as immediately involved in (co)constituting what exists and in supporting (or undermining) a particular view of reality, thereby partaking in ontological politics. There is no 'disinterested' social research, no 'neutrality'; there are definite effects from any research endeavour, may they be stabilising or destabilising, which is where a traditional sociology and a '*relational*' sociology (Latour (2005) terms it the '*sociology of association*') part:

> For the sociologists of the social, sociology should strive to become a science in the traditional disinterested sense of a gaze directed to a world outside, allowing for a description that is somewhat independent of the groups being materialized by the actors. For the sociologists of associations, any study of any group by any social scientist is part and parcel of what makes the group exist, last, decay, or disappear. (Latour 2005, p. 33)

Writing a thesis '*deconstructing*'[31] the taken-for-granted social identifications of 'the drug user' and 'the human service workers,' I am at the same time unwittingly helping these subject positions to live on, maybe in a 'moderated' form, but nonetheless living on. Paradoxically but logically, therefore, studying how the 'human service worker' identifies a 'drug user' and these subject positions' systemic reproduction, I am (co-)constituting the very groups I am deconstructing, an insight which brings forth the demand for *reflexivity* in the research process. The researcher is in no way socially privileged 'to know' and has to reflect not only on his/her own work but also on the very knowledge production and ways of studying by other researchers and colleagues in academia. This is sometimes referred to as '*reflexivity*', an awareness that '… *in using language, producing texts, and drawing discourses, researchers and the research community are part and parcel of the constructive effects of discourse*.' (Phillips & Hardy 2002, p. 2)

Latour goes as far as to say that researchers are always '*one reflexive loop **behind** those they study*' (2005, p. 33), which, of course, does not mean that researchers should not try to be reflexive in their studies, but that they are as 'caught up' in the social discourses as their

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[31] 'Deconstruction', is a term coined by Jacques Derrida, and escapes an easy definition, particularly because it is meant to be an ongoing process of deconstructing [texts]. In a book Caputo with Derrida tries to capture and describe deconstruction: '*The very meaning and mission of deconstruction is to show that things – texts, institutions, traditions, societies, beliefs, and practices of whatever size and sort you need – do not have definable meanings and determinable missions, that they are always more than any mission would impose, that they exceed the boundaries they currently occupy. What is really going on in things, what is really happening, is always to come. Every time you try to stabilize the meaning of a thing, […] the thing itself, if there is anything at all to it, slips away*' (1997, p. 31).

interviewees and in their own social position, assumptions and ignorance. There can be no assumption or pretence of researchers being elevated, more insightful or more knowledgeable than the researched. Again, Latour cautions us not to presume to be '*in the know*':

> Actors do the sociology for the sociologists and sociologists learn from the actors what makes up their set of associations. [..] For them [critical sociologists], actors do not see the whole picture but remain only 'informants'. This is why they have to be *taught* what is the context 'in which' they are situated and 'of which' they see only a tiny part, while the social scientist, floating above, sees the 'whole thing'. (2005, p. 32)

Any account of any research is necessarily limited and idiosyncratic, yet must be internally coherent; recognising this 'perspective' in research is critical because it means abandoning the belief in the one-to-one representation of 'reality' in language and the belief in the fixity of 'reality'. Little Bear describes this well from an American Native point of view:

> In the Blackfoot mind, what we know is simply a temporary marking in the flux, which is then used as a reference point. One can say the temporary reference point is what constitutes our reality. If that reality is not re-created, a different reality will come into being. A new reality may not include our present reality. Thus, the felt need to renew. (Little Bear 2005, p. x)

The awareness of the 'reference point', the *perspectival* nature of 'knowing' is essential for any research that seeks to illuminate social practices; Mitchell finds that '*To admit the perspectival character of knowledge should be to sharpen rather than blunt our critical stance*' (1999, p. 10) and Law's *After Method* (2004) is partaking in a reflexive understanding of knowledge. Ironically, he still poses 'modernist' questions in his timely and important reminder of the 'messiness' of social life:

> If much of the world is vague, diffuse or unspecific, slippery, emotional, ephemeral, elusive or indistinct, changes like a kaleidoscope, or doesn't really have much of a pattern at all, then where does this leave social science? How might we catch some of the realities we are currently missing? […] If the world is complex and messy, then at least some of the time we're going to have to give up on simplicities. (2004, p. 2)

*Giving up on simplicity* means that, whenever one poses research questions, one only ever '*earns*' more questions: whether looking at the history of the 'drug user', encountering or feeling alienated by the way research was being conducted and interpreted in the drug and alcohol field, or having different epistemological assumptions than other researchers. I cannot pretend to come up with a simple (or complex) policy 'recipe' for others to 'follow,' nor am I able or willing to

pretend that I just need to 'go out there' to find 'answers' or 'solutions' to the 'problem' that was posed.

It became clear that the original research question (how community services could meet the needs of drug-dependent client groups) was no longer relevant or plausible and not compatible with the adopted constructionist position.

## The research question

I would like to share some of my initial suspicions and hesitations; I found it initially very difficult to assume my own position, approach and research question until I realised that changing one's position is as 'natural' as the world around one is changing. Many people wanted me to *reduce* (or 'focus') my endeavours and perplexity to *one* research question. I refused as I realised that the way one researches has immediate implications for how the research question needs to change. The 'research question' is, at best, an *organising principle* for thinking and writing-up research, but questioning is always iterative and ongoing; it took me a long time to realise why this was the case and that social constructionism indeed *demands* that one studies the way a problem is constituted by and from different points of views. I also failed to see how I could have engaged in either deductive or inductive research approaches, as they occur simultaneously and are equally organic to the process of knowledge production.

Using a constructionist lens, I began to study the socio-cultural and socio-economic 'framing' of the situated context of the encounter between a 'human service worker' and a 'drug using client', transforming my research question into a four-fold exploratory journey:

***Which practices and discourses constitute the drug user and the human service worker, particularly in the service relationship, in the drug welfare service system, in the 'war on drugs' and harm minimisation and how do these discourses and practices change within the helping culture?***

This exploratory question structures the entire thesis and formed the basis for the selection of literary texts I deemed relevant; this led to a further logical step in that the methodology of *discourse analysis* would be most appropriate and aligned with the constructionist epistemology as it is able to explain differences and variations in people's realities as they are discursively achieved.

## The discourse of discourse analysis

'Method' derives from the Greek and signifies the 'way across,' referring to '*a way, technique, or process of or for doing something*' (Merriam-Webster Dictionary 1995). Thinking about and deciding my method is, therefore, describing how I '*walk the way*', my way (*hodos*) towards/across (*meta*) finding out about something. It was a journey that had just as many 'organically' as 'artificially' set beginnings and endings.

Discourse analysis is 'a *methodology rather than just a method*' (Phillips & Hardy 2002, p. 3) and should not be seen as '*a method of analysis detached from its theoretical and methodological foundations*.' (Jørgensen & Phillips 2002, p. 4/5) Critical discourse studies, Critical Discourse Analysis, Foucauldian Discourse Analysis, discursive psychology or simply discourse analysis are variants of studies of discourse and often have multiple theoretical and disciplinary underpinnings and traditions. Jørgensen and Phillips (2002, p. 6-7) differentiate between '*Laclau and Mouffe's discourse theory*,' focusing on the discursive struggle between different discourses, '*critical discourse analysis*,' analysing through inter-textuality whether discourses have a transformative or reproductive effect and '*discursive psychology*,' seeing '*individuals both as products of discourse* ***and*** *as producers of discourse in specific contexts of interaction*.' Accordingly, Willig defines discourse analysis in terms of language:

> Discourse analysis is concerned with the ways in which language constructs objects, subjects and experiences, including subjectivity and a sense of self. Discourse analysts conceptualize language as constitutive of experience rather than representational or reflective. (1999, p. 2)

Language, in fact, matters so much that federal Justice Minister, Chris Ellison, expressed his wish to outlaw the *terms* 'party drug' and 'recreational drug' '*because we need to get through to young Australians that drugs are dangerous*' (quoted in The Australian 14/12/2006). In congruence with social constructionism's view of language, discourse analysis goes beyond its everyday understanding and regards language as even more important. Potter & Wetherell summarise the underlying assumptions when discourse analysts employ the term 'language':

> 1. language is used for a variety of functions and its use has a variety of consequences; 2. language is both constructed and constructive; 3. the same phenomenon can be described in a number of different ways; 4. there will, therefore, be considerable variation in accounts; 5. there is, as yet, no foolproof way to deal with this variation and to sift accounts which are 'literal' or 'accurate' from those which are rhetorical or merely misguided thereby escaping the problems variation raises for researchers with a 'realistic'

> model of language; 6. the constructive and flexible ways in which language is used should themselves become a central topic of study. (1987, p. 35)

Accordingly, when interviewing people, a discourse analyst is interested in the *variations* between different texts and talks that seemingly portray the 'same' object or subject'; as language does not simply reflect reality, s/he is interested in how texts and materiality are assembled by and through discourses to give them meaning, yet is crucially aware of the instability of meaning systems. In fact, it is the discourse analyst's task '*to plot the course of these struggles to fix meaning at all levels of the social*.' (Jørgensen & Phillips 2002, p. 25)

As discourse analysis that *only* investigates language *use* and *analysis* is unsatisfactory, a notion of *critique* came into discourse analysis and although I have not explicitly followed any one formulation of a critical stance in discourse analysis, it nonetheless has informed my approach and I align my work broadly with its aspirations. McKenna views eight characteristics as central for defining '*critical discourse studies*': teleology, theory of discourse, materialism, historicity, constructionism (constructivism), theories of subject, ideology and power (2004, p. 10-14). Discourse analysis does not treat phenomena as given and by analysing the workings of discourses, it can be shown how fragile, instable and contradictory social practices are. In showing how we view the world and ourselves by revealing the relationships of texts, contexts and social practices, discourse analysis can offer a critique and new ways of seeing things, making social change conceivable.

Fairclough outlines the '*ingredients*' for a critical approach to discourse analysis as needing to be concerned with analysing linguistic texts, viewing texts as products of social processes and (potentially) ambiguous as well as studying them in their diverse meanings and forms, studying discourses as fluid, historic and socially constructive for subjects and social relations and in their power and ideological effects as well as their transformative and reproductive effects (1992, p. 35-36). Such critical approaches to discourse analysis have provided me with a firm basis upon which to engage with my interview material and theorise it beyond the micro-macro divide of studying social life, informed by a conceptual framework outlined in Chapter Three. Adopting a critical stance does not in itself promise or hold any solution or change, but it raises one's awareness for inconsistencies and contradictions in social practices. Destabilising or at least de-familiarising meaning-making is in the critical tradition; it is a tradition that helps us to imagine a world in which current practices ceased:

> That is, a pragmatic and critical philosophy asks the present to imagine how the current ways of speaking, thinking, and acting would look from a situation where those ways are

> no longer practiced. This exercise will not necessarily show how those who share in the present practices could opt for different ones, but it might encourage the questioning of incongruity and incoherence that otherwise would be ignored. (Hoy 2004, p. 213)

Ways of engaging in discourse analysis vary widely, not only in data sources used and disciplinary traditions adhered to, but also in the degree to which they link micro- (everyday life) and macro- (hegemonic/dominant) discourses. Phillips and Hardy locate the different approaches to discourse analysis on a two-axis continuum: context-and-text and constructivist-and-critical (2002, p. 20). Alvesson and Kärreman produce a typology based on where discourse studies locate their theoretical and empirical interests: one continuum identifies discourses as being located between '*close-range interest (local-situational context)*' and '*long-range interest (macro-system context)*', the other tracing the degree to which discourse is viewed as *determined* or *autonomous* (2000, p. 1135). Rather than looking for a 'definitive' statement on discourse analysis, I regard openness to various theories, disciplines, methods and data sources as one of the advantages of using discourse analysis, enabling a reflexive way to engage with data and other research.

**The multifarious uses of 'discourse'**

As with any methodology, there are problems in 'applying' and thinking with discourse analysis; one charge that has been mounted is that 'discourse' is ubiquitous and used in confusing ways and with multiple meanings (Bacchi 2005). Another is that, whilst discourse studies have reached considerable maturity, it is still viewed with suspicion due to different definitions in social theory, different countries' academic and theoretical orientations in how they interpret discourse studies – a linguistic vs. social science enterprise (see Fein & Florea 2006) – and language study per-se (Fairclough, Graham, Lemke & Wodak 2004, p. 3). These are legitimate concerns and demand clarifications and - most importantly - ongoing dialogue.

The question what a 'discourse' 'is' is not easy to answer; Fairclough describes it as three-dimensional '*relationship between **texts**, **interactions**, and **contexts***' (1989, p. 26). Phillips and Hardy draw on Parker's work by defining a discourse '*as an interrelated set of texts, and the practices of their production, dissemination, and reception that brings an object into being (Parker, 1992)*.' (2002, p. 3) Indeed, Parker moves beyond the written and spoken texts to analyse visual and physical texts, to study '*discursive practice*' with a '*conception of textuality as a material force, with analyses of cities, organizations, gardens and sign language*.' (1999, p. 8)

Fairclough, Graham, Lemke and Wodak do not regard discourse as reducible to (the analysis of) text or talk (or their interrelatedness) either, instead arguing that

> […] discourse (in the most abstract sense) is an inherently relational term for one moment of the social which has no existence except through its relation to other terms (be they, according to the particular social theory, institution, habitus, materiality, and so forth); (2004, p. 4)

Sawyer outlines how, contrary to widespread academic belief, Foucault is not the originator of the contemporary usage of 'discourse' and argues that part of the explanation for its widespread use in and appeal to different theories and disciplines lies in its ability to fulfil multiple theoretical 'gaps':

> 'Discourse' has captured the totalizing and semiotic connotations of 'culture', combined it with the Gramscian and Althusserian notions of 'hegemony' and 'ideology', blended it with Lacanian psychoanalytic concepts, tapped into the linguistic turn in literary theory, and then introduced Foucault's historical perspective on power/knowledge relations. (Sawyer 2002, p. 449-450)

For me, discourse is not purely 'interrelated texts', neither purely 'language-in-use' nor materiality, not simply a body of knowledge, a meaning system or a social practice. There are theoretical differences in how we use the term discourse '*between the abstract use of 'discourse' when referring to a* ***type*** *of social phenomenon in general, and the specific use when we are dealing with a concrete example*' (van Dijk 1987, p. 4) of text. If we want to use discourse as both structure and process, we need to qualify whether it has a '*sedimenting*' or '*liquefying*' effect in the way it is deployed. Most likely, it has both those effects over time, but discourse that '*achieves*' materiality is more rigid and lasting than others. I concur with Fairclough and Wodak that discourse should be seen as having a dialectical quality:

> A dialectical relationship is a two-way relationship: the discursive event is shaped by situations, institutions and social structures, but it also shapes them. [..] [D]iscourse is socially *constitutive* as well as socially shaped: it constitutes situations, objects of knowledge, and the social identities of and relationships between people and groups of people. It is constitutive both in the sense that it helps to sustain and reproduce the status quo, and in the sense that it contributes to transforming it. (1997, p. 258)

It is difficult to provide a clear-cut definition of what discourse is when many researchers have identified it as a fuzzy, ambiguous and 'hard to catch' concept, precisely because it is expected to fulfil so many theoretical promises. Its fuzzy complexity may be regarded as its strength and weakness, in many ways, it works like temporary social glue, organising and holding meanings (and subject positions) whilst simultaneously keeping them at play, temporarily

binding more or less fragile and incompatible practices and *being in relation to* other discourses that strengthen and/or undermine it.

The concept of discourse is appropriate for a study based on interviews, because it can locate the social logic of interviewees' perspectives *in the discourse* (that constitutes us and that we constitute in language and social practice) rather than 'in' people (escaping the internal/external dichotomy). In other words, the use of 'discourse' allows the researcher to escape the '*blame game*' of seemingly problematising people or being misunderstood as claiming people act in '*false consciousness.*' Instead, it shifts the focus to analysing how discourses operate and to which effects problem constructions produce or how particular interpretations automatically prevent other interpretations.

Assuming that discourses 'speak us' as much as 'us speaking discourses' provides insights as to the potential trappings of discourses as well as the potential liberation from discourses, thus enabling thinking and acting 'differently' and critiquing current modes of subjectification. It is doubtful whether one can *be* 'outside' discourses but, arguably, one can strive to at least *think* outside them, continually question them and then begin to use them (more) strategically. Underlying this line of argument is theorising a '*subject who is simultaneously made a speaking subject through discourse and who is subjected to those discourses*.' (Bacchi 2005, p. 205) Another advantage of using discourse analysis is that it starts with the '*taken-for-granted*', studying the rule as much as the exception. Latour explains how research projects (used to) have a (de)fault line:

> Until laboratories, machineries, and markets were carefully scrutinized, Objectivity, Efficacy and Profitability – the three Graces of modernism – were simply taken for granted. Social scientists had fallen into the dangerous habit of studying only those activities that *differed* from those default positions: irrationality should be accounted for; rationality was never in need of any additional justification; the straight path of reason did not require any social explanation, only its crooked deviations. (2005, p. 97)

Latour unsettles us further, putting the question as to what is 'social' on its head: '*the social has never explained anything; the social has to be explained instead*.' (2005, p. 97) So, if I were to '*explain the social and not offer a social explanation*' for the encounter between the 'human service worker' and the 'drug user,' I need to trace associations and relationships. Asking which discourses and practices *constitute* the drug user and the human service worker, it is crucial to query *the very basis upon which their constitution was and is possible and the concept of discourse is important to explaining such constitutions*.

**Studying Experience**

Starting to understand some complexities prevalent in drug and social policy, finding out how drug problems are constituted in the service system and in broader contexts demanded me to talk to people working in this system. A qualitative research approach appearing most appropriate for previously discussed epistemological reasons, I interviewed 'generic' human service workers about their experiences of working with drug users. In line with the assumptions of discourse analysis, I was not simply interested in their experience but in the discourses and practices constituting their experiences. I wondered what it meant to them to be a 'human service worker', to encounter a 'drug using client' and what they thought a 'drug problem' was; how did they make sense of their experiences?

But this is not how I began doing discourse analysis; this starts with the minute one opens a book, attends a conference, reads a newspaper article or listens to a song on the topic, by seeing billboards advising of construction work for a new government-funded treatment facility, tobacco advertisements and lavish pubs. It starts with finding medicine packs in pharmacies developed for 'hangovers,' coming with a bottle-opener attached (just in case one doesn't have the tools to organise a hangover to then need the medicine). Discourse analysis happened when I read signs in pubs, advising me of penalties applying in case of intoxication or when talking to my pharmacist who would not provide a methadone program, because he wants his pharmacy to be viewed as 'family friendly', augmenting the re-sale value of his business.

I started to think of my 'data' in three distinct categories: first, data gathered from academic literature and other texts; second, data gathered from what I call 'conference ethnography' – meeting, listening and talking to people who work in the 'alcohol and other drugs field' – and, third, the data to be gathered by interviewing people. From a constructionist point of viewing language as social *action*, my data originates from three actions respectively: *writing* (texts), inter-*acting* (conference ethnography) and *talking* (interviewing people). As discourse analysts are interested in the '*socially constructed nature of the research categories themselves*' (Phillips &Hardy 2002, p. 10), the literature review in Chapter Three is written as an analysis of more or less dominant discourses originating from and governing the academic landscape of drug discourses. As the literature helps to illuminate which discourses operate in which accounts, it is used throughout the subsequent Chapters as well, as an important resource to situate and contextualise interview material.

The *written data* represent the journey through the extensive literature in order to identify prevalent discourses, from newspaper and website articles to 'drug user' magazines, from government policy documents, Senate reports, governmental inquiries and committee reports to academic and literary works. From the auditory and visual 'texts' of drug songs, poems, posters to the ABC's comedy show 'Backberner,' ridiculing the government's mailout of 'educational' brochures for *illicit* drugs to every Australian household in 2001 by showing the reaction of a street-based prostitute to the campaign by saying '*Yes, brochures, that's what we need! More brochures,*' I have 'elevated' the examined texts not only as part of the study of 'drug problems,' but as a co-constitutive instance of 'drug problems'.

The literature review is written as a kaleidoscope, assembled to position discourses in relation to one another, but with each snapshot the picture moves and different discourses and practices emerge that further complicate matters, modifying what was said before or bringing new materials to light. Changing position, the kaleidoscope changes again and, in an endless assembly of jigsaw pieces, new pieces and colours smudge, mess with or make crystal-clear the previous shapes which had emerged. Selecting what was relevant, I asked myself how the literature could serve to illustrate on which 'stage' the two subject positions, the human service worker and the drug user, encounter each other and how that encounter would be '*contextualisable*'. I had to use multiple contexts, such as – following Keller – historic-social, time-diagnostic, institutional-organisational and situative contexts of texts (2004, p. 96), as it is clear that there are *stages*, not just one stage, upon which encounters take place. I organised the discussion of each context in line with my conceptual framework.

The *interacting data* were generated by taking extensive field notes during experiences of 'conference ethnography', during which I went '*native*' by talking to countless experts, academics, specialists, workers and policy makers at conferences, making presentations, attending seminars and training workshops and policy consultations, thereby having ready access to the taken-for-granted notions *and* the (political) struggles in the social- and drug policy fields. This type of data gathering taught me that many conflicts are being fought out '*behind the scenes*' between and among researchers, policy makers, service agencies and other 'stakeholders', with only a few of these reaching the public arena and being published in journals. In fact, it took me a long time to be able to *decipher* the different actor 'positions', their political aspirations, institutional allegiances and their knowledge making. Who envied whom for recognition, influence and financial capital? What relationship with the government must one have? The battle lines over which institution, which researchers, which disciplinary paradigm

should be used are continuously redrawn, sometimes slowly, sometimes quickly. The strategic 'research games' that are being played when writing grants, which experts' opinions are carefully navigated and which experts are appealed to when attempting to portray evidence-based approaches as somehow neutral. Yet, I have only managed to scratch the surface of the politics of researching and the ongoing meaning-(re)making.

The *talking data* derived from my interviews; I first held some preliminary conversations with workers to ascertain some facts, figures, current 'issues', language and service system parameters. Interviews are not 'naturally' occurring talks; they are produced with an interview *instrument* and narratives are produced with a specific and assumed purpose: *research*. Narratives are always generated as '*appropriate*' for a situation and researcher and researched co-produce this 'appropriateness' and the 'knowledge' resulting. Further, when asking workers about their clients, I am looking for *constructions of clienthood by others* and am *not* calling on clients in absentia to be my witnesses to the 'truth' of the accounts or the accuracy of my and the workers' constructions. I have not interviewed clients; my account of the workers' experiences does not lay claim to knowing or identifying the 'reality' of human service workers and their work, rather, it puts forward a particular view of how their interpretations of their experiences shape their 'reality'. My account is itself, therefore, a political project of shaping 'reality', the 'ontological politics' of research(ers).

With these three data categories 'collected', I scrutinised them using discourse analysis; the different data sources are not necessarily made explicit in the thesis, but they all helped me to make sense or question *across* data: the interview data threw new light on academic literature and the conference ethnography contextualised interview and academic data and so forth. The different data sources enriched, in fact, made possible the conceptual framework and brought about many iterative cycles of questioning. This 'discourse assembly work', however, was not carried out following a distinct set of instructions and is not in the traditional meaning of the word a '*method*'. There seems to be general agreement that whenever people *do* discourse analysis, they do not recommend nor do they follow '*easy 'how-to-do-it' rules*' (Burman & Parker 1993, p. 161), in fact to offer a recipe-like approach would be antithetic to discourse analysis. Rules or steps for doing discourse analysis would change the fluidity of what I am analysing and of the analysis itself.

As quantum philosophy has taught us (Skolimowski, 1994), an insurmountable difficulty in any research process is that one needs to 'stop' the flow of reality in order to describe it (capture its processes), but by suspending the fluidity of reality for the purpose of analysis, one

alters the very processes in which reality unfolds. As well, we cannot think in 'stereo'; when asking reality to '*stop*' and trying to take it '*apart*' for study, we alienate the parts by isolating them and depriving them of their *relational* and their *processual* character, their ongoing relationship with other things and people, indeed, representing the most difficult part of studying any phenomenon. The relational represents the fluid *in-between* and as soon as we categorise the in-between, isolate the parts from the whole, we change the in-between and therefore change the nature of what we were trying to capture in the first place. The slippery nature of the study of social phenomena has brought the social (and other) sciences into yet another mode of reflexivity towards their own 'methods'. The study of experience (in my case through interviewing people) has a long philosophical tradition; Jay (2005) has delivered perhaps the most comprehensive, if not the most illuminating evaluation of this tradition to date, outlining some of the pitfalls of scholarly attempts to theorise experience:

> [The] adherents variously identified [experience] with dialectical rationality, the metaphysics of the presence, too quick a confidence in the pervasiveness of meaning, and a strong notion of a centred subject whose meaningful life could be narrativized in a coherent way. (Jay 2005, p. 364)

Mindful of all these possible fallacies, I have tried to approach theory eclectically, like a tool-woman selecting which tools are useful to the project, constantly trying to interweave available text with interview data and theoretical insights, whilst at the same time endeavouring to render my interpretation and the empirical data explicit, realising that the two merge to the degree that it is obviously me (with my prejudices, blind spots, ignorance and experiences) that is interpreting the data. Deciphering our collective and individual theoretical trajectories is very significant for our worldview (*Weltanschauung*) and makes us aware of how it changes as we change. As mentioned before, this approach to research and theory is necessarily idiosyncratic and could not be otherwise. Having established which data sources informed my discourse analysis, I will now present those I interviewed and how I recruited them.

**Interviewing people at their workplaces**

The three industry partners, Catholic Social Services Victoria, the Council to Homeless Persons and the Centre for Excellence in Child and Family Welfare (formerly, Children's Welfare Association of Victoria), were instrumental in initiating the research project and partly funded the project, most of the funding deriving from the Australian Research Council. I was,

therefore, aware of needing to accommodate and gain a real understanding of where the industry partners were 'coming from' and what they expected from this research and I visited each one repeatedly, finding out more about their work and their intentions.

It was agreed that forming a reference group would be a meaningful way of involving the industry partners on an ongoing basis, utilising their 'insider' perspective to inform the research, consulting with them and keeping them up to date on progress and findings of the research. The reference group was advantageous in many respects, particularly to gain access to participating organisations; it also presented a disadvantage in that the diverse interests of members – consisting of - at least - three representatives of the industry partners, two supervisors and a few people who were recommended as knowledgeable in the field – had to be accommodated.

Throughout the entire research project, I took extensive field notes wherever I went, also drawing mental maps to conceptualise the data and to manage the massive amounts of information I was collecting. As part of '*getting a feel*' for the helping culture, I conducted several 'expert interviews,' discussing the current debates regarding 'drug using clients' and their 'management': two interviews with CEOs of industry partners, one each with a policy worker and a domestic violence worker at the 'coalface', helping me to develop my *interview instrument*.

This semi-structured interview schedule was also a reflection of a developing (at the time rudimentary) conceptual framework, capable of capturing the complexities of working in the human services field. The instrument aimed to capture five areas: (1) a brief description of work role, prior training and program in which the workers were currently (and previously) employed, (2) their definition of 'drug use', 'drug using client' and 'human service worker' and the 'nature of their relationship' (including their influence and focus within this relationship), (3) the support and/or prevention of their work by their organisation (employer) and government (including policy and training needs), (4) their (preferred) approaches to and learning from working with 'drug using clients' and (5) their identification of areas requiring change and whether they identified with a particular social class.

After preparing the interview instrument, I formally applied for Ethics approval to Australian Catholic University's Human Research Ethics Committee (HREC) and obtained clearance. Additionally, I was involved in a long and drawn-out process, seeking Ethics approval from non-government organisations [NGOs]; as mentioned earlier, my industry partners' involvement in the study helped me to gain access to 13 organisations and informed consent was sought and obtained from interviewees prior to the interview.

The notion of informed consent is a very complex one; its wording is carefully monitored '*ethics-committee-speak*' (Guillemin & Gillam 2004, p. 263), even to the extent of governing punctuation and grammar, and is dominated by legal(istic) phrases. In some sense, the consent participants grant can never be fully 'informed', since, as the information is collected, a story is *unfolding*. What this story is, what it consists of and how the data will be received, publicly or otherwise, is often not clear to the researcher or the researched. It is also often *after* the story has been unfolding that the researcher needs to exercise judgements and responsibilities (Cant & Sharma 1998, p. 260).

As described by Caulley (2000), there are ethics guidelines that we believe in and follow, such as confidentiality, anonymity, respecting privacy and whilst they often seem like idealised versions of research and practice and of participants' interests, it is worthwhile, indeed necessary to strive towards an ideal. Conducting research in an ethical manner also involves acknowledging the politics of doing research and the politics researcher and researched are currently (often inadvertently) subjected to. Granting of access to organisations is a very political process as is the wording of ethics statements themselves.

Vulnerability is not only a matter of understanding that socio-economic differences and inequalities between the researcher and the researched may have concrete repercussions; it also applies to the circumstances of the research encounters, requiring sensitivity in preparing and conducting them and care in handling of data. For example, ethics regarding illicit 'drug users' are still in their infancy; the Australian Injecting and Illicit Drug Users' League (AIVL) (2003) demands that the *legal* implications of research involving illicit drug users need to be more properly acknowledged than is currently the case and advocates for more peer-based education and research. Ethics guidelines and statements have their own history and institutional powers: Briskman and Noble describe the Australian Association of Social Work (AASW) Ethics Code as expressing the '*individualistic politics of liberal thought*' (1999, p. 57), whilst Agger problematises the ideological-political character of disciplines themselves, by warning that sociology may act as or even become an '*ideology through the institutionalization of its positivist discourse*.' (2002, p. 447)

After the 'scoping phase' and setting-up the reference group, the latter recommended a number of organisations to be included, 13 of which agreed to take part and I then set out to investigate how 51 human service workers, working in *non-government* and *non-drug related* community service organisations in metropolitan and regional areas of the State of Victoria, interpreted their experiences working with drug using clients. After successful ethics applications

were obtained, I asked the respective NGOs to nominate a contact person to become my main source for recruiting participants. For the first 5 interviews I tried the snowball method to gain informants, but then decided that the most coherent way for recruiting interviewees was to seek them through the contact persons, nominating the people I was interested in interviewing. I selected for different years of experience, different gender, different training and services in order to maximise the spread and backgrounds of the workers, enabling me to assemble a heterogeneous sample, reflecting the diversity of this particular workforce.

The human service workers derived from 13 agencies across Melbourne (Frankston, Dandenong, Springvale, Noble Park, Footscray, Richmond, St Kilda, Werribee, Preston) and regional Victoria (Bendigo, Morwell), working for residential, adolescent, family (preservation) services, foster/home-based care and family support programs as well as parental education programs; they worked as counsellors and financial counsellors, for bail advocacy and support programs, provided domestic violence services for women and delivered programs for homeless and Indigenous people and they were (para-)legal, emergency relief or youth workers; 41 derived from metropolitan and 10 from regional services. The latter worked for three organisations, one of which was incorporated into a metropolitan agency structure. The ten regional workers delivered housing, residential, youth and counselling services; one ran a juvenile justice conferencing program, two provided help for clients at a consumer and tenancy resource centre, whilst others were legal or Indigenous support workers. Overall, there were 17 males and 34 females and I will refer to their gender as appropriate as I will to the three Indigenous workers as subgroups. For the reader it is important to keep in mind that the workers interviewed were not working in harm reduction's or social movements' grassroots organisations nor at the grassroots level although they worked on the coal face of harm reduction nonetheless.

As discourse analysis is interested in the variety of discourses operating and in the variation of discursive accounts, it was useful to have a bigger sample than the usual 30-odd people other qualitative studies have. Of course, I have not identified all possible variations and discourses workers drew on or rejected; the aim was to identify at least some variations present in the interviews and show how different discourses constitute 'drug problems'. The overall, fully transcribed interviews amount to over 387,000 words, or roughly 516 pages.

I conducted the interviews between the 26th of March 2003 and the 19th of August 2004 using the appended interview schedule (see Appendix). I visited workers at their workplaces (except twice for reasons of their convenience) and the interview length varied between 30 to well over 100 minutes. Several times I enjoyed meaningful discussions with the workers after the

interview had taken place, reflecting their interest in the project; some of these discussions were not only inspired by a sense of solidarity, but gave interviewees and me time to have 'light bulb' moments. When asking workers to reflect on their experiences in interviews, some were impelled to think about their practice in a different light and felt they were not alone with their queries about 'the sense of it all', providing me and themselves with new insights. Having obtained sufficient information enabling me to speak confidently and meaningfully about interviewees' interpretation of their experiences and to link it usefully to existing literature, I felt that my primary data were saturated and ceased interviewing (Glaser 1978).

I always attempted to create a *mood of conversing* with the interviewees, which helped achieve a 'natural' feel to the dialogue, the workers seeing the relevance of my questions for their working situation. On a few occasions, however, interviewees felt examined about their 'knowledge of drugs, partly to be explained by the unequal power balance between researcher and researched and partly due to the fact that I was investigating a topic where some had no training or formal education in and were insecure before the interview.

Interviews rely almost solely on *language* as the carrier of meaning, leaving a great deal of 'data', only felt in the direct – often non-verbal - interaction between participants and myself, unreported and only implicitly analysed. I felt and feel an enormous responsibility to present their stories revealing the emotional work they (have to) invest to help others relate to their own and their clients' stories. I, therefore, do not ever intend to claim that workers are 'wrong' or are 'victims' to 'false consciousness', nor do I wish to diminish the difficult and ambiguous 'reality' of their 'situated context'. Rather, I try to detect discourses and practices in operation, so as to show how 'escapable' their difficulties may be(come), *if* social changes *and* changes in our thinking would occur. As mentioned, the goal is to try and think *outside* established discourses, even if we cannot escape them in a bodily and environmental sense, certainly not immediately. '*Bracketing*' (Husserl 1967; Denzin 1989) the interviewing experiences is all the more important when trying to analyse them as *data* and dis-cover *meanings* and *taken-for-granted views*, both in the researcher's and the participants' thinking.

**Relevance, analysis and limitations of the data**

Data generated using a semi-structured interview schedule are not '*naturally occurring*' talk; it is produced for and influenced by the interview situation and interview questions have guided, if not steered the conversation in a particular direction. Topics, comments and

impressions have, therefore, been a deliberate teasing out of workers' everyday meaning making. Often using semi-structured interviews, discourse analysis is deliberately selective in the accounts it produces, partly governed by the research question or research interest; it is not *suggestive*, however, although *existing and possible* interpretations are clearly put 'out there' for scrutiny; identifying existing meanings and evoking context 'provokes' new insights and elicits meanings which may not have been thought like this before.

Workers often commented that they had not thought before about a given topic evoked by my questions; they were, therefore, instrumental in rendering the workers' accounts into what they are. Interview data are thus products of a *quadruple abstraction process*: the workers interpreted what the clients told them, which, of course, is already some version of the clients' interpretation of what the worker should/needs/does know about them and others. Then there is the third interpretative filter of workers telling me, as the researcher, about the two prior interpretations and I add the fourth interpretation, as I show or narrate the three previous interpretations as discourses and practices. In this sense, I am fully aware and stress that I have engaged in the narrating of a story – originating from data derived from encounters in the field – from my own perspective, reflecting my reflexive engagement with the data, itself based on and informed by other sources of discursive 'data' as explicated before. I offer but one possible reading of the interviews and of the texts 'out there'.

The interviews drew out a great variety of themes; I read the transcripts and listened to the recorded versions multiple times and made extensive comments. This close reading was necessary to detect *contradictions* in the discourses and practices workers engaged in, expressive for the social and economic contradictions in which we all live. Kvale reminds us that empirical methods *ought to detect contradictions*: '*In other words, if social processes are essentially contradictory, then empirical methods based on an exclusion of contradiction will be invalid for uncovering a contradictory social reality*.' (1996, p. 57).

The material selected was chosen for its relevance to the research question or its context(s) and coding followed this logic; Willig argues that any discourse analysis could be repeatedly performed on the same material and, when analysed again, would produce new insights; in this sense, discourse analysis is never finished: '*The need for coding before analysis illustrates that we can never produce a complete discourse analysis of a text*.' (2001, p. 95)

After careful consideration and familiarising myself with qualitative data analysis packages and computer software's strengths and weaknesses, I made the conscious decision not to use them, preferring a more hands-on and tactile approach to the analysis, allowing me to draw

endless maps and arrows, using lines and different colours to capture the data and their relational quality. Sticky notes, huge cardboard poster-size papers and whatever the stationery shop offered were all used to bring the story alive on paper. Selecting the quotes for insertion in this thesis, I tried to choose those, capturing in a representative and dense way what had been expressed, also removing identity markers and organisational details and only where relevant mentioning interviewee characteristics.

Trying to compare and evaluate the quality of discourse analytic research with other research approaches leads to difficulties; Phillips and Hardy (2002) argue that criteria of *reliability* and *validity* are nonsensical for evaluating discourse analysis; however, sensitivity and refinement of argument, plausibility, contextualisation, insightfulness and awareness of political implications of claims and research may well serve as 'substitutes' for such evaluation (2002, p. 79/80). As discourse analysis does not lend itself to usual tick-lists of 'methodological rigour' or 'audit trails', we are left with an appeal to scrutinise the scholarship with which discourse analysis is produced (Cheek 2004, p. 1146).

A limitation and potential criticism of this research is the individualisation of the researched, only interviewing individual workers, thereby excluding the group or other collective dynamics which arguably would have revealed other discourses and not 'individualised' opinion. Other limitations in using discourse analysis in relation to theoretical, methodological, political and practical implications apply (see Parker & Burman 1993) to this study as well.

Summarising, I started the research journey by entering the 'official' drug research field as a reader and in person, examining with some bewilderment the terms and conditions of its operation, only to become immersed in deep ontological, epistemological divisions and theoretical disagreements. I adopted a constructionist approach and chose discourse analysis as my methodology, working with three distinct sets of data (written, talking and interacting) to enable me to contextualise and situate the interpretations of the workers I interviewed and who were - like anyone else – 'caught up' in discourses that 'produced' them as subjects but which they also produced themselves. Research questions guided data selection, reflecting a quadruple abstraction process. A conceptual framework formed both deductively and inductively through my engagement with 51 workers' interviews and the literature and theories current in the field. The development of this conceptual framework, functioning as an analytical and reflective tool for making sense of empirical data, will be elaborated in the following chapter.

# Chapter three

# Continuing the journey:

# The literary manufacturing of drug problems

> *I recognize that this new corrective callisthenics might make us sore, but who said the practice of social science should be painless? […] If the social sciences per-**form** the social, then those forms have to be followed with just as much care as the controversies. (Latour 2005, p. 227)*

In Chapter One, I established that the drug user came into being and was produced by multiple discourses, such as prohibition, child protection and lunacy/mental illness and that the new subject position of the *'drug user'* became materially and institutionally constituted. These developments made a variety of other and interdependent subject positions possible (indeed, they were portrayed as necessary and were themselves products of social struggles for 'progress,' etc.), such as the drug-squad officer, the drug and alcohol worker (human service worker), the addiction specialist, etc. These subject positions are only thinkable *in relationship(s)*: the mutual dependence between the police officer and his/her *partnered other*, the criminal, the drug user as the *partnered other* to the human service worker or the non-user, etc. Today, the very existence of these other subject positions make the 'drug user' subject position continually assumable (and at times inescapably so) in distinct social settings. It would, however, be a mistake to imply some 'order' or 'necessity' in these developments or to seek out which of the respective subject positions came first: '*Origins are always plural, muddied, and contested*.' (Valverde, Levi & Moore 2005, p. 88) The contingent and always open history[32], unfolding as actors struggle to achieve their interests does not allow for a concrete or fixed '*pinning down*' of origins most of the time, although we can track people, places and ideas to a fair degree and detect trends with documentation, scholarship and extensive research.

Chapter One was based on the *chronological* 'order' in which the drug user came about; the present Chapter, however, needs a different basis as it serves a dual purpose: *first*, it aims to continue the historical journey by critically analysing the more contemporary contexts in which

[32] Castoriadis reminds us that history needs to be thought of as the '*domain in which there unfolds the creativity of all people*' (1991, p. 12 my emphasis).

the human service worker and the drug user come to encounter one another as discussed in the academic literature and, *second*, it elaborates a *conceptual and analytical framework*, providing the basis for outlining the relevant literature and analysing (and interpreting) the interview data in subsequent chapters. Emphasising in this chapter the discursive *contexts* of worker-client encounters, I will only let the worker and the client 'appear' when it is conceptually useful and contributes to a more nuanced reading of the workers' narratives and 'situated context'.

I have approached the literature 'review' as a three-fold task: *reading* the relevant literature, *deciphering* (and problematising) the logic of studying (and manufacturing) drug 'problems' and *developing* a conceptual-analytical framework able to capture more complex relations. Whilst some may feel undue 'suspense' in waiting to hear the stories and experiences of workers working with clients, this thesis wants to also offer a theoretical contribution for which this Chapter is instructive and necessary. Literature will not be discussed solely in this chapter, but equally throughout the data chapters, so as to illustrate the ongoing conversation between data and the '*literary production of drug problems*'.

The chapter is organised in two parts: after outlining the conceptual-analytical framework, I discuss the social- and drug policy literature as they are the defining platforms where the human service worker and the drug user encounter one another. The constructionist perspective leads me to read the literature as (co-) constituting the *manu-fact-uring of drug problems*, the construction of drug '*fact*s' and drug problems in texts and its associated materiality. Apart from identifying contexts and discourses, my interest is in how the different authors have manufactured these contexts, approaches to and constitutions of drug problems (and thereby implicitly or explicitly the drug user and the human service worker) *differently* as they studied and wrote about them.

## 1. The conceptual-analytical framework

A first observation was that much drug research – Australian and overseas – has not critically engaged with the 'drug user' or the 'human service worker' subject positions; indeed it has not recognised them as (to be interpreted) subject positions. For example, there is very little ethnographic research available about (the fluid nature of) drug user and human service worker encounters and their inherent 'problem constructions' (see also Chapter One). In the literature, the *drug user* appears as the '*ultimate target of intervention*' (therefore positioned at the *individual level*), whereas the *human service worker* is reduced to 'staff' (therefore positioned at the *institutional level*); in other words, s/he is being seen in a '*functional*', if not instrumental

way. Research on human service workers (or any other profession working with drug-using clients) is mostly interested in 'staff attitudes' to, 'beliefs' about or 'views' on working with drug users (see Swift & Copeland 1998; Warrington, Potter & Jabour 1999; Jacka, Clode, Patterson & Wyman 1999; Siegfried, Ferguson, Cleary, Walter & Rey 1999; Happell, Carta & Pinikahana 2002; Walsh, Bowman, Tzelepis & Lecathelinais 2005), or studies them in terms of '*workforce development/retention*', '*training needs*' and drug and alcohol '*competency*' (National Centre for Education and Training on Addiction (NCETA)). Not only is it problematic that studies treat the worker in such a utilitarian way, it also precludes us from learning anything about human service workers as people, their interpretations of their jobs, their experiences working in particular 'service sector fields' and about how these fields shape their experiences and understandings with and about clients and how they change their interpretations over time.[33]

With exceptions – the literature regards the human service worker mostly as an instrument, acting at the institutional level (for organisational purposes, accountability, case loads, quality improvement and 'outcomes', suitability of qualifications). Jamrozik admits that there is a '*lack of knowledge of what the welfare agencies and the professionals they employ* ***actually do*** *in their encounters with individual 'clients"* (2001, p. 279 my emphasis), leaving us to know little about the client-worker relationship[34]. I will first outline a conceptual-analytical framework, to build on existing theorisations assisting me to illuminate the worker-client encounter in its complexity in later chapters.

### 1.1. Outline of the four levels

The basis of this chapter represents a theoretical tool, aiming to raise substantive questions about the discourses and social constructions of drug policy, social policy, human service work, drug use and welfare; it is a product of my (ongoing) struggle to make sense of 'what is going on'. From a constructionist perspective, the framework is the result of my

[33] I fully acknowledge that scrutinising human service workers' activities and experiences further may make them more vulnerable to increasing surveillance and 'management' of their workplaces, making it politically problematic or even unwise to increase our social-scientific 'knowledge' about 'them', for it could threaten discretionary practices and much more. This is why scientific studies are potentially damaging *as well as* potentially improving the current state of affairs.

[34] Some 'knowledge' about the service encounter is already available; for example, Wearing describes the encounter as possessing the following characteristics: '*shame and embarrassment; ritualised forms of depersonalising the encounter and denying emotional work done in the encounter; the use of worker's local knowledge; the desire for an efficient service economy*' (1998, p. 103).

engagement with the data, available theorisations and the formulation of a critique of what I have found lacking in existing alcohol and other drug research (see also Chapter Two).

I aim to avoid three theoretical fallacies: first, I will not 'taper over' the cracks, contradictions and loose ends of social processes by developing an overarching rationale or, worse, an overarching intentionality for 'why things are the way they are'; second will not argue that society's principles or standards simply do not 'match' its practices (because they never do); third, I will not posit societal 'standards'[35] and norms[36] as *given*, rather than as socio-historically achieved and, therefore, changeable.

One way to avoid such fallacies is offered by Latour's *actor-network theory*[37], formulated to make the social *traceable*: If '*we have to try to keep the social domain* ***completely*** *flat*' (2005, p. 171) and bring back into analysis '*the very production of place, size, and scale*' (2005, p. 171) and '*render visible the long chains of actors linking sites to one another without missing a single step*' (2005, p. 173), we will start to stitch a *quilt* of connections and associations creating the '*drug using welfare client*' and the '*human service worker*'. By rendering '*the social fluid collectable again*' (Latour 2005, p. 174), we start investigating '*chains*' like: 'the drug user' – 'human service worker' – treatment programs/agency, its policies and contracts – specialised and competing sectors and agencies – (peak) bodies trying to influence policies (and funding) for the sector – state government departments – Victorian government – mediating action plans (Drug/Social Action Plans/National Drug Strategy) – national drug policy advisory bodies/stakeholders – federal government departments – federal government – international influences and policy bodies (e.g. geo-political manoeuvring between 'developing'/'developed' countries or International Narcotics Control Board, World Trade Organisation) and so on.

I concur with Latour's insistence to trace the '***associations*** *between heterogeneous elements*' (2005, p. 5) that make up the *social* and his idea of making it *traceable* through human

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[35] For example, Henri Lefèbvre expressed that *'[w]hat we want to demonstrate is the fallacy of judging a society according to its own standards, because its categories are part of its publicity – pawns in a game of strategy and neither unbiased nor disinterested; they serve a dual practical and ideological purpose*.' (Lefèbvre 1984, p. 71)

[36] Castoriadis makes the following useful assertions about norms: '*Autonomy is only possible if society recognizes itself as the source of its norms.*' (1991, p. 114-115) '*There is no norm of norms which would not itself be a historical creation.*' (1991, p. 115) However, '*[t]he norm is that there are no norms*.' (1991, p. 185)

[37] The later to be introduced political economic level is an important addition here because it can help to overcome the two criticisms of actor network theory (ANT): its tendency to be '*presentist*' (Moore Dawn 2007, p. 53) and theoretically '*middle-range*' (Fine 2005, p. 91).

and non-human '*agency*', but I am yet to be convinced that we can trace all entities, processes, inter-subjectivities and inter-objectivities *fully*[38].

Mol's (2002) approach of studying how 'objects' differ across social settings would suggest that drugs are not the same drugs in different social spaces and - paradoxically, yet logically - that the same drug can be a 'different' drug to different people in the same setting. A drug to someone is a means to something (intoxication, pain management, etc.) and/or signifies a certain relationship; a drug to two friends might be a sharing medium, to two lovers it might be the source of intimacy; to a doctor, it might be a pharmacologically 'loaded' substance and to a judge a criminogenic property whilst a lawyer may be consider it the cause for a dispute; a drug to the therapist appears in its 'ability' to cause psychological effects or mood swings, whilst a social worker may see it as a source of social disruption or chaos, etc. In specific setting, like a courtroom or an office of a social service, however, the drug will remain this 'different-yet-nominally-same' drug to all these different parties, despite all being in the same place and situation.

Studying '*drugalities*', another illuminating approach, is defined as the '*personalities of different drugs*' by Dawn Moore (2004, p. 419), who combines actor-network theory and cultural perspectives to investigate the technologies and discourses by which drugs are specified and generalised in different settings, thereby constituting the very personalities they are assumed to '*inherently possess*'. Particularly associating drugs with gendered, racialised and classed groups, Dawn Moore describes how the technologies of generalising drugs (as opposed to specifying contexts, substances and situations) allow the targeting of *all* groups under the 'generic' term 'drug' in a constant regime of management without appearing to engage in discriminatory tactics or other targeting of specific groups (2004, p. 423). Furthermore, not only do we make drugs *agentic* by ascribing certain 'active' characteristics to them, we also make *drugalities* subject to change: '*drugality conversion*' appears when demonised or morally degenerative drugs are medicalised, made illegal or by being used by different groups, leading to their gaining or losing symbolic or status value (2004, p. 424). Dawn Moore's article assists in raising other important questions: through which rationalities, technologies and practices do we invest drugs with meaning? On which basis do we make decisions (or simply act) to address different drugs

[38] Not only would this imply somewhat 'perfect' information (flows) to make the social fully traceable but there is another problem: if we were to find all chains, interests and networks that connected actors, would we be able to resist the temptation to detect the (utilitarian) purposefulness of the social that we are so inclined to diagnose?

differently, specifically and/or generically? In any case, using the term 'drugs' is *generative* and not merely linguistic, as Dawn Moore points out:

> Rather, evoking the term 'drugs' affects a particular technique of generalization such that 'drug' is conjured as an over-broad, catchall term which, regardless of its vagaries, proves capable of informing a great deal of action, has particular consequences and largely political purposes. (2004, p. 422)

Having introduced some more drug-specific theoretical influences, the challenge remains to establish a conceptual-analytical framework which allows us to 'track' more complex processes and the time-and-space intersections which constitute social reality. Borrowing from the works of Latour, Castoriadis, Valverde, Rose, Lefèbvre, Bourdieu, Boulet and many others and whilst trying to make sense of empirical data, I have attempted to produce such a framework in dialogue with existing literature. Whilst not claiming that my approach is fully consistent with - or even necessarily reflective of - these scholars' work, elements of their work are chosen as much by what I needed to explain to myself as by what I found in need of explanation. The *four levels of analysis* I established are the *individual, relational, institutional and political economic* levels.

Whilst, in a way, this is a reformulation of the old macro-meso-micro idea of representing 'society's' processes and structure, I do not conceptualise these 'levels' as discreet and recursively reproducing spheres or hierarchical structures of society. Rather, in a Latourian mode, they are treated as *abstractions* and as theoretical *collectors*[39] of 'flat'[40] social agency, whilst certain actions, agencies and effects can be *analytically* lifted and collected whilst still regarding them as part of the overall fluidity of life in a flat landscape.

As to the utility of the framework, I agree with Latour that notions of 'framework', 'infrastructure', 'level', 'zoom' or 'context' may be quite problematic if they are used to signify hierarchies, set boundaries of actions, determinist connotations, superimposed 'constraints of agency' or deductive deployments of 'societal logics' (2005). Latour critiques the notion of

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[39] 'Collectors' assemble social-historical imaginations which are more or less bound by similar operating mechanisms. Collectors transcend the traditional material/social dichotomy. Nature/Society divisions '*which do not describe domains of reality, but are two* ***collectors*** *that were invented together, largely for polemical reasons, in the 17th century*' (Latour 2005, p. 110). But collectors can also refer to sedimented and sedimenting or ruptured and rupturing subjectivities, instituting experiences or political economic his/stories. Collectors may also assemble disparate social processes as long as they are theoretically meaningful in their combination.

[40] I am drawing on Latour's insistence to conceive of the social as flat (plane) (2005, p. 171). Hierarchy is thus seen as a result of traceable connections and networks rendering it more stable than non-hierarchical connections: '*No place can be said to be bigger than any other place, but some can be said to benefit from far safer connections with many* ***more*** *places than others*.' (Latour 2005, p. 176).

*context* for abstractly (and from the outset) limiting actors' ability to act by implying constraints by 'outside social' forces (2005, p. 215). In other words, he objects to a superimposed 'scale' on which actors, objects and processes occur and that is set by sociologists before they study the given phenomenon (2005, p. 183/184); instead, he pleads to study scale as something '*actors achieve by* ***scaling***, ***spacing***, *and* ***contextualizing*** *each other*' (2005, p. 184).

Whilst I have used the data to build the framework as much as the framework was used to build the data, it *remains a theoretical tool*. The four identified levels do *not* refer to an individual, relational, institutional and political-economic *locus*, a 'place' or 'site' where the political economy 'sits' or the institutional is 'enacted' etc. The levels refer to *collectors* that illuminate and give meaning to particular effects of everyday action, in particular everyday agency. When using the word 'level' – an unfortunate choice, as it immediately implies a hierarchy – I refer to a *collector* of flat social action which analytically extrapolates entities, actors and processes that occur parallel or simultaneously, but each 'level' producing different repercussions.

Drawing on Lefèbvre, who proposed three levels, global, mixed, private (2003, p. 136)[41] and Boulet whose three levels are everyday acting/structure, political-economic acting/structure and institutional mediating acting/structure, (1985, p. 245), the latter, referring to the former, defines levels as *interpenetrating, implying each* other and as 'places' where entities, concepts and agency *may simultaneously (or in parallel manner) occur at each level*: '*That means that concepts used on one level will display a level-specific content while at the same time "evoking" or "implying" the content of other levels of constitution*.' (Boulet 1985, p. 247)[42] Lefèbvre summarises how the idea of the level is most instructively *conceptualised*:

> A *level* designates an aspect of reality, but it is not just the equivalent of a camera shot of that reality. It allows for it to be seen from a certain point of view or perspective; it guarantees it an objective content. […] Wherever there is a level there are several levels, and consequently gaps, (relatively) sudden transitions, and imbalances or potential imbalances between those levels. […] Levels cannot be completely dissociated one from the other. Analysis may determine levels, but it does not produce them; they remain as units of a larger whole. The schematic of a scale or of a formal hierarchy of degrees is

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[41] Lefèbvre regards the global level as of '***the most general, and thus the most abstract, relationships****, but also the most essential: the capital market, and the politics of space*' (2003, p. 137). I find it perhaps more useful to think of the global level as abstract and historically more stable, thus sedimented, than as the 'most general', unless 'most general' is not understood as necessarily less common place. As Lefèbvre asserts himself, the private level is '*no less complex than the others because it is 'micro'* (2003, p. 139) and he asks us to part with the Cartesian assumption which '*identifies the small with the simple, the large with the complex*.' (2003, p. 139)

[42] The idea of evoking and implying is a far more useful way of thinking about levels than Ollman's statement that the more general levels limit the possibilities of the less general levels because he thereby asserts an a priori limitation (1993, p. 65).

much too static. Although by definition they are distinct and are located at different stages, *levels* can interact and become telescoped, with different results according to what the encounters and circumstances are. As one level mediates another, so they act one upon the other. (2002, p. 119)

The idea of 'level' therefore also encompasses *flexibility*, *diversity* and *flux*:

Level must not be thought of as being incompatible with the process of becoming and with mobility. Realities rise to the surface, emerge, and take on substance momentarily at a certain level. […] each one of them is therefore both *a residual deposit* and *a product*. […] Finally, multiple 'realities' coexist on each individual level, implying and (mutually) implied, enveloping and enveloped, encompassing and encompassed, unmediated and mediated (unmediated in themselves, mediated in relation to other vaster or more restricted levels). (2002, p. 120)

Lefèbvre thus clearly articulates that levels and their content are '*the result of an analysis*' (2002, p. 120) and that levels are '*uniting mobility and structure*' (2002, p. 120). It requires some conceptual acrobatics to keep the dialectic of flexibility/rigidity 'thinkable' and to conceive of levels as possibly limiting and possibly opening up (new) ways of living and acting. Levels thus simultaneously explain the relative social stability *and* the spaces of change (and the possible interventions) in which we operate. It is very important to understand that the four identified levels (i.e. collectors) are *already* products of the social imaginary and have been socially constructed.

There would be good reasons for summarising the individual and relational levels and, at times, I have done so, specifically in Chapter Four; summarising or 'collapsing' these two levels as '*everyday life*' level is theoretically meaningful, particularly in the conceptualisation that Ian Burkitt, informed by Lefèbvre, developed:

This makes the lived experience of everyday life multidimensional, because it is related to *all* activities and to *all* the different social fields. Moving through these fields in daily life, we are aware of passing through different zones of times and space.' (Burkitt 2004, p. 216 my emphasis)

I decided to *distinguish* between the individual and the relational level, because by differentiating the everyday level further, it can be shown that the individual can act differently in different relationships and relations and that the relational can take on different forms when different individuals (and entities) meet. These dynamics can substantially alter the everyday life level, making it more or less bearable, enjoyable or difficult, depending on the situation.

### 1.1.1. The individual level

The *individual* level expresses the dynamics of subjectivity and subject positions which are made available by discursive formations: neither are we all the same, nor are we all different and the range of assumable subjectivities and subject positions is neither finite nor infinite. This level also aims to capture those dynamics in which subject positions can be interpreted, modified, resisted or adhered to. Latour conceptualises subjectivity itself as an *achievement*, a careful layering of active *interiorising*[43]:

> Am I [..] an 'individual'? Of course I am, but only as long as I have been individualized, spiritualized, interiorized. [..] Every competence, deep down in the silence of your interiority, has first to come from the outside, to be slowly sunk in and deposited into some well-constructed cellar whose doors have then to be carefully sealed. None of this is a given. Interiorities are built in the same complicated way as Horus's chamber in the center of the pyramid of Cheops. (2005, p. 212/213)

Similar to Valverde's idea of the '*piling up of rationalities of governance*' (1998, p. 177), we can picture subjectivity as a piling up of '*interiorising acting*' which becomes sedimented but at times (is) liquefied. Rose, who thinks of subjectivity as an '*infolding externality*', regards subjects '*as 'assemblages' that metamorphose or change properties as they expand their connections*' (1998, p. 172), urging us to study the link between subjectivity and modes of subjectification:

> The 'interiority' which so many feel compelled to diagnose is not that of a psychological system, but of a discontinuous surface, a kind of infolding of exteriority. [..] The fold indicates a relation without an essential interior, one in which what is 'inside' is merely an infolding of the exterior. […] Folds incorporate without totalizing, internalize without unifying, collect together discontinuously in the form of pleats making surfaces, spaces, flows, and relations. Within a genealogy of subjectification, that which would be infolded would be anything that can acquire authority: injunctions, advice, techniques, little habits of thought and emotion, an array of routines and norms of being human – the instruments through which being constitutes itself in different practices and relations. (1998, p. 37)

Rose regards interiority as a psychological effect in which '*human beings relate to themselves in terms of their psychological interior: as desiring selves, sexed selves, laboring selves, thinking selves*' (1998, p. 172). The individual level must incorporate '*the psychological*' as '*real*' but still treat it as a *discursive effect* in as far as it recognises the institutional shaping

[43] Note: I prefer the gerund, the interior*ising*, not the interioris*ed*, so as to indicate the *ongoingness* of this process.

and the discursive power of psychology to make us construct and relate to ourselves with and in psychological knowledges:

> Psy knowledges[44] and authorities have given birth to techniques for shaping and reforming selves assembled together within the apparatuses of armies, prisons, schoolrooms, bedrooms, clinics, and much more. They are bound up with sociopolitical aspirations, dreams, hopes, and fears, over such matters as the quality of the population, the prevention of criminality, the maximization of adjustment, the promotion of self-reliance and enterprise. They have been embodied in a proliferation of social programs, interventions, and administrative projects. (Rose 1998, p. 173)

This is why arguments about which to change '*first*', individuals or society, are non-sensical, because the abstractions of individual and society are 'in reality' inextricably linked. Our agency, our acting and acts are, nonetheless, ethically motivated and we seek to constantly influence our shaping and our being shaped, which Bourdieu would probably refer to as the '*dialectic of the internalization of externality and the externalization of internality*' (1977, p. 72).

Whilst having their own *logics*, there is a close link between the individual and the relational level; with poststructuralists, I posit no *essential self*, no *true self* waiting to be discovered or unearthed; rather subjectivity '*happens*' in the relational, perhaps the single most important dimension to incorporate in our analyses, as it shapes everything:

> However, the unity of a society […] cannot be analysed into relations between subjects mediated by things, since every relation between subjects is a social relation between social subjects, every relation to things is a social relation to social objects, and since subjects, things and relations are what they are and such as they are only because they are instituted in the way they are by the society concerned (or by society in general). (Castoriadis 1997, p. 178)

The individual level also encompasses the discourse-analytic perspective in which *subject positions are created by discourses*. For discourses to be able to define the drug user in a particular way and to compete to 'know' him/her, they first have to *constitute the subject position*

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[44] By 'psy' Rose means '[t]he psychosciences and disciplines – psychology, psychiatry, and their cognates' (1998, p. 2). He refers 'to the ways of thinking and acting brought into existence by these disciplines since the last half of the nineteenth century as 'psy', not because they form a monolithic or coherent bloc – quite the reverse – but because they have brought into existence a variety of new ways in which human beings have come to understand themselves and do things to themselves.' (Rose 1998, p. 2) Rose's notion of 'psy knowledges' encompasses psychological, psychotherapeutic, psycho-dynamic, psychoanalytical and other knowledges beginning with 'psy'. He argues that 'psychology, as a body of professional discourses and practices, as an array of techniques of judgment, and as a component of ethics, has a particular significance in relation to contemporary assemblages of subjectification. Psy comprises more than a historically contingent way of representing subjective reality. Psy, in the sense I have given it here, has entered constitutively into critical reflections on the problems of governing persons in accordance with, on the one hand, their nature and truth and, on the other, with the demands of social order, harmony, tranquillity, and well-being.' (Rose 1998, p. 172-3)

*of 'the drug user'*[45] as an *a priori*. Once *the drug user* has been constructed and his/her existence accepted (an ontological claim being made), one can invest the subject position with meaning: the *good* drug user, the *moral* or *caring* drug user, the *injecting* drug user, the *young* or *old* drug user, the non-motivated or illicit drug user, the junkie or ex-user and so forth.

If (or when) someone is identified (implicitly or explicitly) or identifies her/himself as 'drug user', one 'automatically' steps into various discourses and particular interpretations of needs. Once a 'drug user', one usually '*becomes*' in '*need of*' all sorts of competing and co-existing intervention discourses. The poorer, the more 'visible' and the more substances used, the more discourses will compete to co-define or 'corral' the user of legalised and illegalised substances: treatment (therapy), education (safe use), punishment (incarceration), usage principles ('planned' intoxication, moderation), conduct pathology (normalised, deviant, (non-)problematic), consumption (modes of administration, appropriate usage locations, times and (social) company), life-course models (enslavement, addiction, recovery), etc.

The *practice of drug using* is thereby transformed into the *subject position of the 'drug user'* and in this act of transformation, the 'problematic drug user' can become inscribed in very different discourses associated with, for example, criminal justice, medicine, psychiatry, psychology, sociology, social work, child protection, addiction/dependence, harm minimisation (epidemiology, neo-liberalism), economy (welfare economics), disability, human rights, statistics, biology/genetics, education/pedagogy, religion, prohibition/law-and-order, accountability, democracy and 'citizenship'), etc. The illicit drug user is temporarily shaped by discourses and in encounters with medical practitioners, pharmacists, treatment agency staff, judges, the police, etc. S/he is constituted in such encounters but this constitution can be strategically played out, undermined, resisted or enforced and emphasised, depending on the 'situated context' and the meaning making of individuals occupying these subject positions.

At the individual level, it is also useful to remember Foucault's theorisations of the exercise of power as '*a "conduct of conducts" and a management of possibilities*' (2002a, p. 341) and of '*governmentality*' (2002b, p. 201 ff). Foucault was concerned with '*the art of government*' and the different ways in which state and other authorities have governed and could or should govern more, less or at all. Rose offers us a dense definition of the term:

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[45] In Chapter One I have argued that the drug user was predominantly 'imagined' by prohibition discourse and that state legislative efforts (resulting from social struggles) inscribed this subject position into the Law. Today, many more discourses are competing for defining subject position statements.

> [What] Foucault termed 'governmentality', or 'mentalities of government': [is] the complex of notions, calculations, strategies, and tactics through which diverse authorities – political, military, economic, theological, medical, and so forth – have sought to act upon the lives and conducts of each and all in order to avert evils and achieve desirable states of health, happiness, wealth, and tranquillity (Foucault, 1979). From at least the eighteenth century, the capacities of humans, as subjects, as citizens, as individuals, as selves, have emerged as a central target and resource for authorities. (Rose 1998, p. 152)

The concept thus can expose the many ways in which individuals are shaped by (and are shaping) hygienic, public, economic, familial or romantic conduct. It also prevents us from thinking in dichotomies, such as asking whether a policy is about social control *or* empowerment, because it usually is both. The approach[46] may become less analytically useful if every social process is explained through (or reduced to) governmental *techniques*.

### 1.1.2. The relational level

The *relational* level reflects the interpretations, enactments and experiences of social relationships as well as the interplay between actual, 'embodied' relationships and the more or less mobile, often reified institutional relationships, which can engender *stabilising* (reproductive) or *transformative* dynamics. The relational level also demonstrates that different subject positions and subjectivities are played out rather differently in different relationships, bring about very different 'sides' of us as we engage and act with others[47].

Relationships between people can be '*dissonant tip-offs*' or '*enjoyable tensions*' and everything in between and beyond: they are *in-betweens* that change as we change. Relationships are not limited to social realms, however; technologies, strategies, institutions and entities also engender relationships. Drawing on Latour (2005), relationships cannot be understood to only be taking place between human beings but also between humans and non-humans (such as drugs and users, users and syringes and users and users). Studying the evolution of the 'drug user' and omitting the drug and associated entities would not capture some of the 'social' dynamics, for

[46] For a critical appraisal of governmentality see Rose, O'Malley & Valverde 2006.

[47] I prefer to think of relational encounters as producing a different sort of music together; every song is not just altered as it is situationally produced, but we draw on very different notes, sounds, intonations and repertoires in different encounters and with different people. Sometimes we produce the 'same' music and seek that music out each time; other times we cannot make it sound well, we cannot even produce or hear a tone or we reject the music because it is the same music or it is so different. We are tired of the music or have found music that speaks to us in a new way. Yet, there are times when the music seems noisy, disturbing or upsetting, we are tired of the harmonies and seek the other (music). We need a new pitch or the comfort of the old pitch. But we still produce music (whether it is 'sound reasoning' or un/orthodox, mysterious or strange, consoling or satisfying, abundant or quiet) with our relational qualities/voices.

example, why some people seem 'fixated' on the use of particular drug paraphernalia; why preparing the drug appears ceremonial; why so many drug users 'decided' to inject with a needle when injecting is one of the most unsafe ways to use drugs; what it is about handling needles, developing retractable needles, the penetration of the needle into the skin and not wanting to undergo Hep C treatment for fear of having to use/be exposed to using needles again.

The relational level *links the subject and the (literal) object*, as Castoriadis emphasised their interrelatedness and interdependence:

> This activity of the subject who is 'working on itself', encounters as its object the wealth of contents (the discourse of the Other) with which it has never finished. And, without this object, it simply *is* not at all. The subject is also activity, but this activity is acting on something, otherwise it is nothing. It is therefore codetermined by what it gives itself as an object. […] it is the fact that *content, no matter which, is always already present* and that it is not a residue, a scoria, something that encumbers or an indifferent material but the *efficient condition for the subject's activity*. This support, this content belongs neither simply to the subject nor simply to the other (or to the world). It is the produced and productive union of the self and the other (or to the world). (1997, p. 105)

The subject-object-relation is an *ongoing* social relationship and, furthermore, the social individual is both subject and object, as Foucault points out: '*The possibility for the individual of* ***being both subject and object*** *of his own knowledge implies an inversion in the structure of finitude*.' (2003, p. 244 my emphasis) The relational level, therefore, seeks to emphasise the many – minute and broad – productive relational capacities of subject-object and socio-material interactions. One instantiation, building the transition between the relational and the institutional level, is encapsulated in Bourdieu's notion of '*habitus*':

> …[*H*]*abitus*, the 'systems of durable, transposable dispositions, structured structures predisposed to function as structuring structures, that is, as principles of the generation and structuring of practices and representations which can be objectively "regulated" and "regular" without in any way being the product of obedience to rules, objectively adapted to their goals without presupposing a conscious aiming at ends or an express mastery of the operations necessary to attain them and, being all this, collectively orchestrated without being the product of the orchestrating action of a conductor. (1977, p. 72)

The *habitus*, '*the strategy-generating principle enabling agents to cope with unforeseen and everchanging situations*' (Bourdieu 1977, p. 72) allows us to conceive of structure and change simultaneously whilst also explaining how we can generate practices appropriate to a given situation and encounter. As the habitus becomes '*in turn the basis of perception and appreciation of all subsequent experience*' (Bourdieu 1977, p. 78), it can show how tastes, socio-

political and personal preferences and 'common sense' come about without any 'intention' or overarching explanation necessary or causal relationship underlying it: '*The habitus is the universalizing mediation which causes an individual agent's practices, without either explicit reason or signifying intent, to be none-the-less "sensible" and "reasonable*".' (Bourdieu 1977, p. 79) The concept of habitus can capture why being alive, consuming, living in a capitalist world, living partnered, full-time working, (minimising) tax-paying, engaging in unpaid domestic labour, having two children (as opposed to having none, one or three), accruing surplus value and driving a car, demand no further explanation, indeed, are *common sense*[48] (in most 'developed' countries). Although they are all 'problems', they are not defined as 'social problems' and are not commonly perceived in need of justification. A trip to the movies has no need of explanation, but an LSD trip does. There are many '*habituses*' and what is *common sense* keeps on shifting and varies in the *habituses*.

### 1.1.3. The institutional level

The *institutional* level mediates between the political-economic and the relational/individual levels. The institution is often understood as an 'institute', a reified building/site, or as 'instituted', a fixed organisation or a range of frozen processes and relations of control/authority. As the conceptual framework, however, aspires to capture both mobility and rigidity of 'reality', it is more helpful to understand institution as *instituting* – an ongoing (and self-altering) process of becoming instituted, a semi-fixed relationship and outcome of a process. Processes of instituting describe 'things' evolving but not predicating, directing but not determining. Institutions become semi-crystallised forms of the relational (level), temporarily 'holding' what is neither totally fixed nor totally fluid. In effect, the institution is a 'virtual structuring process,' ordering and limiting uncertainty whilst simultaneously extending acting possibilities:

> [Interaction and the underlying institutional contexts] therefore both *narrow* options for action or exclude them *and*, simultaneously, make them possible, in that they create a certain "predictability" without which interaction, communication, even "appropriation" as a whole could not actualize nor be conceived of. Institutions reduce the complexity of experiences (and their contradictions) to an understandable, practically manageable size. (Boulet 1985, p. 255)

[48] 'Common sense' is understood as a socio-historical achievement in itself and open to change like anything else.

Put differently, institutions make complexity and chaos deliberately or by 'default' manageable by producing regimes, rationalities, knowledges and technologies that are practicable. Similarly, contemporary theoreticians of 'governmentality' point to institutions in which '*new practices and agencies of governance emerge, such as social work, and new instruments of government are invented, such as family allowances*.' (Rose, O'Malley, Valverde 2006, p. 88) Institutions may be mirrored in organisations but are not identical with them, as they rely on being *enacted* to govern or order, whereas organisations revolve around more explicit rules, regulations and goals. Institutions can be the economy, family, time, money, addiction, welfare, treatment, human rights, employment, but very different organisations or regimes assemble under each of them; institutions represent particular practices (that tentatively hold meaning(s) as we enact them):

> Institutions from the prison, through the asylum to the workplace, the school, and the home can be seen as practices that put into play certain assumptions and objectives concerning human beings that inhabit them (Foucault, 1977). (Rose 1998, p. 152)

Castoriadis inserts one step into the practice-becoming-an-institution logic; he regards *social imaginary significations* as the ideas behind the ability to institute: '*significations owe their actual (social-historical) existence to the fact that they are* ***instituted***.'[49] (Castoriadis 1991, p. 62) As to the 'economy',

> Likewise, for example, the 'economy' and the 'economic' are central social imaginary significations which do not 'refer' *to* something but on the basis of which a host of things are socially represented, reflected, acted upon and made *as* economic. […] This economic signification is 'cashed' or converted, on the one hand, into a host of significations referred to 'concrete' objects (the goods produced, the instruments of production, etc.) and, on the other, into a multiplicity of 'abstract' yet socially effective and active significations (thus, in the capitalist economy, capital, stock, labour, wages, revenues, profit and interest are 'abstract' significations, thematized and made explicit as such by and for the participants; their being-explicit is the actual condition for this society's operation). (Castoriadis 1997, p. 362)

We can enact the economic because we have named it 'economic' (as it is socially meaningful to us); furthermore, contemporary economic sociology argues that *economics* has *made the economy*: '*[I]f* ***economies*** *are the outcome of* ***economics****, as Michael Callon has argued*' (Latour 2005, p. 229/230) and if economic and financial modelling constitute markets, as MacKenzie (2006) has argued, then '*economic*' refers to a type of acting that we define as

[49] However, conceiving of institutions as man-made does not render them reducible: there is an 'irreducibility of the institution and of social significations to "individual activity" (Castoriadis 1991, p. 63)

economic only because the idea of the economy brings buying, selling, trading, labouring, wage-earning and owning into being as '*expressions*' of the economy.

The social-historical imaginary makes only a particular set of discourses available to us at any given point in time to be acted upon, yet produces simultaneously new discourses. The economy is an institution and a discourse requiring a material base (Weedon 1997, p. 102); the more instituted discourses become, the more dominant they can be, yet they are always inherently unstable no matter how stable they appear:

> The most powerful discourses in our society have firm institutional bases, in the law, for example, or in medicine, social welfare, education and in the organization of the family and work. Yet these institutional locations are themselves sites of contest, and the dominant discourses governing the organization and practices of social institutions are under constant challenge. (Weedon 1997, p. 105)

Drawing on Burr's argument (2003, p. 75/76) that institutions position people in relation to themselves, the *welfare* institution divides people into welfare recipients ('welfare *dependent*' being one classification within that group), welfare-*ineligible* people and a whole range of people who may be able to claim some kind of welfare payment or services under certain circumstances. It is instituted by the state and materialises in countless Centrelink offices being scattered around the country, breathing life and relevance into application forms, officers behind desks, telephone operators, information brochures, the 'out there' labour market, queues behind information desks, signs and tinted outside windows, privacy and confidentiality agreements and bank statements. The institution of *Federation* – producing the possibility of acting as a 'nation' and in the 'national interest' with its constitutive parts of states and territories – constitutes citizens and non-citizens, divided into refugees, temporary (student, visitor, etc.) and 'permanent' residents, all temporary and conditional classifications of people into 'populations', with obligations, rights, privileges and eligibilities changeable or revoke-able.

The institution(s) of *treatment* classify people as past, present or future (potential) treatment populations, ('treatment naïve', 'experienced' or 'resistant/non-compliant') and those not 'needing' treatment (including people who attend for social (companionship, etc.) rather than for therapeutic 'needs' and people not defined as 'problematic'). The institution(s) of treatment reflect political-economic relations when defining eligibility for certain treatments; for example, 'drug users' can be excluded from receiving pain management medication or dialysis and alcoholics can be banned from receiving liver transplants.

### 1.1.4. The cultural political-economic level

The *political-economic* level reflects the reciprocal interplay between and mutual shaping of political and economic dynamics; they are irreducible to each other and interdependent. As pointed out at the institutional level, the 'economic' and 'political' are products of the social imaginary, they have materiality and are *instituting*. With Cruikshank[50], I posit that the 'political' should not be conceived of as referring to some political sphere (parliaments or electoral offices) but as something that is played out in administrative, therapeutic and other activities in which social arrangements and technologies form citizens, subjects (1999, p. 28) and *habitus*.

Whilst the legacy of classical and modern political-economic scholarship are acknowledged and the dynamics of (re)production, distribution, consumption are recognised as defining overall political-economic process meanwhile on a global level, in this thesis this level is more concerned with *cultural political economy*. It is based on the assumption that the mode of production and the specific distribution of costs and benefits typical for *capitalism*, have an impact on, indeed are defining features of drug problems, but it emphasises cultural framings as equally important. Ollman offers a brief definition of capitalism as

> 'a form of society in which wealth takes the form of capital, or self-expanding wealth, i.e. wealth (used with the aim of creating still more wealth), and the main means of production, distribution and exchange are privately owned.' (2000, p. 558).

The conceptualisation of this level seeks to avoid the treacherous twins of *economism* (overemphasising the economic dynamics of society) and *culturalism* (overemphasising the cultural dynamics of society) as well as the sophisticated formulation of a '*perspectival dualism*' of redistribution-recognition which nonetheless entrenches (if not reifies) the economy-culture dichotomy[51]. A '*cultural political-economy*', building on the insights of classical political-economy and being the study of concrete phenomena, can help to minimise the *determinist* risks of past theorisations:

> Just as an earlier political-economy imperialistically ignored the lifeworld, it is also possible for an imperialistic culturalism to ignore systems, arguing that actors' cultural

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[50] *'Democratic theory, with important exceptions, counts voting and open rebellion as "political" actions, for example, but neglects or dismisses the constitution of citizens in the therapeutic, disciplinary, programmatic, institutional, and associational activities of everyday life. Dismissing these activities and their locations as administrative, social, "pre-political" or "de-politicizing" reduces democratic criticism to documenting the exclusion of certain subjects from the homogeneous sphere of the political, from places and powers of citizenship*.' (Cruikshank 1999, p. 28)

[51] See Fraser and Honneth (2003) and a useful critique of Nancy Fraser's work by Yar (2001)

> interpretations "go all the way down". However, although culture is everywhere in human society, it is not everything (Jasper 1997). (Sayer 2001, p. 693)

Consequently, as culture is not everything but many things, this level defines culture in a broad sense and not simply as a shared set of meanings of a 'society', encompassing '*symbols, practices, routines, conventions, ideas, objects, industries, economies, etc*.' (Wittel 2004, p. 22). Such definition can not only capture culture in terms of nations', states', cities', suburbs' or street 'cultures', languages and/or ethnic communities, but as 'imagined communities'[52] of people with shared political and/or religious beliefs, lifestyle 'choices', occupations/professions, consumption preferences, shared interests or memberships, 'organisational' cultures, spiritual practices, ways of trading or planting and harvesting and so forth.[53]

This level seeks to illuminate the political and the economic in political-economic acting without implying that capitalism is a congruent or coherent system that works clock-work-like; Wallerstein makes a useful interjection here: '*I wish merely to insist that the explanation must be found in the functioning of the system and not in some supposed deviance from its proper functioning*.' (2003, p. 42). There are many forces at work trying to 'fix' capitalism (guardian reserve banks controlling money supply and interest rates, social democrats and unions seeking concessions and rights from the productive forces/employers (thereby inadvertently keeping the capital-labour relations and therefore capital-labour contradictions alive), market enthusiasts (believing in the supremacy of the 'ideal' market as a regulatory instrument), all pretending that there is *a* proper way in which capitalism functions. If we are to understand, however, the situated encounter of the human service worker and the drug using client in the (*capitalist infused)* social service system (of Victoria, Australia), we need to pay attention to how welfare-capitalism actually functions rather than to how it is *supposed* to function, this letting go of the assumption that there is a steering committee of capitalists '*out there*':

> Schumpeter accustomed us a long time ago to the idea that capitalism would not collapse because of its failures but because of its successes. We have tried to indicate here how the

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[52] I borrowed this phrase from Benedict Anderson's influential book 'Imagined communities: reflections on the origin and spread of nationalism' (1983).

[53] In this broader sense of culture, I can then 'diversify' drug cultures by not limiting them to 'the' Australian drug culture, or substance-related cultures of age, gender, generations and other consumption-related characteristics such as ceremonial, ritual or commercial drug use cultures, party drug cultures etc. Foucault, for example, talks about the fact that '*alcoholism was literally implanted in the French working-class, in the nineteenth century, by the authority's opening of bars. Let us also remember that neither the problem of home distillers nor that of viticulture have ever been solved. One can speak of a veritable politics of organized alcoholism in France*.' (2002c, p. 378) This example illustrates how cultures are continuously made and remade. In any case, economic processes have powerful effects on the development or destruction of 'cultures'.

> successes (modes of counteracting downturns in the world-economy, modes of maximizing the accumulation of capital) have, over time, created structural limits to the very accumulation of capital they were intended to ensure. This is concrete empirical evidence of the Schumpeterian assumption. No doubt, to continue the analogy of the damaged automobile, a wise chauffeur might drive quite slowly under these difficult conditions. But there is no wise chauffeur in the capitalist world-economy. (Wallerstein 2003, p. 66/67)

The political-economic level needs to be able to account for exactly why alcohol taxation, health insurance schemes, prohibition and state regulation of pharmaceutical industries and their profitability, etc. vary across different, nonetheless capitalistic countries and other geographical spaces and when and why they 'became' *imagined*. A cultural political-economic perspective does not seek *overarching* reasons for certain developments, yet it still asks why certain conflicts, conjunctures or changes occur(ed), by incorporating the other three levels and their respective logics in its analysis, yet keeping capitalism 'fore-grounded' without making capitalist relations determining:

> While the causal powers inherent in the social relations of capital are pre-eminent and must be present in the sense that they define capitalist societies *as* capitalist, it does not follow that they have a determinate (let alone deterministic) influence on each and every occasion in shaping the economic geographies of capitalism. (Hudson 2006, p. 377)

Political-economic approaches thus far have significant shortcomings; Wittel identifies three elements which have been excluded from the political-economic purview: analysing culture and communication '*as process, as a circular movement, and as an operation*' (2004, p. 22). Describing the missing dialogue between cultural studies and political-economy (of communication), he laments the lack of studying *agency* and *subjectivity* and argues for '*a political-economy from below*' (2004, p. 11), by insisting that their analysis ought not to be '*reserved for consumers, users, and audiences […] [but also] for the analysis of work and production processes*' (Wittel 2004, p. 25). If subjectivity is to be conceivable at the political-economic level, Burkitt's conceptualisation of everyday-life is important because it would show political-economic acting as grounded in everyday acting:

> In this way, the production of daily reality does not occur somewhere beyond our reach in, say, the 'higher' echelons of the state, and is then imposed on us. Rather, the reality of everyday life – the sum total of all our relations – is built on the ground, in daily activities and transactions. This happens in our working relations but also in friendship, comradeship, love, the need to communicate and to play. (2004, p. 212)

It follows that the political-economic level is itself a product of agency that defines a 'type' of social acting as political-economic acting. By adhering to Latour's '*keeping the social flat*' (cf. 2005, p. 171), *every actor does political-economic acting*. We cannot conceive of acting at the political-economic level as fully *mouldable*, because we are dealing with *sedimented* and *sedimenting* acting, including the stabilising elements of the habitus (as well as built tax offices, built roads and pubs, built prisons and supermarkets, etc); at this level, however, every-'thing' is fragile too[54], which is why achieving a dialectic between 'de-centring' and centring the subject at this level is essential. The political-economic level 'collects' capitalism, patriarchy, taxation (what and who is taxed), growth, development, capital/labour, gender, class, race, prohibition, the welfare apparatus, federal and state budgets, desire, commodification, appetite, group formation/classificatory schemes, drug monitoring systems, etc. Importantly, it also encompasses '*the production of space*' (Lefèbvre 1991); our '*mental maps*' of spaces and the possibilities for thinking spatial hierarchies are collected at this level:

> The *same* abstract space may serve profit, assign status to particular places by arranging them in the hierarchy, and stipulate exclusion (for some) and integration (for others). Strategies may have multiple 'targets', envisaging a specific object, putting specific stakes into play and mobilizing specific resources. (Lefèbvre 1991, p. 288)

Whilst describing political-economic situations, however, I am *not* arguing that economic forms *intrude* on social forms but rather that we have 'forgotten' that we have collectively imagine(d) '*capitalist economic acting*', give(n) it strength and credence and now feel victimised by our own reifications. The political-economic logic is 'only' as strong as it is personally/collectively adhered to and institutionally translated; that is, *hegemony* is dependent on our collective '*habitus*' *consenting*, as Langman, drawing on Gramsci, demonstrates:

> Hegemony, the production of spontaneous assent to domination, depended on the ideological control of culture by intellectuals allied with historic blocs. The control of representations and understandings rendered ruling-class interests normal and natural while critique was demoniacal, pathological, bizarre and immature. But hegemony at the level of culture required individual subjectivity with an elective affinity for hegemonic worldviews and values that sustained rule. (2003, p. 226)

Langman's 'elective affinity' can help us to connect the political-economic with all other levels and expose the potentials for resisting hegemonic views and effects in our habitus.

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[54] When in doubt, thinking of the fall of the Berlin Wall proves how fragile an entire political-economic system is, including its buildings – how quickly buildings can be demolished, curricula changed, rents increased, public art de-funded, kindergartens closed, streets re-named, lakes privately owned and banks and pharmacies established in ex-libraries. Whilst capitalism has proven itself to be more robust than 'real-existing socialism', it remains crisis-prone.

### 1.2. Illustrating the interpenetration and singularity of the 'logics' of the four levels

A few examples will illustrate how the explicated levels should be understood; not perpetuating the Nature/Society divide (Latour 2005, p. 110) or the capitalist idea of a '*separate 'material life"* (Castoriadis 1997, p. 363), we discover some amazing things about the social imaginaries surrounding *drugs at the different levels*. The following 'vignettes' will show how the studying the interplay between the levels can be a useful 'launching pad' to better understand the encounter between a worker and a client, the focus of much of my data collection and analysis.

At the ***individual level***, drugs might be a means to get intoxicated, whilst at the ***relational level*** they might signify a gift or a sharing of an experience and at the ***institutional level*** place someone on a detox waiting list or provide a rehabilitation place and at the ***political-economic level*** they may be someone's production or distribution commodity geared at profit-making. At an ***individual level***, a drug might be the material under someone's microscope, at a ***relational level*** what co-workers talk about in a laboratory or smoke together, at an ***institutional level*** what pharmacists dispense to their customers and at a ***political-economy level*** the material that enables someone to make a career as a public health campaigner/politician, negotiating bilateral international agreements on drug control. Yet again, at an ***individual level***, drugs can be used to have a break from work by smoking, at a ***relational level***, they can ensure one obtains the necessary office gossip by having access to the information shared among smokers, at an ***institutional level*** they can mean employers drug 'testing' their employees (for surveillance and reducing 'risk' at the workplace) or the sharing of the 'compulsory' beer on Friday nights to 'team-build' and making sure employees know what employers want and at the ***political economic*** level, it can be used to sell drugs or paraphernalia with exorbitant surplus value.

Similarly, the *idea of care* on the ***individual level*** can signify helping by giving someone a drug, on the ***relational level*** it can mean the prescribing of a drug to someone, on the ***institutional level*** can become the basis on which institutions (and their associated organisations) care or are made to care for 'drug users' (treatment, detox programs, etc) and on the ***political-economic level*** it can mean the '*medical-industrial complex*' ensuring the supply of the 'caring substances' (pharmacotherapy). *Drug treatment* might be unaffordable at an ***individual level***, may trigger a court hearing at the ***relational level***, may not be subsidised at the ***institutional level*** and may only be available in outpatient form based on managed-care rationalities at the ***political-***

***economic level***. Hallucinating, racing thoughts might be stilled by a drug at an ***individual level***, be a cause for dispute at the ***relational level***, lead to a diagnosis at the ***institutional level*** and be a target for a company's drug development at the ***political-economic level***.

The *idea of a diagnosis* can be a way of legitimising or pathologising someone's 'condition' (and making future interventions possible) at the ***individual level***, the basis for a doctor's health insurance payment claim at the ***relational level***, an entry in a diagnostic-statistical manual governing populations at the ***institutional level*** and the acceptance or rejection of a health insurance claim from a health insurance authority at the ***political-economic level***.

The *idea of consumption* at the ***individual level*** might be the purchasing of a six-pack, the contact with a nice bartender at the ***relational level*** and the undetected breach of a licensing condition at an ***institutional level*** and the un-policed serving of drinks to intoxicated customers at the ***political-economic*** level. The availability of drugs and alcohol close to one's living area, at the ***individual level***, may turn into the assault on a taxi-driver at the ***relational level*** and the crime rate at an ***institutional level*** and the excusable behaviour of a sports-star of an alcohol-industry-sponsored sports team at the ***political-economic level***. The idea of consuming a substance can be the achievement of a social identity (distinction) at the ***individual level***, can signify the making of friendships or the visiting of a 'sponsor' at a ***relational level***, the reason to set up regulatory and surveillance mechanisms at the ***institutional level*** and the subject of a contract for an advertiser to 'product place' at the ***political-economic*** level.

The *idea of law*[55], at an ***individual level***, can prohibit someone the use of a drug, at a ***relational level*** mean the removing of contraband from a prisoner, at the ***institutional level*** the basis for the growth of a prison-industrial complex (privately owned) and at a ***political-economic level*** ensure the continued existence of an illegal industry, thriving on non-taxed profits in an unregulated environment. Furthermore, the idea of the law may provide someone with employment as other people take drugs at the ***individual level***, may be the justification for defending someone else in Court at the ***relational level***, the reason to implement Human Rights legislation for 'drug users' at the ***institutional level*** or a way of continuing marginalising people

[55] Livingstone, influenced by Castoriadis' thinking, illustrates usefully how the 'idea of law' can be understood: '*The law is not the sum of police, legislation, courts and prisons; it is the idea of law that allows the institution to exist, and this idea exists only in the imaginary of those for whom the idea has meaning. Similarly, the idea of religion as an institution (and of society itself) exists not in the church and its priests as such, nor in the bureaucracy, the citizenry, parliament and its representatives. It is first and always an imaginary creation of those who collectively adhere to it.*' (Livingstone 2005, p. 529) Another suitable way of thinking about the law is to localise and scrutinise the processes and situations that come to be understood as legal: '*Thus, to avoid the reification that is inherent in the use of the noun "law", we prefer to speak about "legal processes" and "legal complexes"* (Rose and Valverde 1998).' (Valverde, Levi & Moore Dawn 2005, p. 91)

who use prohibited drugs at the ***political-economic level***. Finally, I will show later in this chapter and in the three 'data' chapters, how the idea of *prohibition* works its divergent ways on and across the three levels constituting this conceptual framework.

## 2. Critically engaging with the academic literature

Australia has gained a considerable reputation in the international drug research community[56], with many research centres involved in drug and alcohol studies and researchers drawing on multiple funding sources. In this section, I engage with current Australian and, where appropriate, international drug and alcohol literature, identifying current shortcomings, especially – as already repeatedly indicated - its failings to recognise the drug user and the human service worker as subject positions. One reason for the lack of development might be found in the absence of *interdisciplinary* practice as '*there is little evidence of this [practice] in the Australian drug field (see Bammer, 1997; Fitzgerald, 2000b for rare attempts)*.' (Moore 2002, p. 279). Another reason might be found in the way we are asking our *research questions*. The US scholar Anthony finds '*we lack definite evidence about the impact of alternative drug policy instruments*' (2005, p. 326) and leave questions in '*evidence-based*' drug policy research unanswered:

> […] with respect to law enforcement, criminal justice, prevention, and treatment, it is widely assumed that "more is better" and there is no evidence to the contrary because no one is probing these assumptions […] (2005, p. 335)

Drug prevention research has also failed to give clear and useful advice to '*policy makers, who today cannot be blamed for feeling frustrated by research that appears fractured, chaotic, and particularistic*.' (Saltz 2005, p. 322) Drug research in Australia is often gender-blind and little research into how women experience drug use or treatment is available, although sufficient evidence links drug-using women with greater stigmatisation, higher likelihood of caring responsibilities and sexual abuse as children (Donath 2004, p. 103) and a greater likelihood of living with substance-using partners than drug-using men (p. 108). Yet another reason for

[56] Australia is one of the countries having pioneered research on alcohol control policies and interventions (Saltz 2005, p. 313), evaluating and testing the harm reduction approach (Klingemann & Klingemann 1999, p. 114) and is seen as a role-model for a fast and effective response to reducing the spread of HIV/AIDS (Ballard 1989, p. 373/374).

theoretical shortcomings can be found in the *socio-spatial arrangement of drug research*, possibly preventing social-theoretical and disciplinary cross-fertilisation as '*the existing [Australian] drug research workforce is concentrated in too few places, geographically and institutionally*' (Moore 2002, p. 282). The lack of *diverse data* sources is another reason for slow theoretical progress; the types of data related to our research questions tend to be too individualistic and, at times, reductionist. For example, the preoccupation with written and marginalisation of visual data in addiction research is critiqued by Rhodes and Fitzgerald (2006).

In addition, the (social) sciences are subject to a *fashion process* (Sperber 1990); arguably, the political-economic perspective has lost much of its appeal among social scientists, the marked absence of Marxist and political-economy approaches within Australian health sociology during the last decade indicative of this trend (Willis & Broom 2004). Interestingly, anthropology still puts political-economic perspectives on the research agenda (see Carlson 1996, Moore 2001, Bourgeois 2003) and is now at the forefront of calling for a more interdisciplinary alcohol and drug research practice (Singer 2001).

If political-economic arguments do appear in Australian drug research, they are often reduced to discussing Indigenous alcohol and drug problems (e.g. Saggers & Gray 2001), as if such perspectives were only pertinent to ethnic and/or marginalised communities. Very few authors in drug policy – notable exceptions are David Moore (2001), John Fitzgerald (2002) and Grazyna Zajdow (2006a) – apply cultural political-economic scrutiny to general societal phenomena. Sociological research perspectives are notable by their absence in drug research (Zajdow 2005a); the fashion process has certainly put epidemiology at the presumed 'cutting edge' of drug research. Lupton and Petersen (1996) deliver a devastating critique of epidemiology and its usefulness in program and policy development and evaluation in '*the new public health*' for the surveillance of '*deviant*' populations. Bourgeois goes even further, bemoaning the fact that '*most epidemiologists allow themselves to remain trapped in a reductionist ontology*' (2002, p. 260).

I do not want to give the impression that drug research should be singled out for its theoretical shortcomings, as social-theoretical research has its own legacy and troubled history. Connell (2006), for example, has argued that social theories are largely written from a northern (Western) and metropolitan point of view, excluding a range of experiences, notably

(neo)colonial ones[57]. Furthermore, we have allowed rationalist, 'scientific' and positivist bodies of knowledge to marginalise the spatial, spiritual, creative and communal dimensions of (post)modern life and its drug-using practices.

Part of the motivation to develop a broad theoretical framework has been a reaction to the dearth of useful theoretical approaches and the need to study the social construction of 'drug problems' with theoretical tools that allow the *relationship* between different societal dynamics to come to the fore. I have previously suggested that the very ways drug problems are being researched are ***constitutive*** of them and the degree to which drug research *itself* – as a 'drug problem factory' – and the budgets which support it are critically and reflexively analysed will prevent or enhance the quality of other research, policy and political options.[58]

The approach to studying drug policy and social policy in this thesis is somewhat different to conventional approaches; I understand, analyse and define ***drug policy as social policy***. This is not a claim about which 'portfolio' drug 'problems' (should) belong to; rather, *social* policy is the (policy) area which ought to address *the aspirations of a community as to how it wants to conduct its affairs*. In my view and in my '*ontological politics*,' social policy is – or should be - foremost concerned with social cohesion, the nation's or state's (institutional) solidarity and their fostering of diverse[59] and respectful communities and issues related to these concerns manifest themselves in social (in)equality, welfare state functions (the 'safety net', poverty), social determinants of health, etc.

Drug policy itself is to be understood as *manufactured and constitutive*, in that it reduces the constitution of the 'drug problem' to certain manifestations, activities and interventions. For example, fiscal policies, public, consumer protection, social and economic policies, trade policies and politics (to name but a few) have just as much bearing on the manufacture of the 'drug problem' as 'drug policy'. Drug policy (acting) thus constructs its own separateness and simultaneously ignores it, its assumed 'independence' itself an expression of political-economic 'acting'. Another effect of political-economic 'acting' is that the link between drug policy and social policy is not being made in policy terms. In the remainder of this Chapter, the literature review will 'overcompensate' by extensively covering the political-economic level as explicated

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[57] Lewis and Wigen argue that there are *'"inverted Eurocentrisms" of critical social theory, noting some ways in which the agenda of the cultural Left paradoxically perpetuates the predominance of Europe*.' (1997, p. 105)

[58] For example, Anthony argues that international conventions and national laws have '*created a straightjacket for drug policy research*' (2005, p. 334).

[59] I do not understand the term 'diverse' to be a different word for 'non-white' communities or backgrounds but refer to ethnic, lifestyle and other cultural diversities, including different sexual orientations, family forms, etc. In short, it refers to understanding and appreciating difference of all matters and choices.

in the conceptual framework, as this is often less addressed in the drug and alcohol literature, particularly in empirical research. The other three constitutive levels – the individual, the relational and the institutional - will be central to the next three chapters, so as to create a dialogue between the reviewed literature and the data. The remainder of this chapter will deal with the birth of the harm minimisation policy and the politics of drugs[60] (including prohibition) as they pertain to the political-economic dynamics.

## 3. The political-economic level: The manufacturing of drug problems

In this section I will outline what can be 'collected' as political-economic 'acting' within 'drug policy'. In the first subsection, I argue that *harm minimisation*, Australia's current drug policy, needs to be understood within the context of '*the nation*' and give a brief historic outline of how it came to be instituted at this level. In fact, harm minimisation forms part of a decades-long wave of devising - or at least calling for - *national* policies (as opposed to state or local (municipal) policies) that has accelerated considerably during the last decade.[61] For my purposes here, harm minimisation 'sits' at the political-economic level – but as indicated in the theorisation above - it is played out at all levels.

### 3.1. Harm minimisation history: The drug user goes national

The regulation of urban life has been a public and state endeavour for a long time; it became more pronounced with the 1838 Act and the '*Consolidating Act of 1865 relating to the management of towns – Melbourne and Geelong – in Victoria (28 Victoria No. 265)*' (Taylor 2006, p. 28) concerning itself also with public drunkenness. Acts attempted to stipulate public order and associated matters of licensing and vagrancy:

> For example, 16 Victoria No. 22 (1852) was intended to achieve the 'better prevention' of vagrancy; 2 Victoria No. 17 (1838), 3 Victoria No. 13 (1839) and 15 Victoria No. 14 (1852) were designed to deal with the licensing of public houses and the sale of alcoholic drink; and 15 Victoria No. 12 was intended 'to restrain the practice of gambling and the use of obscene language'. (Taylor 2006, p. 28)

[60]The 'politics of drugs' is not only located at the political-economic level.

[61] There have been calls for a national framework on child protection, for a national prisoner health information system, there is now a National Medicinal Drug Policy and a National Medicines Policy. The Howard Government has sought to strengthen the role of the Federal Government in many policy areas, including industrial relations, education, water management, etc.

Melbourne's police did not have a 'good reputation' in the 1830s: '*The official record was another sorry catalogue of short-term appointments and dismissals for drunkenness and bribery*.' (Taylor 2006, p. 30) Yet, law enforcement was imagined to tackle the persistence of the 'vagrancy' problems. The governor of the Melbourne Goal complained in 1870 that the Vagrancy Act had become used to shelter the destitute and homeless in prison (Taylor 2006, p. 36)[62]. The lack of '*proper conduct*' was interpreted as not simply an embarrassment for the township but as an indictment of '*the poor*':

> Vagrants, those 'mostly without family, without friends, without bodily strength, ignorant of any trade, of feeble health, and whose only associates are themselves', were living testimony to the failure to civilize and moralize the poor. (Taylor 2006, p. 37)

In the 1860s, drunkenness was widespread and the drunk, '*whose behaviour was seen as a threat to the work ethic, a cause of poverty and crime, and an affront to civilized behaviour*' (Taylor 2006, p. 36), could not simply be '*policed into order*'. New technologies of social 'reform' had to be invented to 'moralise' Victorians.

In 1901, a new social imaginary signification (Castoriadis 1997) came to exist: Australian states and territories became a *nation state* and with it strengthened discourses of citizenship, civil order and civic responsibility. The establishment of the nation state made it possible to think and frame 'drug problems' as *national* problems and also made *inter*-national comparisons of the conduct and governance of 'drug problems' thinkable. 'Australia' started to experience international pressures (for example, the League of Nations and, later, the UN bodies or individual member states) demanding the adoption of Conventions and treaties to fulfil international '*obligations*'. Australia thus became part of successive international (re)arrangements of drug governance at the Hague Conference (1911), with the Treaty of Versailles (1919), the Geneva Convention (1925), the Opium Protocol (1953), the Paris Protocol (1948) and the Single Convention (1961) (Manderson 1993, Fitzgerald & Sewards 2002, p. 5).

As nation state and federalism developed, it became clear, however, that 'policies' had to be devised to bring about at least some level of coordination of 'affairs' and cooperation between the states in the 'national interest'. In the first thirty to fifty years of federation, little concerted effort to create a national response to drugs eventuated, but slowly things started to change,

[62] Today, we can observe that Victorian prisons are becoming holding bays for people with mental health problems for whom services are desperately lacking.

triggered partly by international complaints at Australia's assumed high drug-use rates by worldwide standards:

> For the first time [in 1947/48], the Department of Trade and Customs took a serious interest in Australia's obligations under the 1925 Geneva Convention and the Paris Protocol of 1948. This was during a period where there were relatively few addicts and drug-related crime was low. (Makkai 2002, p. 1572)

Whilst nationally the Customs Act (1901, revised 1970) (Fitzgerald & Sewards 2002, p. 5) as well as the Pharmaceutical Benefits Act 1951 (Manderson 1993, p. 121) made 'drug issues' predominantly a matter of customs and medical prescription, not many policies pertaining to 'drug issues' nationally existed, but this changed in the 1960s to 1970s. Thirty years ago, Baume called Australia an '*intoxicated society*' (Senate Standing Committee on Social Welfare 1977) and between 1966 and 2000, Australia had 43 major public inquiries into alcohol and drug use (Fitzgerald & Sewards 2002, p. 70-72). With only one exception, '*these lawyer-dominated inquiries all offered 'more and better laws' and improved enforcement as the primary solutions*' (Brereton 2000, p. 93), but in the 1970s, recognition of broader drug and alcohol issues was followed by a widening of the policy constituency:

> In the 1970s drug policy was weighted towards alcohol issues, and the 1977 Baume report noted that the coordination of the State − Federal strategy needed attention. (Fitzgerald & Sewards 2002, p. 18) It is evident that the late 1970s saw an acknowledgement of the role of multiple stakeholders in drug policy, and of the need for a sensible strategy that fitted into an Australian ethos. (p. 12)

Somewhat reflective, certainly symptomatic of the slow paradigm shifts occurring (from medicalisation to multiple-stakeholder, multi-professional and -disciplinary involvement) in Australia are the name changes undergone by APSAD. Established in 1981 as 'Australian *Medical* Society on Alcohol and other Drug *Problems*' (AMSAD), renamed 'Australian Medical *and Professional* Society on Alcohol and *Other* Drugs' (AMPSAD) in the late 1980s, changed to 'Australian Professional Society on Alcohol and Other Drugs' (APSAD) in 1993 and renamed to its current title of '*Australasian* Professional Society on Alcohol and *other* Drugs (APSAD) in 2004 (van Beek, Saunders & Roche 2007, p. 191), arguably indicative of more general trends: the disappearance of 'problems', the inclusion and increase of other than medical professions in the *management* of drug and alcohol issues[63], alcohol being regarded explicitly as a drug – leading to

[63] Zajdow argues that harm minimisation policy is '*clearly part of the New Public Health (NPH)*' and that the New Public Health '*requires armies of new professionals*' (2004a, p. 74-75).

the name 'alcohol and other drug sector'[64] – and, finally, the expansion of the society across the geo-political region.

Fitzgerald and Sewards identify (then Prime Minister) Hawke's daughter's involvement with heroin and his visible distress on national television in September 1984 (2003. p. 198) as the deciding factor for calling '*a meeting of the Australian Heads of Government in order to establish what was to become the National Campaign Against Drug Abuse [NCADA] and later the National Drug Strategy [NDS]*.' (Rankin 2003, p. 259) With the impetus and resolve of Hawke and his election promise, *harm minimisation policy* was born in 1985. Its concrete historical existence was dependent on the *national space*, produced not simply by 'nation-building' processes but by political, economic, military, religious and cultural forces and instituting (ideas about) a 'national currency', capital, labour, property, territory, borders, wealth, land, trade, commercial relations, 'belonging', custom(s), solidarity, identity and governance.

What needed to be assembled to make this national drug initiative possible? A national space, a Commonwealth, a federation with states and territories, a national capital, an electoral system with citizens eligible to vote and electorates demarcating spaces, a representative democracy with political parties to choose from, a parliament and a house for parliament, governments, a constitution, a position of Prime Minister, a drug called *heroin*, an institutionalised group called *family* in which one member was 'using', media outlets reporting 'personal troubles' of the PM, a public observing, a motivation 'to do something about it', a formulation of a 'drug problem' and so on. But also quite likely a street [or any other actual location] to buy the drug on, a person willing to buy the drug with knowledge of where to acquire it, a person to buy the drug from, a 'drug market', a (convertible) currency, the idea of measurement (comparable quantities of drugs), a family table to discuss the 'issue' around, syringes to inject with, a body to inject into, a language with which to transport information and meaning, a television camera, aeroplanes to fly heads of governments to meetings, a hierarchy of levels of government and microphones to talk into, etc. Obviously, a lot of objects, entities, concepts, buildings, documents, practices and emotions have to be assembled to get a drug policy instated.

Harm minimisation started to evolve; Hackett describes the early days of the 1985 workshops for drug policy like this:

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[64] The social struggles preceding such naming (now a naming convention) are illustrated by Marquis (2005) who speaks about the history of the '*alcohol and other drugs movement*' in Canada.

> Had we been in clear thinking France there would have been entire structuralist, theist, existentialist, Marxist and anarchist policies offered for us workshoppers to choose from. In the Canberra Workshop, we largely ignored even the proffered belated policy guidelines and straightaway we chose minutiae. Thus we did not have to look at the difficult wood; we preferred to see easy trees. The outcome, although a monument of small prejudices and compromises, was a lot of trees that probably added up to much the same wood that we would have got had we started the other way round and scratched, patched and adapted an original ideal social policy. Pragmatism, decency and ignorance, well-mixed, usually get as far as the philosopher king on Australia Day. (Hackett 1985, cited in Brown et al. 1986) (Fitzgerald & Sewards 2002, p. 11)

Hackett illustrates how the nation's development, the preferred styles of deliberation and intellectual-philosophical traditions and inclinations at this point in time came to bear on harm minimisation taking shape and which questions were being asked to make drug policy. Whilst drug law enforcement remains the main drug budget spending component until today, a shift to include health, education, etc. in a multi-pronged approach became visible:

> Launched in 1985 with broad agreement from the States and Territories, the National Campaign Against Drug Abuse (NCADA) provided significant funding towards a range of efforts, effectively shifting the primary focus away from law enforcement and towards a more multi-faceted approach to managing drug problems. (Fitzgerald & Sewards 2002, p. 11)

Instrumental in the early national drug policy development were Dr. Les Drew (for professional advice) and Dr. Neil Blewett (for political leadership) (Rankin 2003, p. 259). The birth of harm minimisation was preceded by another important event: the 1983 recognition that HIV/AIDS can be spread; Blewett, Health Minister in the Hawke Government, – together with other experts, gay and other community activists – was quick to respond to AIDS by adopting a consensus style of decision making, following a non-partisan line and by devising policy responses, such as national working parties and task forces aiming to protect blood supply and transfusions by screening tests[65]. Whilst states had constitutional powers over health, the *Commonwealth* assumed de-facto responsibility and made funds available (Ballard 1989). When HIV was found to be spread by sharing needles among intravenous drug users, cross-linkage to drug-related organisations became pivotal and other commonalities between HIV and drug 'problems' appeared:

[65] '*Australia was the first country in the world to have every single blood transfusion unit tested for HIV because we had a good organization, good research and international contacts and good political support.*' Penington 2001, p. 1104

> We had been responsible for introducing syringe and needle exchanges back in 1987 to help control spread of AIDS […]. Nonetheless, it seemed to me that public antipathy to drug users was in some ways similar to the antipathy to gay men that we'd faced back in 1983 over AIDS[.] (Penington 2001, p. 1104)

The potential spread of blood-borne viruses, such as the HIV and Hepatitis C viruses, lead to or was at least part of the rationale for *three significant innovations*: Needle and Syringe Programs in 1986/87[66], methadone programs in prisons in 1987/88 (Rees 1995) and formalised drug-user organisations following the National HIV/AIDS Strategy in 1989.

In the wake of this Strategy, drug users had been involved in consultation processes alongside governments and research/medical experts, as they had been identified as one of the target groups. The Strategy recommended funding for drug-user organisations at state and federal levels (Crofts & Herkt 1995), which eventuated via government grants in the early 1990s, the national peak body, the Australian Injecting & Illicit Drug Users League (AIVL), receiving funding since 1998 but having operated unfunded since the late-1980s, formally constituting itself in 1992 (AIVL n.d.). Herkt and Crofts argue that the development of such organisations needs to be seen within the context of the consumer and community health movements, boosted in the early 1970s by the Whitlam Government's introduction of a National Community Health Program and that, although the Strategy paved the way for a climate of recognition of the role 'users' could play in HIV prevention and education, it required nonetheless governmental will and action at other levels to move towards peer-based education through user groups (1995):

> These "user groups" are funded by health departments in each state [and territory] and provide a range of important services for IDUs and other illicit drug users. […] The organizations are seen as highly accessible to street-level drug users, who have come to trust and rely on services such as needle exchange and safe sex and injecting equipment, referral to appropriate agencies and specialist support groups. […] The philosophy of the groups focus on human rights issues, quality of life and status of IDUs. They have an influential role in the formulation of policies and education projects, and provide advocacy for people who face discrimination and legal problems. (Rees 1995, p. 145-146)

[66] The '*drug using client*' can now access around 850 Needle Exchange Programs around Australia, with the first ones being established in 1987 (Anex, 2004).

Foucault understands power through analysing resistance to it (2002a, p. 329)[67] and, theoretically recognising that 'where there is power there is resistance', I argue that drug-user organisations emanate from resistance to prohibition (not suggesting that they are purely politically motivated organisations). Via the HIV Strategy funding impetus[68], their resistance became instituted and somewhat 'channelled', facing considerable pressure to become an adjunct, if not an arm of the treatment sector. For example, drug-user organisations provide '*Treatment Referral Service Coordination*' and '*Pharmacotherapy Advocacy & Complaints*' services. It is problematic to view these organisations as purely positive developments, since they inadvertently are part of the spectrum of techniques in the *governance of drug users*. As Pat O'Malley points out, harm minimisation is yet another form of governing users in that it seeks to guide and manage 'drug taking behaviours':

> It can also be a form of government by stealth as normalization is deployed only because it 'works', in the sense of most effectively aligning the behaviours of the users with the aim of the strategy. (O'Malley 2002, p. 215)

Drug-user organisations also face the inevitable '*strings attached*' by accepting government contracts and consequent dilemmas of protest movements becoming instituted (see Chapter Five for further discussion).

It is worth pointing out again that the national dynamics have played a pivotal role in triggering a paradigm shift to '*drug user participation*': the formalisation of 'drug-user groups' made drug users 'employable', not because they were labourers who happened to (have) use(d) drugs, but because of their drug use itself. The struggle to arrive at (or impose or foster) a notion of the 'drug user' herewith reached new heights, as the discourse was now not only being shaped

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[67] Foucault explains the power/knowledge nexus using the example of the (birth of the) 'inquiry': '*In conclusion, we might say that the inquiry is absolutely not a content but, rather, a form of knowledge – a form of knowledge situated at the junction of a type of power and a certain number of knowledge contents [*contenus de connaissance*]. Those wishing to establish a relation between what is known and the political, social, or economic forms that serve as a context for that knowledge need to trace that relation by way of consciousness or the subject of knowledge. It seems to me that the real junction between the economico-political processes and the conflicts of knowledge might be found in those forms which are, at the same time, modes of power exercise and modes of knowledge acquisition and transmission. The inquiry is precisely a political form – a form of power management and exercise that, through the judicial institution, became, in Western culture, a way of authenticating truth, of acquiring and transmitting things that would be regarded as true. The inquiry is a form of power-knowledge. Analysis of such forms should lead us to a stricter analysis of the relations between knowledge conflicts and economico-political determinants.* (Foucault 2002d, p. 51-52 his emphasis). Therefore, power and knowledge are irreducible to each other.

[68] It needs to be pointed out that drug user organisation have existed at least since 1986 (before the Strategy) in some way or another as self-help groups and that they vary considerably in constituency (membership), acceptance of IDU and non-IDU staff, in agenda, in funding sources, in management style and aims (Crofts & Herkt 1995). It was thus not solely due to the AIDS Strategy that illegal (often only injecting) drug users became organised. What perhaps unites all drug-user organisations is the struggle to keep or make drug interventions 'user-focused'.

by the law, the government, various professional groups and institutions, but by the drug users themselves, campaigning for what was 'rightfully theirs' and thereby explicitly accepting and politically forging the 'drug user' subject position.

In 1995, the 'drug-using client' *went national*: the *Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS)* created after an Alcohol and other Drugs Council of Australia (ADCA) forum concluded that comparable national data about drug and alcohol treatment services were lacking and commenced data collection on July 1st 2000 (AIHW 2006a, p. 2):

> The Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS) collects information on a wide variety of community-based treatment interventions including detoxification and rehabilitation programs, pharmacological and psychological treatments. (AIHW 2006b)

I mentioned earlier that Hacking (2002) argues that statistics '*make up people*'; whilst statistics can create ways of (ac)counting (for) people and things, they do not *necessarily* translate into 'beings' or 'acting' per-se, but are very powerful in making beings and acting possible based on '*having the numbers*'[69]. How many 'drug users' in Australia have statistics created? Of the currently 17 million adults (16 yrs. and over), 6 million have ever used drugs and 75,000 people inject drugs (Stevens, Hallam, Trace 2006, p. 1[70]), the latter being referred to as '*injecting drug users*' (IDUs), a 'sub-population' of people who use drugs. Who is the most common national 'drug user' produced by the statistics? People who use alcohol:

> Between 1993 and 2004, the proportion of Australians aged 14 years or over using illicit drugs during the previous 12 months decreased with few exceptions; however, the proportion that used alcohol increased. In 2004, about 5 in 6 Australians aged 14 years or over had drunk alcohol in the previous 12 months. About 1 in 12 had drunk at levels that risked harm in both the short and long term. From self-reports in 2004, about 1 in 7 Australians aged 14 years or over had used an illicit drug during the previous 12 months, with 1 in 9 using cannabis. (AIHW 2006c p. xiii)

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[69] I am referring to Latour's warning that '*it is not the sociologist's job to decide in the actor's stead what groups are making up the world and which agencies are making them act*.' (2005, p. 184) Drawing on his arguments, I assert that we could not think of ourselves as belonging to groups, marginalised populations, classes, generations, localities or a gender if we did not hear about them on the radio or in other conversations, read books that tell us about 'social classes' and see and use gendered toilets, clothing departments etc. This spatial and social constitution of subject positions is often taken as given. A census makes us position ourselves – if not think about ourselves – as wage earners [employers], [non-]domestic labourers, [non-]home owners, [non-]citizens etc. Once this information is provided, collected and analysed, economic, town, policy and municipal *planning*, etc. become possible and accountable.

[70] Interestingly the report does not specify which definition of drugs was the basis for this estimate.

Prisoners *made* particularly vulnerable to Hepatitis C and HIV infection in prison settings, are also affected by the national space as some rights come (or go) with the levels of government they are attached to:

> In Australia, prisoners are excluded from the national comprehensive insurance system ''Medicare'' (a Commonwealth Government instrumentality). This is explained because of residual powers vested in the individual states and territories at the time of Federation in 1901; thus it is the individual states and territories that administer the Australian correctional systems not the national government. (Levy 2005, p. 68)

Since its inception, *national harm minimisation policy* adopted a three-pronged approach: demand reduction, supply reduction and harm reduction; (Hamilton 2004, p. 160) the policy has received criticism based on many worldviews and political persuasions whilst also being celebrated as a collaboration (and 'pragmatic compromise') between many sectors and interests (law enforcement, drug and alcohol and welfare sector, etc). This can be explained by *the reification of harm minimisation* by various (policy) players and which will be discussed at the institutional level in Chapter Five. The *critique* of harm minimisation has intensified during the Howard Government years and bipartisan support weakened after 1997 (Bammer et al. 2002), reaching a new height in 2007, when a leading pragmatist policy-maker was attacked for advocating it rather than '*zero-tolerance*' by the Chairman of the House of Representatives Family & Human Services Committee and Liberal Party parliamentarians[71] – despite the national policy of harm minimisation still being in place. John Howard, PM, is '*listening to the Sydney churches*' who advocate for '*no safe injecting rooms, no drug [heroin] trials, no talk of legalisation*', claims Marr (1999, p. 6). He had previously appointed a Sydney hardliner (for total abstinence), Salvation Army Major Brian Watters to head the Australian National Council on Drugs (ANCD) and later delegated him to the International Narcotics Control Board (INCB).

It is, however, counterproductive to think of Howard's *zero-tolerance* position as a conspiracy or a reflection of undue or 'external' influence from conservative media or churches,

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[71] Mrs Bronwyn Bishop said the following on February 28th 2007 during the Inquiry into the impact of illicit drug use on families: *'[T]he Prime Minister has been absolutely uncompromising in what he believes is the policy. The Deputy Chair of the Australian National Council on Drugs, Margaret Hamilton, has written that it was unfortunate that the Prime Minister has a zero tolerance approach to drugs, but we have managed to handle him by saying that it only applies to education. How dare she? How can we have an effective policy when the Prime Minister has spelt out the policy and the deputy chair says, 'We have handled the Prime Minister; he was a bit of a problem for a while'? How dare she? Who are you listening to, the Prime Minister or her?*' (p. 7) '*This woman [Prof Margaret Hamilton] is a deputy chair of a government authority which is supposed to be carrying out zero tolerance policy in accordance with government policy.*' (p. 21) Standing Committee on Family and Human Services (2007)

international prohibitionists, etc[72]. Conservative politics is not per-se to be translated into zero-tolerance as conservatives (such as William F. Buckley and George Schultz) and neo-liberals (such as Milton Friedman) also believe in drug legalisation (Rowe & Mendes 2004, p. 7). It can equally – and more convincingly – be argued that the PM is simply creating his own policy style when it comes to illicit drug use:

> I never embraced the trendy notion that there was a level to which you could happily agree that people should take drugs and all you had to do was embrace this odd notion of harm minimisation. It's always seemed to me, to be a contradiction in terms, if something is harmful you ought to try avoid it altogether, you don't just sort of settle for 50 per cent harm or 75 per cent harm, you actually try and avoid it altogether. […] And for a period of time I was derided. I can remember having some arguments with, even some of my own state colleagues in various parts of Australia, who said that we should legalise marijuana, we should adopt a more progressive approach. People said get with it John, you're out of date, you're old fashioned. Now it's very interesting with the passage of time and more understanding of the impact of marijuana use on the mind and the link between suicide and marijuana, the link between depression and marijuana use, there is now a much more realistic approach to drug use and a much more solid support for the zero tolerance approach. (Howard 2006)

I would argue that Howard is right when calling it *counterintuitive* to *minimise* harm when one could avoid it and that *public health* concerns are to be discussed in the drug policy debate (such as linking drug use with mental health concerns). On the other hand, his observations are followed by unsustainable causative intimations and do not account for the complexities of 'drug problems' (let alone their manufacturing) and lived experiences. Furthermore, whilst the Howard Government named its policy initiative '*Tough on Drugs*', it is only tough on *some* drugs: the illicit ones. For example, tobacco directors are allowed to host Liberal Party national conference sessions (Snowdon 2000) and in an age where companies competitively bid to try and influence major parties, lobbying is big business:

> Taxpayers aside, the major financial supporters of parties include merchant banks, *gambling proprietors*, property developers, construction companies, military contractors, *pharmaceutical giants*, *private* health and child-care operators and *tobacco companies*. All have a vested interest in keeping politicians onside. Last financial year, Philip Morris and British American Tobacco contributed more than $450,000 to the Coalition parties. A Labor fund-raising club pocketed $50,000 from British American. (The Age 2006, my emphasis)

[72] It is particularly important not to reduce the 'zero-tolerance' stance to a popular or political rhetoric as if it is some added-on layer to the politics and material interests of drug use, because we would miss studying political rhetoric as the very way with which policies can achieve a problematisation of something (see the development of '*argumentative policy analysis*' Gottweis 2006).

In contrast, '*[u]nlike alcohol and tobacco, illicit drugs do not have powerful and well-resourced corporations and their lobbyists to add an extra dimension*.' (Zajdow 2004a, p. 73)

Concluding this subsection, I have argued that birth and critique of harm minimisation policy in Australia can be usefully seen as a development dependent on the *national space*, although it was not the only requisite to making harm minimisation thinkable and possible. Chapter Five, for example, will illustrate on the institutional level how many other dynamics are involved for a policy to become instated, interpreted and contested. The national space, however, was, is and will remain an important place for drug governance and governmentality[73] and I will now move to the *politics of drugs and prohibition*, equally pertaining to the political-economic level.

### 3.2. The politics of drugs and harm *production*

In this subsection I will briefly discuss the *manufacturing* of drug problems by prohibition regimes, other capitalist ventures and by social policy; I shall argue that the dynamics described below can be usefully interpreted as *system(at)ically producing harm*[74], an argument pursued throughout the thesis. I agree with Jamrozik's assessment that much literature focuses '*on the victims of social and economic policies rather than on the process of 'victim creation' through such social and economic policies*' (2001, p. 279), but the notion of 'victim creation' somewhat simplifying and, at worst, implying 'societal intent'[75] and potentially preventing us from examining in more detail the complexities of the dynamics of drug policy as social policy.

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[73] While the 'governmentality literature' has much to offer by describing how liberal power regimes produce selves, clienthoods and versions thereof, it '*downplays the role of the national state in favor of every other type of governmental and nongovernmental agency and social movement, but especially the actors of the global economy*.' (Dean 2002b, p. 132) But as we have seen, the national space remains important in understanding governing regimes and is of particular importance in the age of Australian sedition laws and life in the post-9/11, post-Tampa world, where '*governing in liberal democracies [...] is no longer fundamentally liberal*.' (Dean 2002b, p. 135)

[74] I benefited in my thinking about this phenomenon from discussions with my supervisor, Dr. Jacques Boulet.

[75] This does not mean we cannot make general claims about societal processes; it does mean rejecting conspiratorial or necessarily intentional assumptions about them. Bureaucratic bodies are often inconsistent, over- or inactive and governed by many conflicting discourses which can produce 'victims' with or without coordinated efforts. For example, Cruikshank found that the surveillance and disciplining of welfare recipients was an *effect* of administrative discourses and the linking of computer databases when trying to '*clean up, police, account for and discipline an unruly welfare program*' (1999, p. 109), rather than an *intention* for which administrative and communication means were needed to make welfare fraud detectable (1999, p. 109). Here, a political strategy would be to question those discourses which presume welfare spending is *by default* open to manipulation, fraud or fiscally irresponsible and to scrutinise how discourses governing taxation construe a generalised taxpayer's intention (for example, taxpayers often prefer services over tax cuts but they do not get them).

The metaphor of *harm*[76] *production* is intended to illuminate the workings of *drug and welfare regimes* as they pertain to harms, such as social inequality, pharmaceutical/alcohol industrial might, the regulation (or absence) of drug consumption markets, the inertia or over- or inactivity of and the '*will to ignorance in bureaucracy*' (McGoey 2007, p. 212)[77], the (un)availability and (in)affordability of treatment 'options' and housing, prescription conventions, police confrontations, imprisonments, (non)protection from infections, ideological products[78], lack of (free) welfare-, health-, legal- and drug services, etc. Harm production can also be analysed in terms of electoral preferences of taxation spaces, '*budgetary cultures*' in the fiscal space (Cameron 2006, p. 236) and '*harmful tax competition*' internationally (Cameron 2006, p. 246), multiple-tiered health and education systems, (institutional) solidarities, (socio-economic) fragmentation of communities and (in)voluntary school exclusion, based on drug use at school, etc. Space and time and other social-historical imaginations mean that we cannot imagine alcohol as being harmful without imagining that we need to drive cars and operate machines or other equipment, without imagining ourselves as being in social relationships in public and private spaces, where harms caused by alcohol consumption become conceivable (being violent, unpunctual, unreliable, dishonest, having bad breath or vomiting, etc).

The complexities of social life demand precise analysis, flexible and dynamic responses and can be too fluid to allow '*a priori politics*' of setting a blueprint of what should be de-commodified, what should be taxed, funded, abolished or (re)instated. In any case, understanding someone's [or one's own] '*situated context*' can be called a political act, just as criticising the federal budget can. In my view, *harm production analysis* is the act of trying to describe the complexities of drug policy as social policy dynamics, which, in turn, is a prerequisite for a more sophisticated and strategic politics of drugs. *Harm production analysis*[79] is always a political

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[76] I concur with Valverde that the switch in drug and alcohol research and policy '*to the language of harm does not necessarily help to produce consensus about treatment*' (1998, p. 176). Arguably, it is unlikely that any concept or phrase (risk, harm, need, disadvantage, care, etc.) will bring about treatment or any other policy consensus.

[77] I am drawing on McGoey's recent article on antidepressant regulation in Britain; he discovers the '*oxymoronic*' phenomenon of '*strategic ignorance*' (2007, p. 217) when it comes to drug regulatory bodies which experience internal '*conflicts of interests*' because they do the '*pre-licensing approval of drugs and the post-marketing surveillance of their use*' (2007, p. 216) as faults with the drugs effectively equate to regulatory oversight.

[78] I refer to phenomena that have been produced by 'common sense' or more direct selectivity of what is being (publicly) said, funded or perceived to be 'possible' actions. For example, DeGrandpre and White demonstrate how pharmaceutical science not only justifies but, in fact, '*serves the ideology of differential prohibition*.' (1996, p. 44).

[79] Fred Leavitt's (2003, pp. 195-208) excellent harm *production* analysis at the political-economic level demonstrates the utility of continuing the war on drugs and how this maintains 'harms' in the US: the organisational interests of particular government bureaucracies, national security offices and the prison-industrial complex in terms of growing their organisations' influence and size; to finance foreign wars; enhancing the political influence of parties; to keep

exercise (as are most things) but it is *not* a political program per-se. As Cruikshank asserted, the '*revolutionary subject*' needs to be constituted too and a first step towards this subjectivity can be the act of resisting to act as a 'drug user' or '*the refusal to act **as** a [welfare] recipient*' (1999, p. 121).

Furthermore, harm production analysis applied *across* the levels of the conceptual framework used in this thesis renders the claim that drugs 'belong' or are confinable to a particular portfolio absurd. Drugs do not properly belong to *any* portfolio or policy area – practically or theoretically. A-priori claims that drug responses need to be '*fundamentally a matter for health and welfare sectors*' (Dietze & Keleher 2004, p. 238) are unhelpful; from a constructionist perspective, it cannot be argued that drug problems are either health, economic, legal or social 'problems' per-se or by nature. Whilst arguing that drug 'problems' are *health* 'problems' and not *legal* 'problems' might make sense *politically* so as to counter prohibition discourses, this thinking still holds us back, as even if one were to advocate for a *health* response to 'drug problems', the former is already pre-defined by other discourses and itself a cultural product, as Foucault has shown:

> I am merely emphasizing that the fact of "health" is a cultural fact in the broadest sense of the word, a fact that is political, economic and social as well, a fact that is tied to a certain state of individual and collective consciousness. Every era outlines a "normal" profile of health. (2002c, p. 379)

Addressing drug problems as health problems is, therefore, no less economic, social and political as Brook and Stringer have shown, when questioning the assumption of automatic improvement in the drug *problematique* if they were redefined as 'belonging' to a different portfolio (2005). It is only too well known that *any* policy area and sector is and can be problematic and that, at best, we earn new or different problems when re-labelling, to which Room adds the difficulty of parting with the dichotomy of moral and medical discourses of alcohol and drug 'problems':

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the law-enforcement industry afloat (job security, limited accountability, police corruption opportunities); to make profits for small and big business (from privatised prisons to drug-testing kits for teenagers' parents and employers, private investigators, money laundering opportunities); legal drug industries making sure that their patented products retain the highest profits because competing drugs in the same market are illegal; the treatment industry (with its largely ineffective programs); a government protected monopoly of illegal drug provision with maximum profits for major drug traffickers; to finance terrorism or other political causes. This is a 'thick description' of harm producing in contemporary capitalism and although varying from country to country in magnitude, it is an international phenomenon, Australia possessing similar 'drug-factories'.

> The ideas that there are multiple models, and that medical and moral models were not necessarily mutually exclusive, have received some further attention (Room, 1974, 1978) but are still overlooked in much analysis. (2001, p. 35)

The not-mutually-exclusive co-existence of discourses[80] prevents us from rushing into the 'reformatting' of drug problems under any (other) name or sector if we are to hold onto the complexities of '*situated context*' encounters. Harm production analysis, therefore, needs to study the *relationships* between different and co-existing discourses and sectors, not just 'the' drug and alcohol sector, and show exactly how they interact, clash or negotiate with each other. It also needs to investigate different phenomena and societal processes – from budgetary and parliamentarian decision making, professional formations and education to lived experiences – as well as the implications and effects of socio-political claims-making[81].

After this brief but necessary explanation of the term 'harm production,' I will analyse two dominant harm production phenomena, *prohibition* and the *drug trade*, so as to illustrate the benefits we may derive from this perspective.

### 3.2.1. Prohibition and the capitalist imagination of the drug trade

At the political-economic level drugs are made into *commodities*, characterised by value, use-value, exchange-value and price, concepts or aspects the meaning of which can be expanded beyond their relation to the market. The '*exchange-value*' of drugs within the global market is multiple: they might serve as de-facto currencies, wages, investments and sources of profits. Their '*use-value*' represents as means to satisfy psycho-social 'needs' within indeterminate[82] meaning systems and serves as natural, transformed natural or manufactured resources. As illustrated in Chapter One, drugs are *reified* in their use-value as resources, modifiers, cures or means for (psychological) warfare, torture, cultural rituals, commerce and terrorism as well as '*mental* foods'. Goux argues that, apart from use- and exchange-value, there is also a '*desire-*

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[80] Valverde's idea of '*piling up of rationalities*' (1998, p. 177) in Chapter One prevents us from ignoring historically sedimented logics and from identifying discourses as mutually exclusive; instead we can see governmental rationalities and discursive formations as overlapping, intersecting, subsuming and 'piling up' on each other.

[81] Elsewhere, I have analysed the usefulness of Fraser's '*The politics of need interpretation*' (1989), but whilst finding many elements of her framework useful, I feel it does not go far enough to illuminate how socio-political struggles might be thought about and '*needs claims*' are (un)successfully mounted. Fraser demonstrates how needs claims are *politically* contested but takes the 'needs' themselves for granted; she also implies that need claims can always be mounted by the people who are 'affected' by the 'need'/'problem' construction, which is not (necessarily) the case for 'drug users.' (see Campbell 2007)

[82] I am drawing here on Castoriadis' idea that meanings are indeterminate (1997).

*value that is in principle subjective, variable, ephemeral, but globally regulated in social games of exchange and combined total desire*' (1990, p. 200). If we consider drugs as having 'desire-value', we have to discover, acknowledge and take into account the '*rational irrationality*' of drug use, intoxication and the stilling of '*metaphoric thirst*':

> […] to produce desire is also to produce the lack or scarcity that will intensify desirousness and increase the anticipation of *jouissance*. The marginal economy must therefore be a society of both plenty and paucity, of surfeit and scarcity, repletion and appetite, satisfaction and desire. It is within this contradiction that *metaphoric thirst* can be exploited. Superfluity is required for the thirst to become metaphorical and to seek satisfaction in signs and imagination, which make it potentially infinite. (Goux 1990, p. 200-201)

With Goux, I link the economic operations of capitalist societies (for example, their consumption politics - and production of the illusion - of 'scarcity' amid abundance) with 'our' desire to consume drugs to reach different states of consciousness or togetherness or a sense of security or normality, of being creative or thinking differently.

The political-economic comes into play when reductions in opening hours, increases in alcohol prices or restricting the number of alcohol outlets[83] are at odds with national competition policy (Zajdow 2006a). It is played out when taxation regimes[84] are devised or when state revenue relies heavily on maintaining gambling and other addictions or when legislative changes to the protection of '*addiction as a disability*' are sought. Political-economic rationalities influence whether Opal, the BP-produced non-sniffable petrol, is supplied to prevent petrol sniffing in Indigenous communities and how different competing petrol stations will accept responsibility for equally providing non-sniffable petrol to the community. The political-economic also indicates how alcohol production, distribution and consumption are set into relation:

> There are other projects and strategies designed to govern populations through alcohol. Taxation, tariffs, excise policies, subsidies to wine producers, and other measures located in the realms of fiscal and economic policy form a very important dimension of alcohol regulation. (Valverde 1998, p. 144)

The workings at the political-economic level *commodify* drugs and the prohibition paradigm operates here; I have outlined in Chapter One how prohibition was historically

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[83] The *Herald Sun* recently reported that the state of Victoria experienced '*[a]n explosion of bars, pubs, cafes and stores selling alcohol – up 36 per cent in five years*', recorded the '*hospitality industry's turnover almost doubling in five years*' and witnessed the '*liquor licences climbing from 834 to 1149 in five years*.' (Herald Sun 2007) This means alcohol supply is at an all-time high in Victoria.

[84] '*Alcohol is generally taxed according to volume and not alcohol content*' (Zajdow 2006a, p. 16)

achieved through various legislations and other dynamics in Australia and gave rise to the drug squad, drug screening and other technologies. Australia's harm minimisation policy was, since its inception, a '*thin veneer covering a very solid core of law enforcement intended to restrict drug supply*.' (Wodak & Moore 2002, p. 17) In fact, prohibition is one of the most successful policies worldwide with near universal coverage; it seems even more hegemonic than capitalism itself:

> Virtually every country in the world has adopted the prohibition model and criminalizes the recreational use of cannabis, cocaine and opiates. By 1 November 2001, 175 states had signed up to the 1961 Single Convention, and only sixteen states had not (INCB 2002). […] To introduce an unpopular and costly policy against determined opposition, gain the support of almost every nation, and maintain the policy in the absence of any evidence of effectiveness is a diplomatic success almost without parallel (Reinarman and Levine 1997). (Harrison 2004, p. 117)

Prohibition is also described as the '*war on drugs*'. The war metaphor has been used in many policy initiatives (the wars on poverty, on terrorism, on drugs and the culture wars) but one cannot be *at war with a practice*, let alone *drug* use. This punitive and prohibitionist '*US-led trend has been one based upon a particularly western, ethnocentric version of 'progressive' and humanist thinking that (without irony) has led to declaration of a 'war' on drugs*' (Coomber & South 2004, p. 14); it is about moral, ideological and political '*needs*' (p. 14-19). The US are still the dominant force in the international drug control system, a role they assumed before achieving their '*superpower*' status, using the 'war on drugs' to legitimate foreign policy interventionism (Room & Paglia, p. 309-311). US interference into Australian drug policy making has occurred on multiple occasions (Hamilton 2001). That thoughts about how Australian drug law enforcement's effectiveness in a '*generic drug law enforcement performance measurement framework*' could be measured are only emerging – despite massive spending and the predominance of law enforcement in Australia's drug budget - reveals the political-economic logic and the hegemony of prohibition (Willis, Homel & Gray 2006; Homel & Willis 2007). Following political-economic logic, we also still have many more (and comprehensive) data on *drug users* than on *drug markets* in Australia.

Reinarman states that the war on drugs is not '*about the systemic efficiency of capitalism; it is closer to a religious crusade, which is why it is so irrational*.' (2001, p. 22); indeed, from an economist's point of view, prohibition is a road block for economic efficiency: '*[D]rug policy attempts to reach economic efficiency within a framework distorted by an institutional limitation: drug prohibition*.' (Kopp 2004, p. 113) The commercial stakes are high as illicit drug traders conquer new markets and compete for different market shares: '*Supply has undoubtedly created*

*demand. […] Profits, estimated at $US 85-350 billion, provide the oxygen for relentless expansion, the search for new customers, new wholesalers and retailers and new products*.' (Wodak, Sarkar & Mesquita 2004, p. 800) Kopp, however, warns not to make hasty conclusions about profit rates:

> Numerous analysts 'forget' to treat the risk as a cost and thus over-evaluate the profit. […] Hasty assertions whereby the repression serves the traffickers by allowing them to increase prices and profit are based on an outdated hypothesis of total inelasticity of demand to price. (2004, p. 136)

The geopolitical split between (purely) producing and (purely) consuming nations of illicit drugs has disappeared and injecting drug use has spread at unprecedented rates in developing nations, with an estimated '*200 000 deaths per year among the global population of over 8 million drug injectors*' (Wodak, Sarkar & Mesquita 2004, p. 799). Devaney shows the many links Australia has to South East Asia, ranging from law enforcement to harm reduction '*capacity building*' (2006) and with Reinarman I suggest that we need a '*sophisticated analysis of the relationship between capitalism and prohibitionism*' (2001, p. 22), which would require explaining how different capitalists undermine each-other, how capitalists frequently operate on the borders between legality and illegality – including the corrupting and lobbying influences of capital. The relationship between *generalised* and *specific* capitalists interests needs exploration, because a certain *anarchy* exists in capitalist production and distribution, often undermining the '*generalised*' capitalist's interest in effective social reproduction. Jessop, drawing on Marx's insight, explains:

> Competition discourages individual capitals from undertaking activities necessary for economic and social reproduction that are unprofitable from their individual viewpoint and it may also lead them into activities that undermine the general conditions for economics and social production. (2002, p. 42)

A sophisticated analysis would also have to explain why prohibition is *not a homogenous universal discourse* in the sense that every country and each jurisdiction, in their mix of institutional practices, decides how prohibition is *interpreted*. Drug laws might target the same substances internationally and bi-laterally, but the '*drugalities*' might vary considerably (*drugalities* of cannabis in the Netherlands are different from those in the US or Australia). Laws vary with regards to drug using, possessing, trafficking, cultivating, syringe using and also in the different sentences, (death) penalties, fines or diversion and expiation schemes attached to them. The decriminalisation of drugs in Portugal proved that capitalism and prohibition are not

necessarily 'co-dependent' and future discourses of prohibition will become increasingly diverse across the globe, similar to alcohol regulation:

> In marked contrast to substances that are internationally problematic and generally subject to outright criminalization – cocaine, heroin, cannabis – what is striking about alcohol policy is the incredible variety one finds in regulatory strategies. (Valverde 1998, p. 146)

Prohibition in Australia has been modified through various schemes in the last decade; in the late-1990s and early-2000s, the idea of '*drug diversion*' has been implemented through a variety of initiatives and programs; it is defined as the '*diversion of drug users away from the criminal justice system into drug treatment*' (VIDDISRG c. 2006, p. 6) and it may involve avoiding incarceration, a criminal record or higher-level sanctions, fines and sentences. In Victoria, a *cautioning* scheme for 'low level' offenders has been operating since 1996 (VIDDISRG c. 2006, p. 0) and eight programs[85] funded by Commonwealth and State sources are operating throughout Victoria. The '*Drug Court*', a three-year pilot program in Dandenong (South-Eastern-Metropolitan Melbourne) from 2002 until 2005 and extended until 2009, issues a '*drug treatment order*' for up to two years involving three steps: stabilisation, consolidation and re-integration and has been evaluated as cost-effective (Courts and Programs Development Unit 2006), with over 15,000 Victorians accessing these programs between 2000 and 2005 (VIDDISRG c. 2006, p. 9). The goal of all diversion programs is to relieve the community of the (cost-)burden of 'drug user' and 'drug crime':

> For the drug user, diversion may lead to a reduction in drug use and high-risk drug-taking behaviour, improvements in social functioning and less involvement in crime related to drug use. The goal, ultimately, is to decrease the burden on the criminal justice system and reduce the impact of drug related crime on the community. (VIDDISRG c. 2006, p. 7)

Here, the political-economic level juxtaposes '*the community*' and '*the drug user*' and individualises the responsibilities and 'symptoms' of the prohibition regime whilst *the causes* of drug crime remain outside the discourse. Absent from such juxtaposition are most of the harm *production* regimes (see below), including the fact that '*aggressive policing actually increases the risks for blood-borne virus transmission in street drug environments (James & Sutton 2000;*

[85] They are known as: (1) Victoria Police Cannabis Cautioning Program, (2) Victoria Police Illicit Drug Diversion Program, (3) Rural Outreach Diversion Workers, (4) Court Referral and Evaluation for Drug Intervention and Treatment (CREDIT) Bail Support Program, (5) Deferred Sentencing, (6) Children's Court Clinic Drug Program, (7) Koori Drug Diversion Program, (8) Drug Treatment Order (Victorian Illicit Drug Diversion Initiative State Reference Group (VIDDISRG) c. 2006, p. 8).

*Maher et al. 2001)*.' (Fitzgerald 2003, p. 205) The hegemonic prohibition *habitus* keeps this juxtaposition alive:

> In no other field that I know of, in either health or law enforcement, would the community be willing to accept a mounting death toll, a mounting crime rate associated with illicit drugs, and increasing prison populations, without there being a call for alternative approaches to be tried. (Penington 2001, p. 1109)

Dawn Moore recently argued that in (Canadian) drug treatment courts (DTC) *legal* knowledges are used by therapists and *therapeutic* knowledges are used by judges and other legal professionals, thereby divorcing the experts from their 'traditional' knowledge domains and deliberately making legal-therapeutic (hybrid) knowledge spaces *enact* '*therapeutic jurisprudence*' (2007). In DTCs, '*therapeutic knowledge cohabits with legal knowledge*' (Moore 2007, p. 46), transforming them into places where judges assess clients' treatment motivation and therapists utilise/affect legal sanctions 'for' their clients, a variety of translations occurring that radically interpret older ingredients of legal processes:

> Through translation in the DTCs, cure and control become synonymous. […] Detention translates into therapy, a warrant is now an incentive and appearance in a criminal court a chance to process a drug-use relapse. Translating these practices into a network with a broader curative goal does not erase their punitive, disciplinary intentions or effects. (Moore 2007, p. 57)

Despite endless assertions that (Australian) diversion programs represent a '*shift away from a punitive approach*' (VIDDISRG c. 2006, p. 6), Dawn Moore (2007) powerfully illustrates that cross- or interdisciplinary knowledge regimes can be just as punitive as disciplinary ones and are perhaps even more effective in their domains because they become all-encompassing. Paradoxically, – but logically – cross-disciplinary or multi-disciplinary knowledge formations may prove to be politically and rhetorically more robust (and, in effect, more stable than singular disciplines) because the multiple perspectives they incorporate can be more reflexive and thereby not as easily disturbed by questioning or critique as non-hybrid knowledge regimes are.

On the other hand, drug prohibition and the 'war on drugs' are now widely regarded to be failed policies[86] in Australia and overseas (Levine 2003, Wodak 2003, Bewley-Taylor 2004, Harrison 2004, Jensen et al 2004, Macintosh 2006, Baume 2002), but prohibition has remained relatively stable. Hall locates the problem with the Australian drug law reform movement in its

[86] There is also a perception among some drug law reformers that prohibition is the only drug problem we have and if it would be lifted we would rid ourselves of drug problems. One only needs to look at the problematic relationship between capitalism and legal drug use (tobacco and alcohol for example) to lose this illusion.

political strategy: *'[T]he proponents of reform have been more successful in raising doubts about the effectiveness of prohibitionist policies than they have in persuading the public of the wisdom of relaxing prohibition.*' (Hall cited in Brereton 2000, p. 95) Baume attributes failures to convince with drug law reform proposals to a lack of '*political smarts*' (2002, p. 78); he would like to see a 'Bill Clinton astuteness' to lead the action, but politicians' skill and political preferences are only part of the story, as Pat Stack reminds us: '*More people went to prison for drug offences during the 'Bill-I did not inhale-Clinton' period than in the 'Richard-I am totally obsessed with dope smoking hippies-Nixon' period*.' (2003).

There are theoretical shortcomings in the '*tiny international drug law reform fraternity*' (Wodak 2003, p. 222); as Manderson points out, laws are not just reflective of social values, they are essential for creating them (1993, p. 13). The strength of the prohibition logic rests on its common sense and humanist appeal and on the sedimented ideology of capitalism (individual vs. collective responsibilities and rights) as well as the almost random coincidence of different interests[87]. In short, to change prohibition involves challenging a very strong '*infolded exteriority*' in our habitus; if held to be a good policy and successfully having 'hooked' itself in the popular imaginary, politicians will be the last people to question it as they are electorally dependent (even if they do not always act within the logic of that dependence). The 41st Australian parliament '*still cannot be said to 'mirror' the Australian population*', it is '*middle-aged, well-educated and (mostly) male*' and likely to have been '*employed in politics-related occupations, business or law before entering parliament in the last decade*,' all of these having an effect on their attitudes to drug law reform and mounting an argument for reform with the professional political class dominating parliament (Miskin & Lumb 2006) is probably less likely to succeed if not preceded by public pressure for change. As Fitzgerald explains:

> With a conservative government in place, and abstinence-oriented politicians continuing to favour law-and-order drug strategies, there is plenty of work ahead to produce research stories that can have some impact on drug policy. (Fitzgerald 2000, p. 314)

[87] Cruikshank has powerfully argued that searching for the one reason why dumpsters were being locked up or the one institution having ordered it, she found that different interests were being served by the lockup but ultimately, there was no cause for this development: '*I sorted over all the different reasons that were given for the lockup which I had discounted because they were contradictory and seemed irrelevant to my goal of finding the doer of the deed. Strangely, all these interests-at-odds never clashed. Insurance companies, the city, garbage contractors, neighborhood activists, store owners, all found that their (different) interests were served by the lockup. [..] No common interest was articulated, only particular and local interests, yet collective action was taken. [..] In short, I found that I had no cause*.' (1999, p. 14)

Having asked in Chapter One who we actually imagine as 'the drug user', our social logic *knows* that there are definite *hierarchies among drug user subjectifications*; when people identify with particular 'user identities,' a thorough *cultural differentiation* is observable: no '*heroin junkie*' would have anything to do with a '*volatile substance user*' and vice versa, no '*moderate user*' thinks of him/herself as anything like a '*compulsive user*'. What we discover is that the prohibition discourse has a strangely *unifying effect* on an otherwise very disparate, heterogeneous, antagonistic and hierarchical drug-using population: the diverse subject positions for illegal drug using people *are socio-politically unified by the prohibition discourse - that is, by the illegality of the substances they consume*. Prohibition then inevitably becomes an '*organising principle*' in the lives of people who use illegal drugs: something to avoid or deal with when 'caught'. The productive power of prohibition not only creates '*the drug user*,' but '*drug user organisations*' engaged in identity politics in which the *opposition* to prohibition assumes centrality and unites its diverse actors.

Drug-user *organisations* then support *illicit* drug users, thereby perpetuating social distinctions along legal lines,[88] probably due to a '*culturalist*' understanding of their own positions and participation in the 'drug culture,' allowing the conclusion that prohibition itself has successfully constituted *the drug-using collectivity*. These organisations, however, are not representative of *all* illicit drug users, as 'well-established' and 'accepted' users would not join for fear of social repercussions, including discrimination, loss of reputation and losing professional licences, *introducing an element of class differentiation in the social productivity of prohibition*. Cruikshank (1999) maintained that the *war on poverty* constituted 'the poor' as a constituency and a 'population'. The same logic can be applied to the war on drugs, creating a drug-user (activist) and, with the assistance of the AIDS Strategy, drug user organisations: the drug user can now act 'on his own actions', having been constituted as a 'drug user' in the first place:

> … "the poor" cannot have interests of their own until and unless they are constituted as a group. That did not happen until the War on Poverty was waged; government did not repress the poor but invented the poor as a group with interests and powers. […] The War on Poverty (like other wars in recent memory) had first to arm the enemy in order to engage in conflict. In other words, the exercise of power in the War on Poverty did not determine the actions of the poor but determined that the poor would act. (1999, p. 86)

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[88] The broadening of the addiction metaphor to sex, love and other 'compulsions' has '*not produced a politics or an ethics which emphasizes the similarities between normal and respectable on the one hand and the illicit on the other. The drug addict remains a firmly marginalised other, subject to profound legal, social and medical discipline.*' (Keane 2002, p. 190)

In all the concern with illicit drug policy and users, discursive constructions ignore the fact that the illicit drug trade (apart from its links with the arms industry) and the pharmaceutical industry are now almost on a par; '*Global annual turnover of the illicit drug trafficking industry has been estimated at $US 500 billion*' (Wodak, Sarkar & Mesquita 2004, p. 800) and the annual sales of the global pharmaceutical industry rising to $US 602 billion in 2005 (IMS Health 2006). The two industries have more in common than is generally admitted (see Leavitt 2003) – even though their methods might vary at times and their public legitimacy certainly does – in political-economic terms, they are essentially capitalist ventures, both acting on

> [the] necessity of harnessing desires and *jouissance* in the dialectic of the market, of producing imaginary appetites capable of making economic demand potentially infinite […] the capitalist appears as a fanatic agent of accumulation who seeks neither use-value nor *jouissance* but exchange-value for the sake of exchange-value and production for the sake of production. (Goux 1990, p. 208/9)

Whilst the '*exploitation of illness for private profit is a primary feature of the health systems in advanced capitalist societies*' (Waitzkin 1983, p. 662), we are facing an increasingly complex system of *illness production*, one of its best known examples '*disease mongering*', in the age of '*neuro-chemical selves*' defined by Rose as involving

> alliances … formed between drug companies anxious to market a product for a particular condition, biosocial groups organized by and for those who suffer from a condition thought to be of that type, and doctors eager to diagnose under-diagnosed problems. (2003, p. 56)

Bell's essay on Australia's '*worried well*' – describing the '*new psychopharmacologised neighbourhood*' (2005, p. 4) and the prescription of anti-depressants to well over one million Australians in 2004 – explains the manufacturing of the epidemic of antidepressant use as threefold: '*the multinational drug companies; the physicians who write prescriptions; and the public who turn to medicine for answers*.' (2005, p. 7) Australian '*pharmaceutical prescriptions [are] up 41% over the latest decade*' (AIHW 2006c, p. xvi).

Some expect that a bifurcation in use-patterns between rich people using legal drugs and poor people using illegal drugs will eventuate; in an age of '*pharm parties*' using pharmaceutical and, therefore, legal drugs; an age where alcohol is the most common form of problematic drug use; an age where 'sadness' has been made 'deviant' and where people mix legal and illegal drugs and inject crushed prescription drugs; an age, finally, of global disease mongering, the stark differences between legal and illegal drug use (and the resulting differences of treatment of the

'drug users'), will become harder to maintain. That differentiation is exposed for its socio-historically achieved arbitrariness, although cases where the prohibition of drugs *did* prevent health problems from arising have occasionally occurred.

Summarising: harm is produced by the powerful workings of legal and illegal drug industries and their relentless pursuit of profits, in which States only seem to intervene when harms become more widespread or when they are effectively lobbied by public health and other advocates. Worldwide prohibition was never imposed because of the *harms* or *health problems* perceived to be associated with the use of opiates[89] (Harrison 2004); as well, the prohibition framework becomes less and less unified, yet, it is still near universal and not just because of pressure by the US or other political advantage. There is no singularity in the way it is enacted and why it continues to exist and in Chapter Six I will show how prohibition is imagined in the service encounter.

### 3.2.2. Social policy as a drug problem factory

I have previously stated that my *ontological politics* view drug policy as social policy; the only author who *explicitly* brings forth a '*theoretical argument that approaches drug policy as social policy*' is Benoit (2003, p. 269). It is an effect of the workings at the political-economic level that policy does not make the link between drug and social policy in terms of addressing the structural factors 'behind' substance use and Australian drug researchers have only recently started to study the links between social inequality/disadvantage and drug use in more detail[90]. For example, Spooner and Hetherington (2005), Mendes and Rowe (2004, p. 7), Loxley et al

[89] The situation is a bit more complex for other now illegal substances.

90 'Firstly, across all drug types, being male and being young are each independently highly predictive of involvement in risky drug use and harm. Secondly, almost any measure of disadvantage will be similarly associated with increased risk and harm from drugs, regardless of gender and age. In relation to legal drugs, however, there is evidence of a U-shaped relationship such that, for example, both low and high income can be predictive of greater consumption and related harm. It is likely, however, that there are different underlying patterns, such as less frequent but higher intake drinking associated with higher rates of acute alcohol-related harm among disadvantaged groups. This latter pattern of drinking and related harm is most clearly expressed among Indigenous Australian populations who also have very high rates of smoking and a host of other health risk behaviours. The *association of drug use and measures of social disadvantage is strongest for the illicit drugs* versus the licit, and also for more intensely problematic patterns of drug use, including dependence. *Addressing social disadvantage* in all its forms has come to be seen as a central issue for modern drug policy to address. Related to findings of social disadvantage, there are indications that *social disconnection* is increasingly a modern driver underlying drug-related harm. Family breakdown, loss of community, increasing mobility and weakened religious institutions are structural determinants undermining social stability that have been identified as developmental risk factors for drug-related harm. The emerging calls within mental health promotion for a focus on social and community wellbeing are pertinent to efforts to address these more pervasive and insidious determinants of drug-related harm.' (Loxley et al 2004, p. 242 my emphasis)

(2004), Vimpani (2005) and Mooney (2005) all call for addressing the *structural dimensions* of *problematic* drug use.

Nonetheless, there is still much need for a better understanding of '*social inequality, stigmatization and marginalization around substance use*' (Room 2005, p. 152) and whilst this research interest is still young among researchers, we know that - worldwide - the relatively small '*group of problem [illicit] drug users disproportionably exhibit the indicators of deprivation and social exclusion – poverty, mental health issues, unsettled childhoods, low educational attainment, unstable accommodation*' (Stevens, Hallam & Trace 2006, p. 1).

The political-economic level is particularly important because it is here where 'harms' becomes *defined*, mostly in terms of *productivity loss* (sick leave, premature death with concepts such as 'disability adjusted life years', the cost for the state to maintain/care for 'unproductive' people etc.) or, *epidemiologically*, in terms of the prevention of communicable diseases (excluding those in prison settings). Harm is not defined in '*quality of life*' terms or as the lack of evidence-based drug policies (including alcohol and tobacco policies):

> Yet, as a consequence of the current policy environment, many drug users do not have the same rights and influence of other citizens. Because the amoral rhetoric of harm reduction does not seek to change many of the major factors which make the use of drugs hazardous, it has yet to challenge the risk environment, based historically on discrimination and bigotry. This risk environment creates a situation where the use of some drugs is extremely hazardous, simply because *drug policy is a mostly evidence-free zone*. (Miller P 2005a, p. 553 my emphasis)

Rhodes has coined the useful term of the '*risk environment*' (2002) in relation to preventing or reducing harm, but neither the *spatial management* of drug use nor the '*risk environment*' of harmful drug use have been problematised in relation to harm production as defined at this level. For example, a person on 'pharmacotherapy' often finds it difficult (if not impossible) to travel interstate or overseas, a person placed on bail for a drug-offence is banned through 'exclusion zones' or even faces outright bans to certain areas if a non-resident of a municipality[91]. The spatial dimension of illicit and licit drug use as well as the wider implications of increasing surveillance and management of public places, buildings and shopping centres need to receive further attention (particularly with regard to social inequality but also the socio-economic clustering of disadvantage (Spooner, Hall & Lynskey 2001). People who are banned from privately-owned shopping centres have been denied access to welfare services and receive

[91] This is a reference to an actual project being implemented in the Melbourne municipality of the City of Maribyrnong (see Winford 2006)

social security payments, because offices operate in these shopping centres. The *spatial production of harm* would also analytically help to move away from *individualising* drug problems, but harm production at the political-economic level thus far has had the effect that little is known on how to reduce harm at community level (Friedman & Touze 2006, p. 134).

A recent study of Melbourne homelessness found that homelessness was a *cause*, *not* a *consequence* of problematic drug use (Chamberlain, Johnson & Theobald 2007). Yet, as Janine Bush, former head of the Victorian Alcohol and Drug Association, a peak body of drug NGOs, summarised, even though we know about the nexus between homelessness and drug use, '*our responses remain strongly focused on addressing the consequences over the causes*.' (2006, p. 4)

Overall, Australian research has gathered much knowledge about the '*social origins of health and well-being*' (Eckersley, Dixon & Douglas 2001), yet the *political will* to tackle poverty and disadvantage is lacking at federal level and is still relatively weak at state (Victorian) levels. The Howard Government's explicit political commitments partly explain this inaction:

> The government that I lead embodies a distinctly Australian brand of liberalism. Our policy priorities reflect a broad perspective which combines liberalisation in economic policy with a modern conservatism in social policy. (Howard 2004, p. 6)

This mix of economic and social policy has meant that '*the burden of structural change and of global integration has fallen squarely onto labour*' (Bryan & Rafferty 1999, p. 92) and that the poor are '*experiencing the highest mortality rates and lowest health status*' (Turrell 2001, p. 85). The growing income inequality, unequal distribution of wealth and the polarisation of employment in households with children (where either both parents or no parent is employed) have been identified as effects of Australian policy (Zajdow 2005b, p. 93-96).

During the Howard Government years, poverty has become a '*precarious public policy idea*' (Adams 2002, p. 89), even if, as Connell argues, change started earlier when Australian corporate lobbyists stigmatised welfare and neo-liberal ideas penetrates the labour movement and bureaucracies in the 1980s, leading Australia to embrace global capitalism fully (2002, p. 5). Economic rationalism has established itself as the dominant economic approach in bureaucracies around the country but first and specifically in Canberra and under Labor governments (Pusey 1991). The shift of political preferences from social welfare to business welfare[92] has prompted some to talk about the '*growing fusion between state and capital*' (Ojeili 2001, p. 229).

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92 Despite the fact that it is '*companies, not nations, that compete in international markets*' (Bryan & Rafferty 1999, p. 91), there are diverse forms of business welfare that are made available under state economic policy, including forgone Commonwealth taxation revenue, state subsidies, tariffs, payroll exemptions and assistance to attract

Added to this general shift is the lack of political competition due to a convergence of the major political parties (in many Western democracies) and their agreement on welfare retrenchment[93]. Governments, however, are very selective in their welfare retrenchment and carefully target specific populations:

> Most vulnerable to real cuts or at least spending restraint have been education, family allowances, social assistance, and unemployment compensation. (p. 203) [...] or [cutbacks] on the least politically-organized, marginal groups (single mothers, the unemployed, or the poor)… (Wilensky 2006, p. 214)

A global study of welfare states, public solidarity and justice preferences found Australia to have a relatively low '*endorsement of institutionalized solidarity*' (Arts & Gelissen 2001, p. 292). Similarly, Wilensky, ranking 19 developed nations in terms of their political-economy and resulting well-being of people, found Australia (together with the US, the UK, Canada and New Zealand) to be ranking lowest as '*most fragmented and decentralized*' welfare regime (2006, p. 214). Esping-Andersen asserts that Australia belongs to a welfare state regime that '*erects a stratification order that blends a relative equality of poverty among state welfare recipients, market-differentiated welfare among the majorities, and a class-political dualism between the two*.' (1998, p. 141). What needs recognition, though, is that political preference for low taxation directly translates into increasing poverty rates:

> Yet, international experience shows that low taxes are unmistakably connected to higher not lower poverty rates. […] low tax democracies all fare badly on the poverty front (measured as the proportion with incomes below 50 per cent of the median). For a country flush with surplus funds, the latest poverty statistics tell a story of national complacency […]. Of seventeen rich democracies cited in Mishel et al. (2005, p. 408), Australia had the second highest level of overall poverty (14.3 per cent), the second highest level of child poverty (15.8 per cent) and the highest level of aged poverty (a staggering 29.4 per cent[94]). Dealing with poverty will inevitably require higher taxes, not just to improve income support but to reinvest in a national economy capable of producing new industries and good jobs. (Wilson 2005)

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investment from interstate as well as falling rates of company taxation, all of this has become known as business welfare (Bryan & Rafferty 1999, p. 72-73). Mark Latham confirms the business welfare habitus among Australian politicians who are lobbied: '*This is the mug's game that Keating used to talk about: businesspeople who reckon the world is full of bludgers and hippies, yet want the taxpayers to subsidise their company to the eyeballs, then trot off to vote for the Coalition. Social welfare is bad. Industry welfare is wonderful.*' (2005, p. 59)

93 Wilenky shows this convincingly: *'[B]oth center-left governments committed to egalitarian solutions and center-right governments committed to market solutions have moved toward retrenchment of the welfare state [..] when reforms are necessary, left-labor pressure results in more equality of sacrifice and fairer outcomes; business interests interacting with right-wing parties resist distribution of income and power downward.*'(2006, p. 214)

94 This number needs to be contextualised in that older people's assets are not always included in statistics.

When authors talk about the '*post-welfare state*' (Jamrozik 2001), '*Schumpeterian Workfare Postnational Regimes*' (Jessop 2000 & 2002a, p. 247ff), the welfare state in crisis[95] or '*post-Keynesian*' rationalities, they may identify *shifts* in governance rationalities, but the new rationalities *co-exist*[96] with older ones rather than being simply new all-encompassing or hegemonic operating principles. For example, Turnbull and Wilson argue that the Keynesian-inspired growth stimulation, predicated upon public debt, is now based on private debt but it still exists:

> Contrary to the apparent 'death' of Keynesian fiscal policies […] the state is continuing to 'pump prime' the Australian economy by relying on household-based deficit spending. [..] Policies on gambling, on construction and on private provision of education, housing and health care, we have argued, amount to a proto-Keynesian and strategically politically management of the economy. (2000)

To understand this we need to look at government's preparedness to tax in particular areas and not in others, and again, this is a global phenomenon: *'[…] consumption taxes and social-security payroll taxes evoke no sustained mass hostility, while property taxes and income taxes arouse the most persistent resentment*.' (Wilensky 2006, p. 203) *Electorally*, therefore, *consumption* taxes (with some exceptions) are preferred and *addiction consumption taxation* becomes a favourite for governments (until opposition to addiction income for the state strengthens, when gambling- or alcohol problems start having severe impacts on 'the community'). In many Western countries, including Australia, fiscal policy serves to *manage* the conflicts between different populations and not to ameliorate them (Cameron 2006, p. 252)[97].

Dean argues that the government's interpretation of '*mutual obligation*' policy is not even to pretend holding up its side of the '*bargain*': '*The Coalition Government's ministerial*

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[95] The assumption that the welfare state is in crisis reveals itself as unsustainable: '*If the "welfare state crisis" is not an inevitably accelerating rate of social spending, not the withdrawal of mass support for social spending, and not the inevitability and dangers of public debt, then surely it means that the burdens of the welfare state universally subvert good economic performance. [..] the evidence is overwhelmingly to the contrary*.' (Wilensky 2006, p. 203)

[96] For example, Harris describes three shifts in Australian welfare rationalities and employment: ''*relief' (1900 to the mid-1930s; 'full employment' (1940s to 1960s); 'mutual obligation' (1970s to present)*' (Harris 2001, p. 7). Apart from the changes in mutual obligation from the 1970s to now and the problems of periodisation, different social policy rationalities continue to coexist. A co-existence perspective could expose relief rationalities in today's emergency relief services and full-employment rationalities in many of today's welfare programs because the latter not only suggests that there should be full employment for an equitable society but that there is work for everybody 'out there' and that everybody only needs to overcome the 'barriers' and then will find a job. Harris also identifies social, economic and moral-behavioural components in all welfare rationalities (2001, p. 5).

[97] '*[T]he combined processes of fiscal centralism and fiscal privatisation/individuation suggest that far from entering a new world of fiscal equity, new forms of inequality are being generated. Divisions are being drawn between individual and corporate citizens, between the wealthy and the poor and the function of the fiscal state is no longer to mitigate these divisions, but to manage them*.' (Cameron 2006, p. 252)

*statement explicitly rejects job guarantees and job compacts and, in so doing, significantly modifies, if not abandons, the idea of reciprocal obligation between client and state*.' (1998, p. 97) Maggie Walter (2002) found that the '*highly disadvantaged position of sole-mother families is related fundamentally* ***to the soleness of their parenting****, rather than personal characteristics such as lower educational levels or, indeed, labour market participation*' (p. 377). This means that we need to challenge the efficacy of increasing work participation to reduce poverty as the '*the material benefit of a partner far outweighs the economic value of labour force participation*.' (p. 374) A study of low-income women's daily experiences with the social security administration found them to replete with 'scrutiny, marginalisation, surveillance, and stigma' (Cook & Marjoribanks 2005, p. 18).

The economy and employment do have an influence on drug-use patterns; Roche and Allsop reported that '*[p]eople in the paid workforce are much more likely to use illicit drugs than those not in the workforce*' (VAADA 2006b, p. 1) and Loxley et al. found that '*the recession in Australia in the early 1990s was associated with reduced alcohol consumption, reduced alcohol-caused deaths and alcohol-related road crashes*.' (2004, p. 66) A qualitative study of 32 Melburnians injecting drugs and using a primary health care service found the overwhelming majority to be reliant on government income, not having conventional employment and generally unemployed, partly due to the incompatibility of employment and '*drug habits*', whilst a quantitative survey revealed that a majority of 149 clients was income poor and had unstable housing or lived in homelessness (Rowe 2003, p. 40-54).

Mark Peel describes the real difficulties of advocating social change in a climate where *'[p]eople were tired of indulging the missionary zeal of this week's trainee social worker or today's 'social affairs' journalist,*' but where the '*complicated question of how to describe grim realities in ways that would attract attention*' (2003, p. 26/7) is still being asked. Effective strategies to reduce poverty (such as the provision of a basic income) and problematic drug use (such as the Ledermann hypothesis to lower the average per capita alcohol consumption of a population to reduce overall alcohol-related problems or simply reduce supply) are not being explored as policy options. Many policy options are assessed in terms of a cost-benefit analysis,[98] measuring whether a public investment is or was worth having.

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[98] '*Proponents of cost-benefit analysis emphasise the advantages of having a method of project evaluation that increases the consistency of decision-making. Its critics challenge the legitimacy of trying to place monetary values on 'intangibles' like environmental quality, even on life itself. Cost-benefit analysis shares with neoclassical welfare economics a distinctive set of assumptions about the nature of the economy and society. It is a monetary calculus of the determinants of community well-being, for better or worse*.' (Stilwell 2002, p. 202)

Zajdow has demonstrated just how such a rationale was used to evaluate the utility of having the Medically Supervised Injecting Centre in Sydney: a potentially life-saving intervention is justified primarily within economic discourse and in such analysis female drug users are '*worth more*' than male drug users because females have reproductive capacity (2004b). Zajdow problematises the narrow economic rationality in judgments about policy and treatment options and their '*worth-while-ness*' for the state and whilst '*moral panics*' are deployed to move bureaucracies' inertia into action (2006b, p. 407); once a facility is agreed upon, the '*social harms*' of pain and distress for family members and friends (2006b, p. 408) are carefully removed from the economic and medical evaluative logic (2006b, p. 417).

Furthermore, Roe's brief history of the harm reduction movement[99] – a global social movement, initiated by activists and workers and started officially in Liverpool in 1990 (Erickson et al. 1997, p. 3), since become fully professionalised – shows that '*the acceptance of harm reduction approaches coincided with a political need to address social disorder and reduce expense in health and legal services*' and he '*criticizes the current assumption that more harm reduction services will automatically result in a more humane society*.' (2005 p. 243) Roe finds that '*mature*' or '*new*' harm reduction works '*with existing institutions and moved away from direct challenges to existing policy and laws*', thereby also not giving serious attention to '*harm creation*' processes; he identifies '*harm reduction's marginalization of activism and its evolving role in the professional, medical management of social problems*' (2005, p. 244) and tensions within 'harm reductionism' between activists promoting social change as well as legalisation and a more '*accommodating*' style of medically managing prohibition's worst effects (2005, p. 244).

Drug user subjectification is more prominent in '*visible*' than in '*invisible*' users; their visibility is influenced by their economic means and socio-economic status: only the poor drug addict is '*othered*' and marginalised, wealthier addicts might be discriminated against if 'discovered', might even occasionally get a court sentence or some sanctions (from sponsors in the case of sports people), but more often than not they can make their exceptional status work for them, because they are perceived as well-off, prominent and 'different' addicts (singers, musicians, song-writers, actors can consume with anonymity and – if found out – as long as they promise to change their ways, there are usually no further consequences to their actions). Middle and upper-class addicts also have the opportunity to be 'invisible' in private health and treatment

[99] Harm reduction is described as a 'grassroots' movement begun in the early 1980s by AIDS activists and addicts through peer-education models on the prevention of HIV infection (Reinarman & Levine 1997, p. 353). '*Harm reduction*' is underpinned by century-old philosophies of drug and alcohol use and control (Zajdow 2004a, p. 73)

systems, whilst welfare recipients keep '*job diaries*' and participants in drug diversion programs keep diaries to '*provide them an insight*' into their own '*drug abuse*,' so as to understand possibilities of self-problematisation and recognise the advantages of self-government.

Whilst surveillance and evaluation statistics keep records about social-economic status and other characteristics, at the political-economic level, *reasons* for use are irrelevant (if not subject to advertising or prescribe-able) and the fact that drug-taking might have a political dimension is ignored at best and denied at worst. Alienation, precarious employment, workplace-related stress, lack of social cohesion and quality of life do not 'matter' at this level; yet, playwright Heiner Müller firmly locates drug-use in the context of industrialisation: '*The drug is the ally of the human being in the battle against the machine. Because drugs mean time gain for the subject, machines mean time loss*.' [my translation] (cited in Kuhlbrodt 2002).

Ironically but not surprisingly, in spite of the power differentials, both *drug-using clienthood and human service workerhood* are marginalised and – worse - described as *un-Australian*: a recent study found that the practice of drug use was seen as such *as was the profession of social work* (Smith & Phillips 2001). At the political-economic level, workforces in the drug- and social-policy-services are politically marginalised; King describes current dilemmas in building workforce capacity within the alcohol and other drug (AOD) sector, where university courses do not teach about AOD issues or do not teach them adequately; he also identifies two problems with workforce development:

> The first is an emphasis on individual workers, to the exclusion of the organisations and broader systems in which they work. The second is an over-emphasis on education and training strategies, to the exclusion of other factors that impact on work performance (such as workplace stress, inadequate remuneration, lack of organisational support, poor leadership, limited mentoring opportunities, and poor career opportunities). There is a sense that this is a *marginalised workforce, providing services to a marginalised client group*. (2004, p. 198-199 my emphasis)

Interestingly, there has been a renewed interest in drug and alcohol issues in Australian workplaces but mostly *excluding* the welfare and AOD sectors themselves, often seeking to evaluate the *economic* implications of workplace or workers' drug use (Allsop, Phillips & Calogero 2001), the only exception being the National Centre for Education and Training on Addiction (NCETA), which directly investigates AOD-related workplace issues; yet, whilst workforce development and retention *are* important issues, there is more to worker-hood and personhood than economic considerations.

The *human service worker* is part of '*a marginalised workforce undergoing a restructuring of employment conditions in some key areas, enabled by the introduction of such new public management strategies as competitive tendering and performance accountability*.' (Wearing 1998, p. 21) Community services workers have lower award conditions and employment benefits than the national average, are mostly women and have fewer career pathways and high turnover rates (Wearing 1998, p. 16/7). Workforce development and third sector sustainability remain pertinent as agencies are '*transitioning toward more entrepreneurial and managerial models as a result of quasi-market strategies*' (Spall & Zetlin 2004, p. 284).

Wearing asserts that Australian welfare *clienthood* is constructed by '*objectified knowledge of administrative and technical expertise*', facilitated by the operation of a uniquely Australian combination of welfare features:

> [M]eans-tested and work-tested social security provisions; ghettoised forms of public housing in major cities; official information collection on, and the statistical mapping of, client populations; and schemes of classification to arbitrate amongst those on the margins of society. (Wearing 1998, p. 64/5).

Harris – debunking the myth that we have as much welfare provision as the economy/the nation state can 'afford' – establishes an important link between the political-economic and the individual action expectations in welfare rationalities:

> And when unemployment and welfare trends are disconnected from economic cycles and international trade patterns, the responsibilities of welfare recipients are personalised and greatly exaggerated, with 'conduct retrieved from a social order of determination into a new ethic of the individualised and autonomised actor' (Rose, 1999: 176-7). (2002, p. 393)

## Conclusion

In this chapter I have introduced my conceptual-analytic approach in a four level framework aimed at making the *manufacturing of drug problems* collectable at these different levels. After the illustration of my four levels I argued that scholarly work is part of the manufacturing of drug problems. I then went on a brief historic journey to describe the beginnings and the crisis of harm minimisation policy seen through the national lens. Subsequently I outlined one of the levels, the political economic level, in detail. There I have described the capitalist imagination of the drug trade and the politics of drug use, in particular with regards to prohibition.

I have also shown how the traditional 'social policy' area has compounded drug problems by placing all responsibility for social development and survival with the individual and his/her capacity to labour. Drug policy as social policy has not been able to lift the worker or the client out of their respective marginalisations, in fact it has worsened their situations in the last decade. The extensive discussion of the political economic level can now help us to understand the different contexts of the encounters between the human service worker and the drug using client through the eyes of the workers.

The advantage of my four level conceptual framework for the data analysis is that we will be able to see the activities of human service workers as acting at different levels simultaneously and therefore discover the breadth and diversity of practices that other framings cannot expose sufficiently: The human service worker's subjectivity at the individual level, the human service worker's relationships with different clients, co-workers, their management and other agencies at the relational level, the human service worker's interpretation of what ought to be achieved in their job and how the organisation, funding, treatment and service delivery should work at the institutional level and their political understandings of the service sector's and their clients' dilemmas, the pay and working conditions and the socio-political struggles that frame their manoeuvring spaces at the political economic level will be seen in full light.

I will now discuss the remaining three levels' literature together with the data. I will begin with the individual and relational level (Chapter Four), progress onto the institutional level (Chapter Five) and close the circle with the political economic level (chapter Six).

# Chapter four

# The professional translation of drug factories:

# Governing the worker and client encounter

Having established the basic methodological underpinnings in Chapter Two and its conceptual-analytical framework based on four inter-penetrating – mutually 'reverberating' – constitutive levels, this chapter 'collects' – using the qualitative material from the interviews – some of the dynamics of the construction of the 'drug problem' at individual and relational levels, seeking to answer the following research question:

***Which practices and discourses constitute the drug user and the human service worker in the service relationship?***

The chapter is organised such that the interview data can enter into a dialogue with the (academic) literature, remembering that the presence of (certain) discourses is as important in data analysis as the absence of others. At relational and individual levels, worker and client are brought into a *strategic* relation, by knowledge[100] and by discourses which compete over inscriptions of roles and interpretations of the encounters as well as by the practices they engage in. As explained in Chapter Two, 51 interviews were held with human service workers[101] not employed in services classified as 'drug/alcohol services' but working with clients who use drugs/alcohol. The clients *indirectly* entering into the 'data' are (primarily) people from disadvantaged backgrounds as described by the workers, who were recruited from a wide range of Victorian metropolitan and regional agencies, employed in welfare services, including

[100] Foucault reminds us that knowledge is the outcome of battles: '… *knowledge is always a certain strategic relation in which man is placed. This strategic relation is what will define the effect of knowledge; that's why it would be completely contradictory to imagine a knowledge that was not by nature partial, oblique, and perspectival. The perspectival character of knowledge derives not from human nature but always from the polemical and strategic character of knowledge because there is a battle, and knowledge is the result of this battle*.' (2002d, p. 14)

[101] As outlined in my approach to discourse analysis, I ask the reader to remember that I think about the meeting between human service worker and drug user-as-client as *encounters* in which *discourses are battled out* and strategically deployed and altered. It is the encounter of discourses (with their material bases) which I am interested in here. In these encounters, individuals do not 'freely' choose meanings (nonetheless, they choose and alter them) because clients and workers are constituted by and through discourses without implying a determinist reading of their encounter. If it sometimes as if I am more 'critical' of workers than of clients, this is not intended but is simply due to the fact that I only interviewed workers and not clients. This is a task still ahead.

(financial) counselling, youth and family services, emergency relief, homelessness and residential and foster care, tenancy and legal services, domestic violence and bail advocacy programs.

From the '*humble*' 19th century beginnings of drug and alcohol 'human service work', it is now considered '*imperative*' for human service workers to be knowledgeable about it:

> Clearly it is imperative that [welfare, youth and alcohol and drug] workers on the 'front line', those who engage with (young) drug users or potential users, need to have accurate, comprehensive and up-to-date information with respect to a variety of drugs and their effects. (Drugs and Crime Prevention Committee (DCPC) 2004, p. 470)

As far as I know, only one article (Fraser 2006) in the Australian drug and alcohol literature explicitly problematises notions of clienthood, without, however, questioning clienthood per-se and only certain particularities of clienthood, the client subject position still a given:

> The paper argues that in the context of the methadone dosing point, time and space co-produce each other as a chronotope of the queue, and that this chronotope helps materialise particular methadone subjects. Often, these are the very kinds of subjects considered undesirable; that is, the 'unproductive', the 'disorderly', the 'illicit'. In light of this, the paper asks whether the demands of the clinic and its convention of queuing reproduce rather than depart from the model of waiting and dependence widely seen as characteristic of lifestyles associated with regular heroin use. (p. 192) From this point of view, the queue offers a significant challenge to these aims in that, rather than simply containing or organising *pre-existing clients*, it *intra-actively performs particular kinds of clients*. At times, these clients can be seen to: • trouble public order; • fail to approximate the liberal goal of independence through paid employment; and • use the time and opportunity afforded by the queue to buy or sell methadone. (p. 200, my emphasis)

The client appears as '*pre-existing*' and is only produced as a '*different*' client by the way a program (or an element thereof) *governs* a client; the methadone subject is a *given* and the queue constitutes ('performs') a particular methadone client. What this type of analysis misses is that clienthood is *itself temporally and spatially constituted* and not just some particulars of clienthood. Programs do not just govern different clienthoods, they constitute them; as the 'drug user' *becomes* a 'client' by entering the doors of a social service organisation, temporal, policy and spatial arrangements of services' '*entry and exit*' points rule the nature of clienthood and any non-compliance can affect client status. Service organisations vary in their 'philosophy', funding base, 'code of conduct' and employment policies, which means the client is not some congruent subject position construction across or even within service organisations. To speak of '*a* drug using client' would, therefore, be misleading.

Different clienthood governance reflects the various and contradictory ways in which individuals can be subjectified:

> '[Human beings] live their lives in a constant movement across different practices that subjectify them in different ways. Within these different practices, persons are addressed as different sorts of human being, presupposed to be different sorts of human being, acted upon as if they were different sorts of human being. Techniques relating to oneself as a subject of unique capacities worthy of respect run up against practices of relating to oneself as the target of discipline, duty, and docility.' (Rose 1998, p. 35)

The almost inescapable tension between self-respecting and subjectifying techniques is also observable in harm minimisation regimes, their technologies targeting the practice of drug use *and* the person of the drug user reflexively, but deployed in a rather sophisticated formulation, whereby the actuarial risks are placed along a 'circulating' continuum between the binaries of the '*personality*' of the user and '*drugality*' (Moore 2004; see Chapter Three):

> The drug-user is understood to be variably free or variably constrained. But, as this also suggests, risk implies that the locus of harm creation lies neither in the properties of drugs, nor in the characteristic of the user, but in the *variable yet calculable relationships between them*. (O'Malley 1999, p. 197-198)

How the 'drug user' and the 'human service worker' are constituted, their relationship as well as the technologies of engagement will now be examined as they were described in the interviews and I shall juxtapose their statements with some of the relevant literature.

## 1. The professional-relational creation of the problematic drug user

In this subsection, I describe the discourses that *constitute* the drug user and his/her problematic '*nature*' in the professional relationship, first outlining workers' descriptions of how they 'know' the 'drug user' or the 'drug using client' and the reasons for drug use. I will then engage the four central discourses which constituted the drug using client: those of *rationality* and *intoxication*, of *pleasure*, of *choice* and of *normality* and *functionality*.

### 1.1. Constituting clients

In the following, I outline how workers have portrayed the drug user and the drug using client and clients' reasons for using drugs. *Knowing* and *constituting* the drug user are thought to stand in a dialectical relationship.

### 1.1.1. The discursive construction of the drug user and the drug using client

A distinction is made between the drug user and the drug using client – a distinction which has been statistically, historically and discursively achieved.[102] Most workers insisted that one cannot and should not generalise about the 'drug user,' as they were all different; nonetheless, during the interviews, they came up with a long list of '*observable*' characteristics making up the drug user and the drug using client:

- *The drug user* was described using *prohibition discourse*: s/he is preoccupied by a '*drug lifestyle*', engages in criminal and drug activity and usually has a '*drug career*'. S/he usually has a drug of choice and is subject to the fashions and cycles of drug use. Drug users have a '*culture of their own*'.
- The *drug user's* personality and behaviour is based on a *social deficit* discourse: they are more self-centred, less motivated to do things and '*very social kind of animals*' (group dynamic, their friends are other drug users), they are not functioning well or at all, have no self-worth, no self-esteem and are insecure. They have poor problem-solving skills, are '*time disoriented*' and generally '*not morning persons*'. There is a lack of responsibility for their own actions; they can be dangerous and unpredictable when intoxicated.
- The *drug using population* is marked by *differences*: '*alkies*' are different to '*druggies*', *chromers* are different to *marijuana smokers*. Drug using parents' addiction makes them put their needs over those of their children; they have an '*addictive background*' (multigenerational drug use, disadvantage, family breakdown, low educational attainment) but what the '*issues*' are varies from user to user. A few workers described them as *different people*: drug users are resilient people and, at times, may be admired for '*how they manage it all*'. They are often spiritual people and are '*the experts of their lives*'.
- The *drug user* has a *problematic relationship to and with the 'community'*. They are tremendously isolated from the rest of the community and should be reintegrated back '*into society*'. They are '*victims*' (sometimes of their own and sometimes of others' acts); they are marginalised and the community has a stereotyped drug user image.

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[102] Roche makes clear that drug using clients are different from the '*average illicit drug user*' with regards to employment and the treatment system: First, there are '*significantly more illicit drug users in the paid workforce than not in the workforce*'. Secondly, in the treatment sector '*many clients are not in the paid workforce; rather they are often ill, unemployed, on pensions, have faced imprisonment and in general are often struggling to cope with chaotic lifestyles*.' People who come in contact with the drug treatment system (and social services) are '*users with severe and chronic problems, and not the majority of drug users who are not in treatment*' (2007, p. 18).

- *The drug using client* is '*a bit wary*' and very suspicious of the welfare system, other workers and particularly child protection. S/he is likely to drop out of and never return to a service. S/he is itinerant, unreliable, unpredictable, unpunctual and more time intensive, scams, lies and manipulates. Drug using clients are nodding off during an interview or in the waiting area; they cause tensions with duty-of-care arrangements and confidentiality (criminal acts, child protection), are often difficult and complex (disrupting organisational goals/client '*turn over*'/case loads), require multiple services (which challenges the fragmented service system logic). These clients are *pushy* people, demanding and '*in your face*', aggressive in the pursuit of their 'wants' and making services neglect more '*deserving*' clients. Quite a lot of workers found drug using clients to be wasteful, *unless* and *until* they became '*genuine*' about wanting to change (the worker and the service system are already drained for resources; if those scarce resources are then '*wasted*' on helping drug users, the system is simply fuelling their addiction). Most workers, however, still portrayed the drug using client as further marginalised by the service system itself.

I include two examples of describing the drug-using client: Henry, a fostercare worker, concentrates on the drug user-as-*client*, whereas Fiona, another fostercare worker, describes the *drug user*-as-client:

> [Henry] *I've found that they can be unpredictable, their behaviour can be pretty unpredictable and volatile at times. Sometimes they present really well, coherent, stable and other times they seem to be irritated, irrational at times and angry, apprehensive, depending on the day and what sort of drugs they have used. For instance, some clients I have had contact with would present as drunk after they have their sort of binge or whatever and sometimes they would present very superficial, not very rational, they look pretty tired and forget things, their eyes are very sort of diluted, you can tell by looking at their face that they're under some substance and although we don't confront them openly, we sometimes sort of case-note, make those records and especially when we are supervising access between parents and their children and if they present as severely drug affected, our job is to terminate the access because it can affect the children and interaction. [..] maybe they are under the influence of drugs, sometimes it's not even very clear and we need to make it on judgment and I guess sort of confront them sometimes*.

> [Fiona] *I find that the mums who use drugs are probably far more self-centred and find it more difficult to put their children's needs before their own need [..] because the drug has such a strong hold on the mother and because the mother's often preoccupied with having to score drugs or alternatively to get her methadone or whatever and to keep herself physically comfortable, that than becomes a major preoccupation as to how she's going to keep herself physically comfortable in order to be able to parent and do all the other things that she needs to do... I've known clients that have sold their children's beds in order to get money for a fix… one particular client that I'm thinking of at the moment who bought a bicycle for her daughter and had it on lay-by for nearly the whole year and*

*so it was very exciting this bicycle that was bought for this child and the child was very excited and the mother needed her fix of heroin and she didn't have any money and so she sold her daughter's new bike and then was guilt ridden for a very long time after that you see. [..] the drug has such a strong hold on them, the addiction is so strong and that they're so physically uncomfortable that they have no choice. They have to put their own needs before their child's needs*.

Workers' descriptions of drug using clients' '*characteristics*' are a direct result of the constitution of clienthood by the service system and a reflection of the '*case gaze*': case management, the framing and the situated context of how amenable the drug user is to being managed. Drug using clients' characteristics are directly produced by the way the service system operates:

1. one cannot be unpunctual unless the service system is appointment-based;
2. one cannot be 'not a morning person' unless society's whole time-cycle is set up for 'larks' (morning people) and not for 'owls' (evening people);
3. one cannot be draining the resources of a service system unless this is set up to create highly differentiated and competing clienthoods with different services and entitlements coming out of politically-artificially set 'scarce' budgets;
4. one cannot be 'time intensive' unless the service system operates on funding-based formulas, given time frames and expected 'turn-over rates' of clients.

Most of the workers' discursively produced '*characteristics*' are not locatable in the drug user subject position, but *purely* products of the service system operation. Most of the remaining 'characteristics' are produced by the socio-cultural operation of the prohibition regime and other normative social logics. Yet, other 'characteristics' are directly produced by (neo)liberal forms of governance, where entrepreneurial creativity and productivity, perpetual self-reinventing, self-improvement and ever-readiness to perform are highly appreciated ways of being within a socially 'acceptable' diversity of lifestyles that still conform to (or at least do not disrupt) hegemonic values (Gerlach 2000).

The most important effect of the discourse is that workers' accounts construct the client as an *individual* whose goals are in opposition to societal/social goals: the relationship between individual client and societal interest is constructed as '*naturally*' unaligned. The governmentality literature taught us that aligning the client's interests with the 'social' interest is one of the major operations of modern technologies (including harm reduction and human service

work; Rose 1999a, 1999b)[103]. Alternative discursive constructions – such as asking how we can build a collectivity thriving on individual's desires and capacities (without simply harnessing and exploiting individual diversity for consumption and profit purposes as currently the case) – were absent from the workers' descriptions of the drug using client[104].

In short, workers' discursive construction of the 'drug user' is still predominantly inscribed as a user of illegal drugs and a kind of '*perverted*' *Homo economicus*[105], a rational utility maximiser in an 'asocial' way, somehow selfish and unproductive, yet suffering social deficits. The drug user-as-client is a misfit who will use resources and require help from the service system without any assurances of 'change'. The challenge for human service work is to tap 'into' the drug user-as-client in a way that can bring out 'the good' and the 'change capacity,' returning the drug user back 'into society'. Facing this challenge, workers insisted one needs to know the reason a client uses drugs. I will explain now how the workers reasoned drug use.

### 1.1.2. Reasoning drug use

A common thread in the interviews was the fact that workers described themselves as either knowing *why* their clients are using or knowing that there are reasons why they are using:

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[103] For example, in talking about the '*government of the soul*', Rose has argued that such alignment between individual and social goals is achieved through more or less subtle technologies and '*therapies of freedom*': '*In the complex web they [the psycho-sciences] have traced out, the truths of science and the powers of experts act as relays that bring the values of authorities and the goals of business into contact with the dreams and actions of us all. These technologies for the government of the soul operate not through the crushing of subjectivity in the interests of control and profit, by seeking to align political, social, and institutional goals with individual pleasures and desires, and with the happiness and fulfilment of the self.*' (1999b, p. 261)

[104] One discourse, not assuming from the outset that there is a conflict between individuals' and community interests is the Marxian utopia: '*Marx thought that the perfect society of the future would be so constituted that each individual would treat his own powers and abilities as direct social forces, thus removing the conflict between individual aspirations and communal needs*.' (Kołakowski 2005, p. 1112) We have to recognise that the fundamental opposition between individual and community is a result of sustained material and discursive work.

[105] It is actually quite difficult to ascertain what many authors mean by '*homo economicus*' or '*economic man*'. Persky asserts that the origins of 'economic man' are often ascribed to John Stuart Mill but it is more useful to think of economic man as arising out of the reaction and critique of Mill's work; however, its origins trace back to other forerunners of economic man (1995, p. 222). 'Mill's economic man has four distinct interests: accumulation, leisure, luxury and procreation' (Persky 1995, p. 223) and was not the abstraction of rational man and choice maker that 'he' has in contemporary usage (Persky 1995, p. 223). What is perhaps the legacy of Mill's conception is that '*Mill demonstrates that much can be learned from considering a simple, but hardly trivial, view of human nature in interaction with diverse real world institutions. This methodology – using economic man as guinea pig in widely different institutional settings – remains an essential tool of modern economics*.' (Persky 1995, p. 226) Economic man is a concept, therefore, that can be invested with numerous sets of assumptions for the purposes of theoretical modelling. What economists regard as its strength, sociologists view as misleading, if not fundamentally naïve and flawed: a de-contextualised, un-situated guinea pig deprived of emotions, empirical basis and social complexities. Gramsci recognised the social and abstract nature of economic man a long time ago, when he defined him as '*the abstraction of the economic activity of a particular form of society, that is of a particular economic structure […] Homo oeconomicus is the abstraction of the needs and of the economic operations of a particular form of society, just as the ensemble of hypotheses put forward by economists in their scientific work is nothing other than the ensemble of premises that are at the base of a particular form of society*' (Gramsci 1971, p. 400 in footnote)

[Angela] *All the drug and alcohol training seems to be around what sort of drugs they're using, how it affects their body and stuff like that and why they're using drugs. But we know, we always know there's a reason why, we always know… we always pretty much know what they're using, um and we always pretty much know how it affects the body because you can see it.*

[Damon] *I guess for the general public initially, there probably is a bit of shock and confusion as to why people do it but I guess I've gone through that stage many years ago and it's more just trying to work through their issues and giving them assistance [...] So my belief is they are people with problems and they basically resorted to drugs usually to overcome some trauma in their life and obviously haven't been able to get off it. So I just treat them like other people and I guess they're people obviously who also had an addiction but that's not the main aspect of their life, their family members and other things as well... They're just drug users, a lot of people stereotype drug users… oh they're a user sort of thing, but that's not their main thing in life and I think they want to get off it and do other things... Some of them it's just a stage they go through and they get out the other end but unfortunately for others it's a lifetime addiction and so they die and some unfortunately die fairly early because of it, but that's the way it is*.

Angela, a youth residential worker, and Damon, a fostercare worker, like most workers, regarded drug use as '*functional*', in that their clients had reasons to use drugs but that '*functionality*' did not apply to how they manage their lives, because they are '*people with problems*'. Damon, on the one hand, used the term 'drug user' and, on the other, complained about them being stereotyped: recognising that someone has a reason for use may be seen as not stereotyping someone, but arguably recognising reasons and stereotyping can go hand-in-hand or co-exist. Here, drug users are constructed as a *group* with distinct and socially identifiable patterns of behaviour, lifestyles, at times resulting in tragedy and death. Most workers portrayed themselves as having learnt why people use (as opposed to the community, who has not).

The individual is '*off the hook*' when biological, genetic or medical discourses become hegemonic, because the source of the phenomenon/behaviour/problem then is '*external*' to the individual's influence (nonetheless, the individual's subjectivity is always part of the therapeutic discourse). Most workers drew on physiological, psychological and pharmacological discourses and only few on genetic discourses to explain drug dependence; most of them, however, found 'social' and environmental characteristics (such as family/employment or income status/education/social networks) or a combination thereof at least equally, if not more meaningful as an explanation of someone's problematic drug use/dependence. This counsellor gave a typical response:

> [Kirsty] *It's clear to me that a lot of it is the environment but I think it's possibly genetic as well. So I'm very clear with those clients, I say, "You cannot use this for the rest of your life if you want your full capacity to function and if you want to get really self-responsible, build yourself into what's important for your children*."

In the counsellor's account, the *causation* of problematic drug use was not central; instead she concentrated on teaching clients about the long-term effects of their actions and to take responsibility. For Gerda, a family support worker, whilst acknowledging multiple reasons, it boils down to drug use being a 'quick fix':

> [Gerda] *There's a multitude of causes. People get into drug use and alcohol abuse for a multitude of reasons. Sometimes it's just socially acceptable, sometimes it's because peers offer it and they don't want to be daggy so they do it. Some people take it because they're depressed and they want to feel better. For some people it's about the pain they're feeling. For a lot of people it's about the pain they're feeling and it's not physical pain, it's mental pain. For some people it just takes all the need to feel anything away. Yeah, there's a huge range of reasons why people take 'em. Some of them slip into it very easily because it's a quick fix to what they're suffering or what they're feeling*.

It is certainly important to know *why* someone is using drugs and to respect such reasons; but it may not necessarily just be 'the one' or any particular reason, because it *may* be problematic[106] to think or say that one knows the *one* reason for someone's actions; first, it supposes that there is rationality '*behind*' every action, that there is *a* reason to *a* human practice. Secondly, it assumes that we can know or at least be made therapeutically conscious of this one reason and address it. Thirdly, it implies that our meaning making (reason-giving) is relatively constant, rather than instable and contextualised.

The reasons for and the reasoning about people's drug use occurs through *mutually achieved* narrative between worker and client in their individual sense-making processes, built and modified by them and performed for the purposes of the service encounter. Whatever the human service worker believes is the reason for a client's drug-taking becomes the basis whereupon s/he decides whether this is a '*reasonable*' exercise, a '*functional*' behaviour or not; it is a matter of helping drug users to see the '*truth*' of their situation, to shape the '*problem*' and evoke their awareness of it and offer different *means* of addressing it.

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[106] One may ask himself/herself why s/he uses drugs or does not, why s/he is partnered or not, why s/he has children or not, why s/he did a PhD or not. Socially, the reasons we give for our actions vary (not only in the answers we give but in the situations and contexts in which and to whom we give them) and are often not singular and may be prospective or retrospective. So, why should drug use be due to only one reason 'per person' (not suggesting that it *could* not be one reason)? Explaining a human practice usually means appealing to multiple 'truths', perspectives and changes in social and individual meaning making. Our reasons for use are always already social, that is, we make them and give them as members of associations, networks and participants in social interactions.

In the workers' accounts, the drug is a means or an end or both, inadvertently making these accounts '*drug-centric*': they *explain humans through their drug use*. Drug-centricity is not in itself problematic (only when seen in isolation) and some approaches that study drug dynamics are very important (Chapter Three, referring to the *social* achievement of manufacturing drug personalities or '*drugalities*', Moore 2004). As mentioned, workers' accounts *individualise* the 'drug problem', emphasising the relationship between drugs and individuals, a construction which does not capture how the 'problems' are socially constituted, shaped and represented in particular ways, at and across all four levels.

Sociological discourses, seeking to portray the *social* logic of drug use, *pluralise 'drug problems'*. Martin's recent article in The Times is a classic example of sociological reasoning about drug use:

> We are told we have a drug problem, but we do not. We have a *poverty problem*; an *education problem*; an *intelligence problem*; a *homelessness problem*; a *refugee community problem*; *an opportunity problem*. We have *a lousy life problem*. This is then exacerbated by drug use. Drugs as an escape; drugs as an alternative. There is a difference between one kid popping a pill to pep up Saturday night and another sitting around smoking crack all day, while drifting from truancy to unemployment and crime. The war against drugs fails to differentiate. Everybody becomes a drug user, as if all drugs are the same, all use is the same, all situations, lifestyles and choices are the same. (2007, my emphasis)

With Martin I can argue that the war on drugs is a *technology to generalise the drug user.* Similarly, Dawn Moore had demonstrated that the supposed non-differentiation of drug using groups is a generalising technology of talking about 'drugs' (2004). Whilst the policy literature remains silent on sociological relationships (Zajdow 2005a), many workers drew - more or less specifically - on sociological discourses which can be generalising about the drug user. Theda, a counsellor, describes the 'type' of person drug users are:

> [Theda] *What I've found commonly with people who use drugs is they're often quite spiritual people, they're quite intelligent and there's a certain frustration because that side of their nature is not expressed but they find that it is when they use*.

Using the sociological discourse of '*pluralising drug problems*', the discursive construction would not be one of an individual drug user having a problem (individualising the drug user), but Theda's comment would be interpreted as a description of a *one-dimensional (wo)man problem*, a *spirituality problem*, a lack of (supportive) *pathways problem* and of *recognition of talents problem*.

Relegating drug use to being *either* a problem of policy, *or* a problem of individuals *or* of society – rather than an all-at-once complex problem (construction) – would be a fallacy; perhaps the most important insight in thinking about people's reasons for drug use – reasoning drug use – is that whatever we choose to believe are the causes and consequences of substance use *will determine our interventions*. As pointed out in Chapter Three, the political-economic level reifies drugs through their *exchange* value; at the individual level, drugs are reified through their (*symbolic*) *use* value. The reasons for which one uses drugs do *not* matter at the political-economic level; at the individual and relational level of the client-worker encounter, however, reasons for use are important, directly and indirectly.

It has – hopefully – become clear that the drug *user* and the drug *using client* are distinct *discursive achievements*; workers drew on discourses encapsulating a range of problem constructions, from communal stereotyping, drugs having a '*stronghold*' on clients, to using the services inappropriately and having to learn to take responsibility. The social environment was deemed to be a major *explanatory factor* for the individuals' problematic drug use, whilst it was recognised that clients had varying reasons for using drugs.

### 1.2. Four dominant discursive constructions of the drug using client

I was able to identify four distinct if partly overlapping discourses in the 51 workers' accounts as the dominant constitutive forces for clienthood: the discourse of *rationality* and *intoxication*, of *pleasure* and its *exclusion*, of *choice* and, lastly, of *normality* and *functionality*. I will discuss each in turn.

#### 1.2.1. 'Rationality' enforcement: Reckoning with intoxication

Most workers talked about intoxication at some point during the interview; Henry, a fostercare worker, drew the line between legal and illegal drug use with the help of the rationality criterion:

> [Henry] *I think drug use is an act by an individual which involves using illicit, unprescribed drugs which affect their physical and emotional health. Illegal drugs, yes. [..] No, I wouldn't say that [legal substances are drugs]. That would be a legal drug because that is sort of consumed to an* ***acceptable*** *extent* ***which doesn't actually make people behave irrationally or it doesn't affect the judgement and emotions****, so I wouldn't classify that [alcohol and caffeine] as an illegal drug. [..] As long as it's consumed within the limit only, when it crosses that line it becomes illegal*. (my emphasis)

Henry regards social and behavioural acceptability as the criterion for a substance's legality and – obviously – the medical discourse rendering drug use acceptable by it being 'authoritatively' prescribed has historically sedimented into workers' habitus. 'Unacceptable' irrationality is associated with judgement impairment. Workers who were confronted with clients who were intoxicated described this contact as a '*them and us*' relation; in these narratives, rationality was juxtaposed to intoxication. Charles and Eric, residential youth workers, portrayed the interaction thus:

> [Charles] *I mean there's plenty of other sorts of instances where the clients have got that high that they don't know what they're doing which can present a danger to themselves and to us, so it's quite scary not knowing what they're capable of… in a sense that they don't know what they're thinking and us as rational, straight people at that time, it's hard to find a connection between us being rational and them being in a completely other frame of mind and you have to be careful with that sometimes because the chrome, especially the butane gas, can really send the kids a bit off the dial and really aggressive*.

> [Eric] *It's very hard to judge how anybody will react when they're drug affected because it actually takes away a lot of the barriers, a lot of the normal things, the impulse controls that they would normally have and so we're dealing with people that might flare up at things that they would never flare up with. You can't have rational discussions with them. You can't sort of talk them down in the same manner as you would with someone who's just angry.*

Very few workers described drug use involving a sense of the institution of time. One counsellor, Theda, talked about *fast time*:

> [Theda] *I mean the kid's feeling sick or got a headache, you know, and you're running around trying to get the dinner ready, the quickest thing to do is to give an aspirin, whereas in fact it might just be really good to sit down and just cuddle them for 10 minutes or just give them a bit of a massage or something or ask them what's wrong, what's the stress all about. But it's easier in this fast society and so I just think that actually what happens is we, as people from a very early age, get used to it being fixed by something else and we're not taught to take that time, to go and have a bath and relax, to talk with somebody about it. So rather than do all that it's straight to the nursing cabinet if you like, or straight to the grog cupboard. [..] I mean I know it sounds simplistic, but the simpler the lifestyle the more time you have for those sort of lovely things, but the way our world is so fast, it's just a whole sociological thing, you enter now into a whole way the world lives and what we as human beings have forgotten to tap into, which is our own natural ability to be still, to be calm, you know, because it's been very quick fix since I can remember.*

In Theda's account, it is not the drug user '*resorting*' to drugs but *everyone*, a generalised person living in a fast society, where drugs enable us to keep going, to avoid standing still. In Chapter Three, Müller indicated that drugs *help humans gain time* (over machines who take time

away) and intoxication is not culturally recognised as a time 'slower'. Here, the idea that drugs are a 'quick fix' in a fast society co-exists with the idea of drugs as time stretchers.

I will return to many workers who identified working with an intoxicated drug user as particularly challenging; it was not until the 25th interview that I encountered a worker who explicitly identified drug use with having fun and as having a positive chemical intent:

> [Isaac] *I think the majority of drug use probably happens because people want to have fun, people want to change, people want to feel relaxed, they like that feeling of stepping outside the norm, they're in this mindset all the time, it's just an experience outside that. They're going to come back to how they were, but just for that little period of time, whether it's to have fun, whether it's to socialise, whether it's to get through a shift at work, there's all sorts of reasons for it, and different types of drug use patterns based on that, whether it be just on Friday nights, or whether it be just when a certain person comes around, whether it be just when those thoughts come up, there's lots of different reasons*.

A youth worker, Isaac captured the '*social functionality*' of drug use in a more complex way. Fun, leisure and pleasure, whilst playing a limited role in the workers' accounts (and featuring most strongly in relation to young people's drug use), are present because they make social sense and are part of how workers experience their clients' drug experiences. Pleasure and intoxication, however, are often excluded from drug policies and, particularly, from the drug intervention literature.

Why these two ideas – intoxication and rationality – play a limited role in workers' accounts and are excluded from policy and intervention literature needs to be explained. Indeed, it is strange, because at individual and relational levels, drugs are almost always recognised as primarily pleasurable and 'social'. The relative absence of these ideas in the discourses can be explained by viewing them from a cultural political-economic perspective. For example, Rose describes it as a legacy of the Age of Reason:

> In our times of rationalization, intellectualization, and the 'disenchantment of the world', ultimate values no longer provide a means of guiding our lives. Persons discharge their lives according to rational rules and impersonal duties rather than by virtue of a set of transcendent ethical values. Complete rationalization denies a space of freedom for the conduct of one's life. Rational principles may specify how to reach certain goals, but they cannot say which goals we should strive to reach. Science, it would appear, has nothing to say about the conduct of life of the free individual. (1999b, p. 259) [..] We are obliged to fulfil our political role as active citizens, ardent consumers, enthusiastic employees, and loving parents as if we were seeking to realize our own desires. (1999b, p. 261-262)

Rose characterises the modern self as having been acculturated into a particular version of rationality, I argue, that this also applies to intoxication. Many workers were worried about the

effects on clients' long- and short-term health and the dangers of being intoxicated. In effect, workers were asking, explaining and sometimes demanding that their clients consider the future risks related to their opting for intoxication, providing them with information about the ill-health their drug use might cause. This is congruent with public health discourse that juxtaposes diachronic time (comfort over time) against synchronic time (comfort in the present) and that demands a *rational* choice for long-term comfort, i.e. better health, can and should be expected. *But comfort has a social bias*.

Arguably, resulting from disciplinary divisions in the Australian AOD research field, social and drug policy research still has relatively few links with anthropology, sociology and cultural studies. One effect of these divisions is that the policy literature remains ill-informed or ignorant about the complexity of and the motives and reasons for use and inadvertently reserves no place for *intoxication*[107] itself. Whilst the bio-chemical reaction or process of intoxicating oneself is explained by pharmacological discourse, the cultural-social imagination of intoxication is left unexplored. Indeed, 'intoxicated states' occupy marginalised discursive spaces in public deliberations and intoxication is predominantly equated with being drunk or 'abnormally' poisoned, leaving no space for the complexity and experiences (of colours, 'trance-cendence', euphoria, non-sobriety) of alternative cultural states.

Yet, the political-economic level is neither silent on excess nor on intoxication: '*binge drinking*' (fashionable term for excessive drinking) (AIHW 2007, p. 14) and (bank and household) '*binge borrowing*' (Gibbs 2007, p. 23) are widespread in Australia. Government revenue – from '*binge taxing*' of tobacco and alcohol – increased substantially: '*the net government revenue associated with tobacco products increased from $4.3 billion in 1995–96 to nearly $6.7 billion in 2004–05*' (AIHW 2007, p. 7) whereas '*net government revenue associated with alcohol increased from $3.6 billion in 1995–96 to an estimated $5.1 billion in 2004–05*' (AIHW 2007, p. 16) When it comes to the *individual* level, however, intoxication features in its *political-economic* relevance only, i.e. in terms of economic/health and productivity costs (absenteeism, accidents, injuries etc). How the political-economic and the individual level interact and are discursively played out is well described by the '*ex-addict turned writer*' Stringer:

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[107] I am drawing on Zajdow's paper (2005c), arguing that we have neglected to understand and take seriously intoxication narratives. She also points to the possibility that there is an experience of '*addiction where desires are no longer the point, but action is predicated on elimination of choice or rational calculation*' (2005c, p. 19).

> But I did try to point out that the assumptions we have about people who have become addicted may not necessarily be true, and that is an assumption of somebody with lower moral character than the rest. I submit that it's probably the other way around, in a sense. I think that people who end up getting addicted are acutely aware of being spiritually empty and it matters to them. Even religion doesn't seem to find its way to talking to us in a way that connects, so we reach out and sooner or later you're going to grab a substance. For some people it's sex, some people it's gambling, for some people it's money. Amongst the people who are successful are some real major money and power addicts, except that we don't call that addiction, we call it success and we praise it. In business [..], they don't call it addiction, they call it brand loyalty. (Stringer 2006)

Stringer links *the individual level* to effects of processes on *the political-economic level*: consumerism is not pathologised under the unlimited growth paradigm governing contemporary capitalism, which has constituted the individual primarily as a *consumer* (Livingstone 2005, p. 529)[108]. Stringer takes the discussion further; not only is there a political-economy 'bias,' the social appetites of which we legitimise, but he brings to the fore what most of the drug literature is silent on: *the emotional, meaning and spiritual seeking that encompasses the drug using journey*.

Describing the '*states of interiority*'[109] to which intoxication is one technology of facilitation amongst others (e.g. breathing, music, dance, certain sports), occurs through the use of many concepts: spiritual, esoteric, transcendental, mythical, mystical, magic, ritual, existential or religious (divine) experiences. Spaces and times of interiority are thought of as tranquillity, oblivion, altered consciousness, trance, soul, vision, ecstasy, euphoria or illumination, or, even more pronounced, as autonomy, freedom, utopia, nirvana, eternity, universality, paradise, which we have identified with imagination, transgression or the tapping into creative or 'innate' energies. For Australian Indigenous peoples, celebrations of connections with ancestors or spirits are part of rituals and ceremonies and going into 'dream time'/'dreaming'[110].

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[108] It is a particularly constituted 'consumer' with limited rights (for example, limited consumers' common law rights) and many 'individualised social' responsibilities (having to make up for the lack of collective responsibility). Consumption keeps the economy ticking over and exactly this is what drug consumption does, whether in the legal or illegal economy. Consumption or consumption patterns are problematised in an individualising fashion (usually not critiquing market regulation or corporate conduct). At times, when becoming widespread, commonly noticeable and 'costing' the community (such as unhealthy eating causing obesity or 'drug epidemics'), governments take action; but the overall imperative to consume is not questioned; companies (by profits) and states (by taxes) survive on consumption.

[109] For a stimulating discussion of the concept of interiority in relation to gambling as well as the thesis of the 'commodification of interiority', see Livingstone (2005).

[110] Although both 'dream time' and 'dreaming' are in use as translations for various original Aboriginal terms, Dream Time has become obsolete 'because it neglects *Tjukurrpa*'s spatial dimension as well as its capacity to combine both times and spaces.' (Poirier 2005 p. 53) It is also necessary to make further distinctions in that there are subtle and complex meanings involved with dream experiences, ancestral orders and other cosmic orders and

The Western[111] capacity to imagine and legitimise such states and particularly the ability to live or reach them has been fairly limited, however; the Western imaginary has mostly captured 'inner' states in psychoanalytical (psychodynamics), psychological, psychiatric, physiological and, lately, neuro-scientific discourses (with exceptions, also in psychedelic discourse, humour and art forms), whilst the Western *economic* imaginary has tried to tap into them through the paradigm of consumption (see Livingstone 2005). The legacies of the Enlightenment, modernity, Euro-centrism, colonialism, industrialisation, urbanisation, secularisation and even the Greco-roman philosophical traditions and the economic fixation on 'development' have, in effect, '*othered*' such states or marginalised them through discourses, such as heathenism, witchcraft, heretics, 'irrationality' and 'name-calling' the 'others' as uncivilised, 'underdeveloped', 'traditional' or 'primitive'. The Western cultural repertoire is challenged when people seek to connect 'inner' spaces and 'outer'[112] spaces.

There are practices of 'interiority' which may not appeal to essential, authentic or humanist selves, practices which are communal, 'non-rational', mosaic, kaleidoscopic, contemplative, visual and creative. The *benefits* of intoxication (other than massive profit reaping) and drug use are often downplayed, if not denied by, in or for modern selves. Keane explains this using the example of smoking and public health literature on premature death:

> The enhancements of existence that can come with smoking are dismissed as illusory and excluded from the calculations of risk. How could they be included? The benefits of such things as solitary peace, self-sufficiency, style, concentration, camaraderie, and rebellion cannot be quantified. Moreover, in the discourse of "health risk" there are no willing gamblers, lucky or unlucky, there are only pitiable or foolish victims. It is assumed that making choices about risk can and should be done "objectively," but this ignores the diversity of values and commitments people draw on, and refer to, when assessing risks in daily life. (Keane 2002, p. 129)

In short, the lack of understanding or even recognition of the diverse spaces, places and times of '*interiority*' and the denial of the social purposefulness of intoxication by social or drug

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symbolic systems (Poirier 2005 p. 54), which are an all-encompassing reality or quite different realities (if not realms with distinct continuities between past and present).

[111] I acknolwedge that this terminology is more convenient than precise. Lewis and Wigen (1997) have problematised the current usage of East and West, North and South as inconsistent, imprecise, a-historical, geographically questionable and as ideologically and culturally produced but with considerable political utility. Lewis and Wigen speak of the development of the 'continental scheme' (1997, p. 21), the division of First, Second and Third World as 'fungible' categories (1997, p. 4) and the difficulty and multifarious ways in which the boundaries of the West are and have been (re)drawn (1997, p. 50).

[112] Inner and outer are in parenthesis because we should not think of them as reified or dichotomous. How can we understand an 'interiority' that is '*a discontinuous surface, a kind of infolding of exteriority*' (Rose 1998, p. 37)? From Rose's perspective, to perceive of culture as external and of psychology (or neurology, etc) as internal makes no sense.

policy effectively leads to *rationality enforcement* and can explain why intoxication is equally marginalised by most workers. The dominance of *rational sobriety* as a cultural ideal of the West, however, clashes with the reliance on (and active production of) consumptive intoxication by businesses and governments[113] (and the associated harms of being intoxicated in an industrialised society).

The dominance of modern, utilitarian and economic rationalities means that policies do not seek to create spaces that celebrate and facilitate creativity, spirituality, innovation, '*non-sense*'[114] and different states of consciousness or spaces in which 'interior states' can be experienced in enabling and not harmful ways. The very notion of 'nonsense' is a product of modern rationality and - as we know - the addiction concept arose within modernity (Bull 1996, Acker 2002). Ironically, drug policies associated with the international war on drugs have demonstrated the West's ability to create *non-sense* everywhere. If people use drugs to escape '*reality*'[115], policy makers do not stop and think about their trade as creating safe spaces to escape to [116] whilst Foucault speculates that experiences and different states of consciousness may be the future of socialisation:

> …it is possible that the rough outline of a future society is supplied by the recent experiences with drugs, sex and communes, other forms of consciousness, and other forms of individuality. If scientific socialism emerged from the *Utopias* of the nineteenth century, it is possible that a real socialization will emerge in the twentieth century, from *experiences*." (Foucault 1971, cited in Jay 2005, p. 394)

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[113] Terry Eagleton identified another cultural clash between diachronic and synchronic pursuit of pleasure: '*We live in a society which on the one hand pressurizes us into the pursuit of instant gratification, and on the other hand imposes on whole sectors of the population an endless deferment of fulfilment. […] The sadistic satisfactions of power are matched by the masochistic conformity of many of the powerless*.' (1992, p. 193)

[114] What I am trying to express is best captured by Nietzsche who asserted this about the 'joy in nonsense': *'[..] one can almost say that wherever there is happiness there is joy in nonsense. It gives us pleasure to turn experience into its opposite, to turn purposefulness into purposelessness, necessity into arbitrariness, in such a way that the process does no harm and is performed simply out of high spirits. For it frees us momentarily from the forces of necessity, purposefulness, and experience, in which we usually see our merciless masters*.' (2004, [1878] p. 127)

[115] This argument does not preclude calls to create a more just and equal society, rather the opposite. If we had a just and equal society, wishes to escape reality (or numb the pain, trauma and social suffering) may be greatly reduced, rendering themselves unnecessary.

[116] In drug and alcohol studies, academia does not explore Utopia or culturally-based alternatives, not even theoretically (given that pragmatic stances dominate). Helen Keane who usefully warns us that cultural accounts of drug use can themselves run the danger of reductionism if they assume that the materiality of the body and the nature of drugs are straightforward and fixed substratum to the complex and varied forces of cultural and personal interpretation (2002, p. 23), nonetheless describes drug recovery as utopian (2002, p. 11). Whilst I can see that recovery can become a cultural dogma, it is something that many people want, strive for and do achieve (with or without help, spontaneously or in prolonged efforts). Equating the notions of universal health or truth with a utopian vision of recovery would seem to dismiss people's desire to give up drugs (even if we understand that this desire is partly produced by cultural influences).

All of this, perhaps, goes some way to explaining *why rationality and intoxication have a rather taken-for-granted status in the workers' discourses*.

### 1.2.2. The discursive exclusion of pleasure

Very few workers talked about the *pleasure* and *fun* of drug use and if they did, they defined fun in three ways: *first*, as a general reason for use or as an expression of the '*forbidden fruit syndrome*' whereby the 'acceptable' is no longer 'fun' to engage in for young people; *second*, when *problematic* drug use has emerged and *fun* drops from the discourse, as the problematic user does not use '*for fun*'; and *third*, after young people have given up and think it '*fun*' to die by using drugs. Workers were – obviously - not talking about the '*average* drug user', but about clients of social services and disadvantaged and marginalised people. This is possibly why most workers, like Noah, working in fostercare, explicitly excluded pleasure or positive reasons for client's drug use; it was all about *coping*:

> [Noah] *Well the substance that alters your mood for whatever reasons, why they use it in most cases, they use it to get over their frustration, use in time when they couldn't cope, just to use to get relief, temporary relief, and then they develop the addiction and that's when things get out of control, the substance controls them in most cases. Some, very few, just experiment and to join their colleagues and friends and partners, but most of my clients really use it just as a relief for their loss, personally for their anger and it varies from client to client but it's never related to something positive. Not like during university courses or at parties, things like that*.

The capitalist market, the labour-capital relationship and the specific design and funding of welfare institutions (and its organisations) do not just affect health, housing, employment, class and education status, they also penetrate, stratify and regulate the very way people can use drugs; indeed, dynamics at the political-economic level *distribute drug enjoyment chances*, if not deterministically, certainly tendentially. Arguably, the fact that most workers excluded *fun* from their interpretations of the reasons for drug use by their clients may well be understood as saying that disadvantaged people do not use drugs for fun, which equivocates with a possible 'assessment' that their clients are '*experiencing unequal drug enjoyment opportunities*' whereby *coping* by far outweighs *fun*.

That 'pleasure' was missing in most workers' interviews may result from the clients' discursive construction of their drug use in their interaction with workers and where 'pleasure' would be avoided quite understandably: discourses of '*the needy*' cannot accommodate '*fun*' or they are thought of as incompatible discourses; in addition, someone cannot simply be poor, s/he

must also have other 'problems' and 'needs',[117] in short, clients are '*othered*'. By contrast, the dynamics at the political-economic level prevent non-poor people's 'problems' to enter the welfare discourses, as they have the *means* to escape, in fact, never become subject to the welfare discourse. Misery, social suffering and the exclusion of pleasure remain preserved to the construction of the *drug-using welfare client* and are not discursively recognised as a *common occurrence*.

### 1.2.3. The imposition of 'Choice' on the drug using client

'*Choice*' also was a central theme within the interviews: the person who uses drugs has the *right to choose* to use drugs and the right *to choose* to use the service system or parts thereof. On the other hand, addiction or problematic drug use is often defined as taking away of choice. Vera, a domestic violence worker, described the *absence of choice* as a drastic, ever-looming possibility:

> [Vera] *I've never thought I was better than the people I worked with because your life can take such a drastic turn through no fault or no choice and you can end up an addict or you can have a really serious car accident and be on morphine for a year and then all of a sudden you're addicted so then you're in pain and you're going to be in pain for the rest of your life. So you do turn to illegal drugs because you can't get prescription drugs any more because of the addiction stuff…*

Most workers tried to instil the making of '*right choices*' in their clients, but if individuals make 'bad' choices that had to be respected too:

> [Gerda] *I can only really assist them to make the right choices in regard to their baby's wellbeing, whether it's in-utero or whether it's born. A lot of them really want to give up the methadone while they're pregnant but they won't allow them to because of the risk to the baby so I'm non-judgmental, it's not my body, it's their body and it's their choice. [..] Quite a lot of the women I feel very sad for them, I feel quite frustrated for them because of the catch-22 they've got themselves into; but again, I go back to it's totally their choice. But I think I feel sad for them more than anything, especially when their babies are born and they see the baby's withdrawing. I feel very, very sad for them because while the baby's in the womb they can't see it, but once they can see it and see the withdrawal the baby's going through and the pain they're very, very sad. They're very guilty and there's nothing that anybody can do to take away that guilt or pain for them, so it's a real double sadness that the baby is suffering and the mum is suffering too*.

> [Xena] *I do find it conflicting but because I've worked here for a long time too I've got an understanding of it and I don't just mean I have to just accept how it is, it's just for me*

[117] The dichotomous construction out of this discourse would be that non-poor people always use for fun, whereas poor people never use for fun. Both claims are unsustainable.

> *that's how it is now, so I try to work with them as best I can in this environment. And if people aren't willing to be helped and their life is so chaotic, unfortunately the consequences for them are that if they have children they could be taken from them, that they could lose their home, that they could lose their spot here and there's sort of nothing else that can really be done if they're not willing to change their life for the better. There's not much more we can do. They've got to want to, it's their choice too, they've got to want to somewhere along this line change that path, really want to change it not just say it, it's the difference between really wanting to do it*.

Gerda and Xena work with families, particularly women, Gerda as a family support worker and Xena as a domestic violence worker. With their knowledge of the (possible) repercussions of clients' actions, they illustrate the dilemma they face: witnessing clients' trauma and distress whilst working in a time of welfare provision which reflects the liberal art of government through *choices* and which they both have come to accept as something that might have regrettable consequences but seems out of their sphere of influence to do much about, so they ultimately respect people's choices.

That workers overwhelmingly accepted their clients' 'choice' to use drugs means, on the one hand, that the liberal discourse is strong (the individual has the right to – problematically – use drugs as s/he wills) and, on the other hand, that harmful drug use is accepted (even if not acceptable to the workers) and legitimised, something '*society*' has to put up with and cannot do much about because '*individuals make 'choices"*.

The *over-responsibilisation* of the client at the political-economic level and the inherent governing liberal and neo-liberal rationalities portray their choices at the individual level as something only they can explain or change, not as something that is produced by the lack of collective will and policies to change clients' situations. Taking the political-economy into consideration, MacCoun and Caulkins find seven factors by which *drug use choices* are influenced by drug laws: there is a 'symbolic threshold' (illegality alone deters use), the 'forbidden fruit' (drug use is promoted by the fact that it is illegal), the 'fear of legal risks', 'stigmatization', 'availability', 'price' and 'informal social control factors' (beliefs about health risks, attitude towards drugs and drug users) (1996, p. 179-180).

Prohibition, the loneliness of carers/parents, the lack of family support and sharing of domestic labour, the over-responsibilisation of the nuclear family to deal with anything that comes its way, the coping strategies of mothers, the gendered forms of drug use, the policing of families by the state, lack of adequate universal incomes – all of this is *discursively excluded*

when workers talk about the '*personal*' choices of their clients: if people cannot look after themselves (and enact their own self-interest), we cannot - *should not* - make them do so.

Not only does this signify a particular interpretation of client's *self-interest*, but workers usually have a *diachronic* approach to clients' self-interest, whilst clients' thinking is portrayed as only capable of dealing with or concentrating on *synchronic* self-interest, the here and now, not anticipating the *tomorrow* into which the '*social repercussion knowledge*' of workers is tuned. The fact that both workers think of their clients as unaware or unable to recognise their self-interest – again – constructs the drug-using client as 'other'.

'Accepting' drug use that is in some way, shape or form *harmful* is, therefore, always a double-edged sword because the respect of someone's 'choice' to use drugs runs alongside the disrespect for failing the social responsibilities accompanying these choices. As well, what workers deemed to be the consequences of clients' 'bad'/ 'ill-informed' choices and which they identified worryingly with their '*social repercussions knowledge*' was not reflected on and is heavily slanted to enforcing and reproducing the status-quo (right choices are good for, bad choices undermine the status-quo). I will return to the theme of *choices* in Chapter Six, where liberalism and neo-liberalism are examined at the political-economic level and where clients' subjectivities are yet differently played out.

### 1.2.4. 'Normality' enforcement: the (non)functioning drug user

Workers often talked about the 'function' of drug use and the 'effect' it had on their clients; whilst most had a fairly broad understanding of what substances may be regarded as 'drugs', a minority explicitly mentioned *pharmaceutical* drugs as 'drugs'. Often describing the distinction between problematic and non-problematic drug use, they struggled to explain where exactly the line could be drawn, trying to find it in a more or less fuzzy version of what it means for an individual to '*function*'. This counsellor shows what functioning meant to her:

> [Kirsty] *Misuse would be where that is impairing their capacity to function, impairing their capacity to relate, impairing their capacity to work, where in fact the misuses come when they're actually reliant and dependent and so that they make sure they've got access to it whatever the cost to themselves, to their relationships, to their work, study, whatever. So it actually impinges on their world to the extent... that would be misuse for me*.

For workers, a central tension consisted in achieving a degree of normality and '*joining the client's will*' in the conflict *between the client's own, the worker's and societal expectations* of what ought to be achieved or achievable. This issue would usually come up when discussing

how drug users were treated by other members of the community. Anne, a legal worker, gave a typical account:

> [Anne] *I think that once someone has admitted to a drug addition then I think they lose credibility with different people. They certainly can be treated differently. They're treated as a druggie. [..] I think perhaps not given as much respect, not necessarily not believed, but things would be second guessed more I think than if they didn't have a drug usage, if they weren't using drugs. [..] I think the justice system does that as well. It's not just the police force I don't think. Probably lawyers do it as well. I think probably society does it.*

Anne's description of the discrimination of the 'druggie' was common amongst workers; her and Kirsty's quotes illustrate the tension between their expectation for their clients to 'function' through '*social participation*' (working, studying, parenting, etc) and the everyday community discrimination they witnessed and which appalled them, a tension, in other words, between normality which we enjoy, aspire or, at least, relate to and normality as suppressive, biased and oppressive. Paradoxically, social and drug policies reinforce *both* discursive and material constructions of normality[118] which, in practice, often contradict *and* combine with each other.

Many workers maintained keeping their value judgements 'separate', being guided by what their clients' goals were; they claimed that clients would often self-problematise their drug using behaviour, as characterised by this family support worker:

> [Ira] *In terms of change I find that it's like they have to always come back and re-visit it [the drug use] even though you know I'm providing counselling to them and we can talk around some of the issues that impact and what it means in terms of the drinking or marijuana use and their availability as parents and their ability to function as parents. It's almost like they sort of gain skills in some areas but they may realise, oh no, we actually need to go back to the drug and alcohol stuff because that's still a big issue and I've just actually come from their home now where the father is saying my drinking still is a problem and I've noticed I've started to do it again more often and I actually need to go to a specific drug alcohol counselling service to address that. So you kind of have change in other areas but it's almost like they have to go back to that as they sort of see that as the source of preventing them from going that bit further in their change*.

From their reports, it cannot be established how much *prompting* occurs in counselling situations or other encounters and how much implied messages clients pick up and construct their 'story' around workers' expectations or hold conforming and self-problematising beliefs themselves. Doubtless, when help is provided, individual clients do find this very meaningful

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[118] Rose, concerned with the government of the family through various expert systems, defines normality in three '*guises: as that which is natural and hence healthy; as that against which the actual is judged and found unhealthy; and as that which is produced by rationalized social programs*.' (1999b, p. 133)

and, indeed, helpful[119]. Whilst for some workers '*not functioning*' explicitly meant impairment, others described their clients' drug use and 'functionality' more as their own incapacity to work with or help their client, as explained by this youth residential worker:

> [Beatrice] *But you know we have no rights to do anything but keep that kid safe, negotiate, speak to the kid, you know which doesn't always work. If that kid wants that needle in his arm, he's gonna put that needle in his arm and a lot of the time there's not a thing you're gonna do about it until maybe later or tomorrow when you can talk to them and they can function properly and understand*.

Workers variedly identified drug use as *problematic* and - hence - when it was worthwhile and justifiable to intervene; some would help clients to '*intoxicate safely*', some would make no excuses to take away drugs and/or paraphernalia, others respected clients' rights to use drugs or turned a 'blind eye' on their use, whilst others would challenge a client on his/her drug use straight away and seek maximum sanctions.

Damon, a fostercare worker, outlined the '*addiction potential*' in all of us:

> [Damon] *…and it's like anything, you can criticise somebody but unless you know them and know why they have done something then who knows if we all went through the stresses they went through we all might also resort to drugs or some form of escapism I guess which to me it is... just trying to escape the real world*.

Damon is not talking about tobacco or alcohol users here; in his account, 'coping' and 'escaping the world' co-exist and seem non-contradictory. Certain stresses 'make' someone '*resort*' to using drugs, which is a '*form of escapism*'. The discursive construction of drug use as an *escape*, in fact, denies that drug dependent people without the means to purchase their drugs (need to) have a very active relationship with '*reality*': they are busy and have to get organised *all the time*, a very busy escapism, indeed! Damon's use of 'escapism' certainly does not have any positive connotation. Presuming that a drug user is '*escaping reality*' through his/her use is as problematic as to contend that the 'real' reality of *abstinence* (or even *moderation*) is the only 'real' way to be. Constructing drug use as an '*escape*' not only attaches the 'odour' of illegitimacy to the practice; an additional discursive effect is that the question as to *why* someone

[119] Whilst I problematise that human service work has the effect of making clients (and workers) 'conform to society', I do not discount that clients would like to give up drugs, deserve to be helped by being given therapy, residential services for rehabilitation and recovery, etc (and I would defend their right to have such services provided). This discourse analysis is not meant to serve as a problematisation of clients and workers, rather it is to explain how discourses have constructed our identity, the way we relate to ourselves and others and what we find meaningful.

has (a) reason(s) to want to escape from a state of mind and/or social situation is not being asked, precluding us to bring them into the discourse and making their change possible.

One worker in the legal field portrayed addiction '*as a life stopper*':

> [Oliver] *It's a life stopper, you don't see them doing much with their lives. When you ask a client to bring in their life story, you realise for the last 10 or 15 years really nothing's happened, that's obviously their 15 years of drug use*.

One can interpret this as the discursive construction of '*living in limbo*' (some workers talked about drug users' *nomadic lifestyle*), but it includes the subtext of not leading a '*productive*' life. The idea that addiction stops life presumes that the addicted person is static, does not learn or change somehow.[120] Most people who '*push*' themselves towards some achievement feel better about themselves and their '*place in society*,' but what is seen as 'achievement' always has a *social* bias and, in Oliver's description, the drug user has not marked time with any achievement. Whilst we celebrate recovery and conforming practices, we should not presume that the 'community' and 'society' to which drug treatment and social services aim to make (drug taking) people conform are unproblematic spaces (Sybylla, 2001).[121] Arguably, to presume that the 'drug user' *wants to* (consciously or subconsciously) conform to societal norms is as problematic as presuming that the 'drug user' *does not want* to conform.

Many authors have argued that drug taking is a practice of 'the self' (Duff 2004); Valverde, problematising our *truth-relation* to drug use, identified a paradox in the drug discourse: we may discover and hide our self with drug use:

> The paradox that emerges from looking at different accounts of the relation between drug use and 'truth telling' is that consuming such substances as alcohol or Ecstasy is *both* a means to get at the real personal truth *and* a way of hiding from oneself, continuing the deception – as they often say, "living a lie." (Valverde 2002, p. 11)

Theda, a counsellor, talked about the '*old jumper beliefs*' she addresses with drug using clients:

> [Theda] *I do a lot of work on beliefs, old beliefs, patterns of beliefs that people have and how we stay in them. Like, you know, when you're 12 you have a school jumper, you would never wear it at 25 because you've outgrown it, yet those beliefs that we had at 12 that we still live out at 25, so this whole concept… you know, they love that, they can*

[120] It also seems to imply that there is only one way of gaining life experience.

[121] The problem is that, for many of us, jobs are stressful, 'performance based' and concentrate on outputs and incomes. These aspects of working have become increasingly alienating and it is this world into which we often then push 'reformed' and 'recovered' drug users.

*identify with old school jumper at 12, of course I wouldn't wear that at 25, so the parallel there being the same… why have the same belief, why work of the same belief structure?*

Whilst - arguably - a socially meaningful metaphor, carrying 'old jumper' beliefs inadvertently describes the drug user as a static and immature person, who does not go with the times. Having '*old beliefs about the self*', however, can hardly be identified as a *unique* quality of a 'client' and, indeed, of a 'drug user,' *unless* a person would come under the *case gaze*,[122] where her/his beliefs are taken apart in therapeutic discourse, when s/he confesses[123].

The ideas that maturity is linear – related to phases and stages that one reaches more or less 'orderly' during the 'life course' – and that congruence with one's self needs to be achieved are widespread. The *institutional level* comes into play here, Martin Kusch (2006) making the point that beliefs are social institutions,[124] or even social structures: what we believe becomes real for us, but it also has an inherent collective dimension:

> […] 'belief' and 'believer' – that is, someone or something capable of entertaining, and being able to attribute, beliefs – are social statuses. And this means of course that they are social institutions: someone is a believer if they are collectively taken to be a believer; and something is a belief if it is collectively taken to be a belief. (Kusch 2006, p. 337)

The collective achievement of beliefs operates as an institution, so that what we believe about ourselves can be just as limiting as what other people believe about us. Thinking about our beliefs, recognising them, resisting or defending them requires *time*, thinking and acting time. Time is not only a social structure that is structured and structuring; it is a scarce resource for many people, privately and professionally. Thinking time has become one of the most precious items in the (post)modern haste to '*get things done*' and Kirsty, a counsellor, agrees:

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[122] It is only in and through clienthood that the 'belief system' of a person is 'worked on'. A banker, a rich retired person, a PhD student or the four wheel-drive mum could not be described thus, because they are 'functioning', are not constituted as 'problem groups' and are, therefore, not entering into the therapeutic 'old belief discourse'.

[123] It is worthwhile reflecting on religious and therapeutic 'confessional' practices: '*It has become central in the governance of modern society, where externally imposed discipline has given way to the self-discipline of an autonomous subjectivity. […] Here, the purpose of confession shifts from one of salvation to that of self-regulation, self-improvement and self-development. In other words, confession actively mobilises a productive and autonomous subject but one who is already governed and, in this way, there is no requirement for externally imposed discipline and regulation.*' (Usher & Edwards 2005, p. 400)

124 Kusch goes on to explain how the sciences, i.e. the scientists, are divided by what they believe in and that neuro-scientists would not believe in psychologists' explanations of the phenomena they study and vice versa, indeed the logic of science means they live in parallel worlds with parallel research explanations (2006, p. 338). What we end up with is a sort of social structure that tries to classify social entities: '*For some authors a belief is a type of physical state of the brain; for others it is a functional state of the brain or mind; still others conceive of beliefs as psychological or abstract, or more or less fictitious entities. […] No wonder philosophers cannot agree on whether beliefs are primarily material, psychological, or abstract entities. Beliefs are none of the above. They are irreducible social entities*.' (Kusch 2006, p. 339)

> [Kirsty] *I want to put my time in, I haven't had enough time to read, I'm still going and taking extra courses because I enjoy it and it's stretching me, but I want time to think about my clients, I don't have enough thinking time, I don't have enough planning time*.

Summarising, remembering that '[c]lients do not exist outside the historical activity of social work; they are the result of that activity' (Chambon 1999, p. 52/53), *drug using clients* are constituted in the professional relationship through many co-existing discourses: they are predominantly viewed as illicit and problematic drug users, described as not fitting into the service system but also as marginalised members of the community. I have offered four interactional discourses constructing the drug-user-as-client and will now turn my attention to the other party in the interaction, the worker. They, just like clients, are subjects and objects constituted by discourses and I will explore their constitution in the following section.

## 2. The professional-relational creation of the human service worker

How *workerhood* is constituted by the workers themselves – and 'individually' - and how the notion of *expertise* is played out in the service encounter are central to this section; other forms of the constitution of workerhood will be dealt with in Chapter Five.

### 2.1. Constituting the human service worker

The person who uses drugs is subjectified as a *drug user* and a *client* in social service encounters; even more forms of subjectification act on the worker: s/he is a '*professional*' (subject to particular workplace cultures), an '*employee*', member of a workforce (with minimum qualification standards) and sometimes a person with *statutory duties*. Both, clients and workers, are subjectified as general members of a community, citizenry and an economy, as well as in other forms that have marked their life trajectories.

Foucault described how people were *moralised* and constituted as *labourers* with the aim of the establishment of '*a working body that is concentrated, diligent, adjusted to the time of production, supplying exactly the force required*.' (2000a, p. 34) Workers (still) work as they rely on wages to survive; they are not in charge of what happens in the organisations they work in and of what determines their working conditions (Rose 1999b, p. 55).

In Chapter One, I outlined how human service work in Australia started with '*friendly visiting*' and the Charity Organisation Societies developing regulatory and administrative discourses about how help should be 'delivered' and who deserves it. Today, professionalisation

has been well-established in many areas of human service work and workers are increasingly and explicitly encouraged to regard their '*self*' as something to foster (against burnout, stress, etc), learn how to take care of and to use it as a resource (see Chenoweth & McAuliffe 2005)[125].

Whilst work continues to be exploitative and alienating, the worker's *subjectivity* has been '*discovered*' as a (re)source of motivation for increased productivity and '*personal fulfilment*':

> The worker is portrayed neither as an economic actor, rationally pursuing financial advantage, nor as a social creature seeking satisfaction of needs for solidarity and security. The worker is an individual in search of meaning, responsibility, a sense of personal achievement, a maximized 'quality of life', and hence of work. Thus, the individual is not to be emancipated *from* work, perceived as merely a task or a means to an end, but to be fulfilled *in* work, now construed as an activity through which we produce, discover, and experience our selves. […] Work itself could, it appeared, be reformed and managed so that it could become an element in a personal project of self-fulfilment and self-actualization. (Rose 1999b, p. 103-104)

Chenoweth and McAuliffe regard the *self* as the principal resource, instrument and mechanism in human service work, arguing that human service workers '*use themselves as the main instrument of practice*' (2005, p. 203); but how did the human service workers I interviewed describe themselves as '*human service workers*'?

Adam, working in a multidisciplinary youth service, for example, thought it was problematic to associate oneself with this term, because it had a strong association with *non-government and non-for-profit*. Angela, a youth residential worker, was repulsed by the idea of being thought of as human service worker, as for her, it meant being associated with the *(service) 'system'*, whilst another youth residential worker, Beatrice, strongly identified with, as being born into a family of human service workers made her naturally good at and passionate about her work. Benno, also working in youth residential care, connected human service work with a societal status and the recognition it brought:

> [Benno] *Undervalued, underpaid, stressed, no social life! It's a job… we have an impact on people's lives, we're certainly not in it as a 'do-gooder' or want to change people's lives or things like that… it's just to assist them through a process so I think that's probably it in a nutshell… It's a job I like doing. As I say, it's certainly not for the*

[125] Chenoweth and McAuliffe are typical for this strain of work in which workers are obliged to relate and exploit their selves in their work: '*How you portray yourself as a social or human service worker depends on your personality, values, knowledge and skills. Having insight into your 'use of self' is an important starting point. Think back to some of the questions raised [..] about your motivations for pursuing this type of work, your personal background and early experiences, your cultural affiliations and your attitudes towards people who seek help*.' (2005, p. 155) *'[S]ocial and human service practitioners use themselves as the main instrument of practice. They engage in practice through the relationships they form with their clients, peers and others in their organisation. [..] Use of self is linked to self-awareness – if 'self' is our mechanism of practice, then it follows that we must have a high level of awareness about who we are and how we behave*. (2005, p. 203)

*remuneration side of it because that side really needs to be improved… so it's just a job like anyone else I suppose, it's just different*.

Clara, equally working in youth residential settings, described human service work more in relation to its *content* and her experiences of shifting from '*idealistic*' to '*realistic*,' whilst witnessing the stress of the work; being '*realistic*' meant to constrain one's expectations, a self-protective mechanism to avoid disappointing oneself (and others).

> [Clara] *I mentioned earlier my frustration and I guess I grapple with that a lot because, especially when I see workers who have been injured, more stressed out, really stressed workers and things like that... I think that's one of the hardest things to cope with because these young people can be,* ***can*** *be... and I stress that... really unlikeable at times when they're in their full flight and they're swearing the most foul language at you and it's really hard to stand there and say 'look beyond this'...[..] I don't think any more that I can make a big difference... I think one time early on I used to be fairly idealistic... but I don't believe that any more. I think you do what you can, you assist where you can*.

In addition, as there is not just one 'model' of drug user, the same applied to workers; self-examination is not only expected of the drug user but of the worker as well: being a worker generates the impetus of *self-reflection* and *reflexivity*, as Dana, a fostercare worker, expressed:

> [Dana] *Being a human service worker it means a lot of things really... and I think liking the job I think is really important and not feeling angry... I really do think that you've got to sort out where you are because that really does influence how you see people and what you might project on people as well through your own coloured glasses if you like, that's really important... so I think a lot of self-reflection... Not a lot, but certainly the ability to be able to self-reflect is really important in human services and to be able to speak about it and not feel... "oh God I've failed" or "I should have done that differently" or to be beating yourself... I always believe very much that you can always do better the next time but you shouldn't have to beat yourself about it, it's an opportunity to say this is how I've done it this time but this is how I do it next time*.

The worker is *naturally* interested in learning from his/her mistakes and observes his/her relation to his clients consciously, adjusting practices where appropriate. Most workers really liked, often loved and derived a lot of satisfaction from their work, generally considering themselves as some kind of '*circuit breaker*' or '*facilitator*'. They described *themselves*, the practices of their *selves* and the *technologies* they employed to be able to do their work as *facilitators (of change), as respectful, empathetic, observant, helpful, trying to make a difference (even if it simply meant that you keep a client alive, not more and not less), being understanding, learning from clients about their experiences, being resilient, 'hanging in there' (many attempts*

*to establish and maintain relationships and trust), keeping professional boundaries, taking nothing personally, being 'non-judgmental'*.

Many felt unsupported, misunderstood or even frustrated and angry with the community, but at the same time, concerned with the public perception and public relations of their work and the maintenance of law and order. Few cited broader *philosophical* leanings (like being a civil libertarian or having socialist commitments) as motivators for their work and others described *ethical conduct* as motivating them. Perhaps the most *explicitly ethical* reasoning for her work came from Kirsty, a counsellor:

> [Kirsty] *I'm interested in human beings and what makes a human being tick. I'm interested in that because I'm interested in helping human consciousness raise itself. So I happen to be doing this work for my own fulfilment. I happen to be working with some pretty difficult clients, but if every single human being that I work with can raise their own consciousness and my consciousness a fraction, then that's what it is about for me. [..] So I'm looking at it from a very, very big picture. I mean I've chosen in my life to live in the communities and work on a huge spiritual level with very, very highly educated, highly motivated people on a planetary level and I've chosen to work through the arts and I've also done work as a building project manager, I've done big buildings and things, and now I'm choosing to work at the very personal level with a different group of human beings because it seems to me that it doesn't matter where you approach it from, it's the same challenge that we all have: How do you actually mature, how do you actually learn about how to be loving and caring and responsible towards yourself and everybody else and everything else? So that's actually what it's about for me*.

She describes her path as a deliberate move to work with particular '*types of people*,' her work to her own and the client's bettering, reaching insights in the art of living, caring and being, as mutual consciousness-raising, perceiving the human service work to be more *personal* than other work she has done.

One of the governing discourses posits the human service worker as a '*professional*' and most interviewees saw themselves – sometimes rather uncritically – as such, considering it a value in and of itself and very careful to observe professional boundaries and conduct themselves '*professionally*'. One family support worker, however, mentioned that she had helped a client by letting her stay in her home as there was no accommodation and rehabilitation bed for the client after detox (it was a '*success story*' where the client '*broke the habit*' and had become a motivational speaker). Many explanations can be imagined for this act of helping and what it says about the two people involved; my own reaction was: 'big *no-no*, very problematic choice of this worker and doubtlessly a very unprofessional act', a taboo for most workers, insisting that they

are not the clients' '*paid friends*'. Only Cora, working with homeless people, conceded that the boundaries are not as clear-cut:

> [Cora] *I think those things are on a sliding scale and I'm probably more on the flexible side with what I would describe as professional or unprofessional. Now I would hear warning bells with that, but I wouldn't necessarily write the worker off either, because I think it's overly simplistic and arrogant to say... there's the professional boundary and there it is and that's right and that's wrong... how I choose to do it, which is the safer option, would not be to take a client home. I would not take that risk but does it necessarily mean that all those sorts of risks are wrong? No, I don't think it does but I think that organisations have to err on the side of caution with that one, particularly because a client is coming into a professional agency, that's the context in which they're walking in… I think it's different when sometimes things like that happen, say naturally out of church community or out of neighbourhood, I think it's different, but I think what can often happen... the risk is that it backfires on the client, let alone on the staff member*.

Cora explains just some of the dilemmas workers and clients can face when their relationship moves beyond the '*professional relationship*'; what is interesting, however, is that the discursive concern about the professional conduct of the worker having a client staying with her, outweighs other discursive possibilities. Absent from the worker's discourse is any feeling about the fact that the service system could not provide her client with the opportunity to consolidate her '*breaking the habit*' and that resources and service coordination were lacking; as well, the *personal* connection between client and worker seemed to be absent.

Professional discourses only tolerate the '*making of a difference*' and '*care*' within given parameters: respect and helping are to be adhered to *within the constraints and prescriptions of organisational procedures and policies and professional codes of conduct*. When policies and procedures are unable to capture the complexities of helping, the worker can be '*stigmatised*' as failing to conduct herself professionally: *care for your clients but do not care enough or more*. The professional discourse *marginalises* or *masquerades* the inadequacy of the service system and the worker felt that, in trying to find a meaningful way to help her client, she had no choice but to invite her to stay at her home. Whilst dangers can arise from unprofessional conduct, it is still noteworthy that *helping* in the professional interpretation *is* a form of '*caring*' that is governed in a paradoxical, if not contradictory way in the tension-laden '*in-between*' of institutional and personal-relational discourses.

A few workers described their work as a *privilege* and the task as one of producing some kind of *authenticity* and *reflexivity*; working in a multidisciplinary youth team, Isaac talked about the problem of *reflexive practice* describing what a few workers - implicitly and explicitly –

recognised, the existence of a *tension* between what the worker desires for the client and what the client desires:

> [Isaac] *Well it means that I think it's a fairly privileged position in that it means that I get to work with people, that I get to step inside people's stories and people's experiences and I have a huge responsibility to respect that, to respect their stories and their experiences and to try and match whatever I'm trying to put in place with them with those stories and experiences rather than from coming from my point of view. That's the main thing that I hold about this kind of work, that it is really about empathy with something that's thrown around, that's a bit of a catch phrase, fairly euphemistic, but to me empathy really means getting outside my hang ups, my beliefs, my values and trying to see it from their point of view, trying to step inside their world, their experiences and match anything that we put in place on that, not on what I'd like to see happen. [..] Yeah, you can't fully escape, you know I can't really step outside my body or my brain or my beliefs and this stuff I'm spouting, this crap I'm pouring out, is my belief in the first place! So you can't escape it but I think it's really important to be mindful of it*.

Workers identified human service work with a particular *type of work* (working with people who are often stressed and stressful but also working on the raising of consciousness), with the *social task* of making a '*realistic*' difference, with a *particular pay* and *structural conditions* of a workforce, with *professionalism* and with having to be *reflective* and *reflexive* and using the *self* as a resource.

Whilst Chapter Five discusses in more detail how *workerhood* is constituted, identifying the operation of professional *duty* (to know the *drug using subject*), I will next analyse the worker's constitution as an *expert* on the individual level, already indicating, however, that the notion of *expertise* is also *dependent on an other* (or the *othering of the self*). This dynamic evokes the *relational* dynamic of constituting *workerhood*, thereby *co-constituting clienthood*, which is why the *professional* is always *already about being in a relationship*.

### 2.2. The making of an expert

*Expertise* often accompanies professional discourses as a notion; the discourse has shifted significantly, however, to encompass many forms of expertise, not simply those based on professional knowledge regimes. Frank, working in a bail advocacy program and describing the client-worker relationship, shows how the idea of the '*professional role model*' co-exists with the idea of making clients the '*experts of their lives*':

> [Frank] *For me it's one based on trust and like it's mutual trust... never coming from an expert perspective myself, sometimes clients will put that on you and that's okay because we are there as a role model I suppose, so I think there is that role modelling but I very much talk to clients in terms of* ***them being the expert*** *and them knowing their stories and*

> *I'm here to hear what it is they're wanting. So I think it's trust and respect of where they are at and honesty is a really big one*. (my emphasis)

Fred illustrates that professional notions co-exist with *lay* notions of expertise; whilst the worker is obliged to exploit her/his '*self*' as a *resource*, so are clients encouraged to be decision-makers of their own life, expert *helms-persons* of their '*life course*'; they are encouraged to discover their selves as resources too and learn effective *self-government*. Quite a few of the interviewed workers regarded the idea that drug users should be treated as experts of their own lives as *self-evidently true*; a family support worker, Roslyn, preferred '*to join the client's will*':

> [Roslyn] *So long as if there are children they're safe, I prefer to join the client's will and say 'Where do you want to go?' I believe a lot of them have the answers. When I tease it out with them they really usually know what would be better but it's just they don't know how to do it. I guess that's how I explain it to them as well*.

Roslyn portrays herself as the '*facilitator*,' expertise neither clearly located *in* her nor *in* the client; rather, it is her facilitating role that makes the client realise chances for her/his betterment. *Joining the client's will* is, therefore, an exercise in carefully mediating the client-worker relationship. That it is possible to be governed by our own aspirations is an achievement of the '*socializing project of the last one hundred years*' (Rose 1999b, p. 133) and what he describes for the government of families is just as applicable to clienthood:

> The means of correct socialization could be implanted in families concerned with the self-promotion of their members without the threat of coercion and without direct interventions by political authorities into the household. Such families have come to govern their intimate relations and socialize their children according to social norms but through the activation of their own hopes and fears. Parental conduct, motherhood, and child rearing can thus be regulated through family autonomy, through wishes and aspirations, and through the activation of individual guilt, personal anxiety, and private disappointment. And the most inevitable misalignment between expectation and realization, fantasy and actuality, fuels the search for help and guidance in the difficult task of producing normality, and powers the constant familial demand for the assistance of expertise. (1999b, p. 132)

The more self-government by families and clients, the more benign and less coercive governmental techniques appear; *joining the client's will* is only possible where the client has understood what would '*better*' her situation and her mobilisation of her own will can then be supported by the worker; the worker thus believes s/he has simply joined, not activated or shaped the will of the client.

The '*self-evidence*' of regarding clients as experts has many reasons: the worker, quite literally, has to learn what the lives of drugs using people are like, particularly when the drug use is illegal; the worker can use the client's self-knowledge to pick up words, phrases and concepts that will ease the worker-client relationship, facilitate engagement and counselling efforts. The worker respects, with basic human empathy, that our lives take different paths and that experiences shape our understanding and interpretations of the world; everybody thus knows deep inside what is best, s/he is the expert. Equipped with the '*right tools*' and awareness, everybody can become competent at mobilising the self.

Workers also employ a range of strategies which try to *copy* clients' behaviours, seek their interests and adapt to their vocabulary; the worker's and the client's selves are *resources for dialogue as much as for governance*:

> [Yolanda] *I rely a lot on my personality to engage them and the building up of their trust. When kids come to me now, obviously they're not trusting of me because the court has ordered them basically to be involved with me so I would spend quite a lot of time just… I'm really good at playing PlayStations and talking about all kid things because I need to establish a friendship if you like before I can ever get to any issues and also to establish a friendship with the families, with the parents. So my approach is basically pretty laid back, what are the interests, let's talk about the footy, play PlayStation games, do any of that stuff until there's a bit of a bond*.

> [Querida] *I use drug language, if they say I use a bit of marijuana, I say how many sticks would you buy a week and I know how much they cost in the community so I can make a balance when I'm doing an assessment. So we're very upfront about those things and we often get very good relationships with our clients about that. I always ask them about are they injecting drug users, are they curious about whether they've gained any infections, have they shared needles and things like that. So we're very, very open about all types of drug use. […] I've often engaged young people by using language where I empathise with them, 'that must be awful having to spend $100 a fortnight on drugs', 'it must be awful seeing all that money go to your drug use', you know, 'it would be lovely, wouldn't it, one day when you don't need that'… and they can empathise and they can come back and say, 'yeah, it's a pain'. I often work with young people around tick because they get tick, you know they run a tab with their drug dealer and I say, 'do you use much tick', so that's again using their language*.

Yolanda, a juvenile justice group conferencing worker, uses her own personality to engage with the client, the all important basis for any work to be done, having a *relationship* with the client. Her words also show that workers actively employ strategies of their *selves* to create '*successful engagement*'. Workers are not simply '*open*' about someone's drug use; they *need to know* for all intents and purposes and being open, empathising, respectful and non-judgemental is a way of engaging with clients to elicit their 'truths' and get them to 'disclose' their concerns, as

Querida, working with the homeless, insisted. Understanding both workers as (professional) *experts* and drug users as '*experts of their own lives*' creates a rich tapestry on and with which to engage in the service encounter, a basis for effective *technologies of engagement*.

## 3. Engaging with each other

How did the workers imagine *effective engagement* with drug users? The most common answer to this question was about the need to *establish a relationship with a client* and the best way of doing this is by developing trust, being non-judgmental and respectful, having empathy and understanding *where clients are at*; furthermore, workers thought finding 'free', 'open', and flexible ways of communicating and servicing clients the best basis for working with clients.

When workers judged their drug using clients unlikely to return to a service, they focused on getting the information across promptly, being clear and straightforward with their explanations. The way of steering clients' expectations in the service encounter was to tell them from the outset what worker and service can and cannot do for them. Workers were also aware of their safety; when clients were perceived to be posing a threat or had a history of being aggressive, workers said they would position themselves near exits, watch their personal safety and may ask a co-worker aware to be on stand-by. One worker explicitly mentioned that leaving valuable items in sight in offices is 'teasing' a client and inappropriate, implying that if something was stolen, it would be as much the worker's as the client's 'fault'.

Once connection is established, workers described themselves as '*tuning*' into clients, adapting to and using their words and phrases, knowing their likes and dislikes, looking for and seizing '*windows of opportunity*' and usually finding the '*underlying issues*' of their drug use, at times challenging their drug use and belief systems. Few workers only mentioned that they reflectively judged whether to prioritise addressing clients' drug use or not and very few explicitly described choosing between both options, most asserting that their priorities changed with different clients. Interestingly, most workers regarded it helpful to be trained to understand drug users, but described and used *generic* skills as most important.

Apart from establishing a relationship with a client, one of the most important tasks of a human service worker was identified as being able to *motivate* a client, which could involve getting them to participate in a program, making sure they were not excluding themselves (or get excluded) from programs or using motivation as a key to 'treatment/service success'. Oliver, working in the legal field, emphasised how motivation makes a difference in a court case:

> [Oliver] *You say to them, look, somebody's going to be standing up in court for you and not being able to say a thing about you because you can't tell me anything about your life. It's not going to help you, you're going to look like an idiot, the barrister's not going to care about you, the magistrates sees say 100 people on a given day, we want to be different from every other loser the magistrate sees, you will look different. So that usually motivates the client*.

How can someone be motivated to change - into a certain, usually socially conform direction? The client learns how to conduct him/herself, to differentiate him/herself from others in order to get a better deal; whilst the middle-class habitus is '*naturally*' able to generate practices that are appropriate for a given situation, clients need '*assistance*' to advocate on their own behalf, on *story-ing* themselves '*out of trouble*' and, with the help of the human service worker, foster a competitive advantage over other cases or people.

The responsibility of the worker is to overcome the client's 'resistance' and to not take it personally when rejected, his/her challenge being to find nothing (or very little) too challenging, to develop tools and methods that can overcome resistance. If the worker(s) fail(s) to motivate the client, s/he is simply not '*ready to change*' and/or a '*hopeless case*', making the entire service system rather unaccountable – in particular with drug users – because it can, by definition, do nothing wrong (i.e. it cannot be accused of not '*helping*'), as drug users are '*by definition*' resistant to change. The *responsibility* to come up with better technologies of achieving change some time in the future is only a *generalised* one.

Almost all workers used the word '*challenging*' to describe working with drug using clients; for some, it meant recognising that clients might '*want to be bad*' (particularly referring to young people who '*seek identity*'), for others, it meant that it was emotionally draining or threatening or that clients' actions were objectionable. Others used '*more challenging*' when referring to those clients being more difficult to engage and, therefore, more 'interesting' and 'enriching', requiring more of the worker. Some workers, finally, were quite cynical about achieving '*success*' with drug using clients; just how differently the word 'challenging' was employed is demonstrated below:

> [Fred] *They're generally more resistant, not challenging, they're challenging and there's different types of challenging there... some of them have challenging behaviours which would be threatening stuff, the other ones are challenging in the sense that they're resisting so much it's a challenge for you to try and engage them. Yes, that's very symptomatic, classic of those ones that are just ongoing because they've just got that blinkers sort of approach and 'nothing's going to change anything for me, this is just the way it is'. [..] They're resigned to it. They've accepted it and even before you've offered*

*them something they're already putting up the reasons why it won't work before they've even heard what you've got to say. A lot of that, yes, a lot of that!* (my emphasis)

[George] *I think you need to be more challenging. Generally speaking you need to be more challenging, challenging their perceptions and their beliefs not necessarily disagreeing with them but questioning and working on other perceptions to see which one's the best fit. So I'd probably challenge them more than I would most clients. […] But you can even challenge indirectly about drug use, about why ongoing drug use is there and what the reasons are for the need for that to continue occurring, whether it's fear or insecurity or loneliness or anger or whatever it is. So to really bring those forward sooner rather than later whereas in general counselling I might wait until the person's ready, they might actually bring it up by themselves 10, 15 sessions later. Whereas somebody that's involved in D&A I might sort of force it to the surface a bit quicker, in terms of safety it might be more important*.

Fred, a bail advocacy worker, and George, a counsellor, portray challenging as integral to working with drug users; Fred finds the drug user in denial or being resigned to the position s/he is in, whilst George found them to be different to other clients by questioning their drug use and saying their safety and the underlying motivations for drug use warrant early questioning. Fred constructs the drug user as *resistant* and the drug 'treatment' literature is much concerned with the *resistant client*: it varies from giving tips, hints and strategies to work with 'difficult' or '*resistant clients*' (Barber 1995), all the way to understanding resistance in the '*treatment seeking*' and '*treatment career*' context (Hser, Anglin, Grella, Longshore & Prendergast 1997), but also as a way for clients to resist the service system, which can have protective and harmful effects (Mulia 2002). The fact that a person might be unwilling, disinterested or opposed to enter treatment is regarded as an *inherent characteristic* of the 'drug user' and simply presents a *challenge* to worker and service system to keep the client engaged.

Workers are made to, want to and need to *engage* with their clients, which is why they seek anything on offer that will help them with this process. Professionals are constituted to change individuals *rather* than '*the society that defines and creates them [drug users] as marginal*' (Sybylla 2001, p 74). Engagement narratives and '*mini theories*' have been subject to critique over many years (for example, West 2005, for the *stages of change* model), but remain essential for the everyday workings of human service work. The addiction field is awash with psychological discourses and engagement narratives: the stages of change model, motivational interviewing, goal setting, strength based and resource oriented approaches and they are all based on the '*philosophy that ultimately it is the client who holds the key to successful recovery*' (Brown 2004, p. 11). The answer is sought in a range of sophisticated technologies to elicit self-

interest in change, but whilst recovery always involves (and is meaningful to) the individual, *reducing the recovery process to the individual* excludes the *social determinants of drug use* and its class, race and policy-produced dynamics (Campbell 1999, Campbell 2000).

Service system and workers being stretched for time and resources, the latter will try to ascertain beforehand if a client is '*deserving*' (because there is always another client who might be more '*deserving*' and '*can be helped*') and will not '*waste their time*'. Whilst objecting to resource scarcity, workers have come to accept this as a reasonable and realistic way of working. Fred, working in bail advocacy, described his strategies to ascertain *desert* as follows:

> [Fred] *I have a very strong sense of commitment to clients and if I feel that somebody is making an effort… because my standard reply to a client is 'you show me something and I'll show you heaps', but I want to see something from you. I'll often set up little tasks... not hard things, but just things to show that all right you're not going to waste my time or that you are going to put in some effort. They'll be relevant to the person... they might be very simple, might be a little bit more demanding if I feel that person's up to it but I will set up little things. I'll make it clear to them too. […] I always believe in giving the benefit of the doubt to a point and I'm not one of those 3 strikes and you're out, but with people it's different… if somebody really is very under-resourced, very vulnerable, you don't expect much so you're going to have a go at something really easy and if they fail the first time you're just going to try something else and say well maybe this is in their scope, because you're looking too at the same time for a bit of direction as well. At some point where I've made the decision, okay you're stuffing me around, I'll let them know quite quickly but then let's lay it on the table... well I want to see something from you... and if I start to see something or if I feel that somebody is making an effort, I will bend over backwards to go the whole hog for them as well. So I'm pretty driven in that way*.

Germaine, an emergency relief worker, talked about *wasting one's time* when someone is drug-affected, in this case, safety being paramount:

> [Germaine] *I think I would say ours is strength focused, maybe even a narrative approach – but that's probably not the language everybody would use – which is to stay respectful of the person's story and their capacities and their struggle which then allows them to maybe feel comfortable enough to disclose what's really going on, but it's not going to be easy because they're very guarded. If they're actually drug affected at the time, the most effective thing is just to help them be safe. You don't try and engage with anything else if they're actually drug affected, because it's a waste of time and energy. It's about safety, theirs and other people's*.

The worker aims at the client disclosing, but may judge it to be futile until a 'right moment'; engaging with drug using clients should help them discover other sides of themselves:

> [Roslyn] *When I work with drug using clients, I try to get them to define themselves in another way, not as a drug using client. That's one of the first things we start to look at. I try and take that definition away from them, but they define themselves that way. [..] As drug users, you know, I'm a drug user therefore I'm not going to be a good mother or I'm*

*not doing this, I can't do that, and I try and move that right away from that, that they have other qualities and I try to get them to re-define themselves … but it's very similar work to someone that's not a substance abusing client. They also have their problems, their lack of confidence in themselves in many, many ways and again it's having a quiet little look at their other strengths and trying to redefine, get them to redefine themselves. But it's probably something that I would do a lot with drug users, yeah. And to that end I will often encourage them*.

Interestingly, Roslyn, a family support worker, did not want her clients to relate to themselves as drug using clients, implicitly or explicitly perceiving the drug-using client subject position as limiting. Whilst being careful not to condone drug use, attention is spent on getting drug using clients to re-define themselves, recognising that whilst they might define themselves as such, it is about discovering their 'other' qualities, the drug user learning not to be one, to *other* him/herself, learning that drug use is incompatible with reaching functioning personhood, reaching goals and fulfilling aspirations that come from the '*inner*' self. *Reinventing your self is the aim*. The *discursive construction of the self* needs to be either *pluralised*, so as to elicit the *socially acceptable* self, or *refashioned* in such manner that old and new selves can '*co-inhabit*' the narratives of the self. George, a counsellor, used psycho-social knowledge to work with drug using clients:

[George] *The issues around self esteem and identity always come to the fore, so I always work on establishing or trying to establish the person's identity, things like strengths, systems, family structure, that type of thing so, where there's support, what sort of supports are in place, but they're all sort of things that I would generally incorporate into counselling anyway but I'd probably put an earlier focus on it where there are drug and alcohol issues*.

Often, however, the tools of engagement that workers used were not necessarily saturated with psychological knowledge; Angela, a youth residential worker, found 'free' and open communication the best way to work with drug users:

[Angela] *I'd say to always be open when they do come and talk to you about your [their] drug use. To go the right way about saying that it's not OK to be using the drugs but you still can feel free and comfortable to come and talk to me about it, coz I feel that it's more important that we know what they're doing than having them hide it from us. I've always been a real stickler for that because I'd rather know what the kids are doing and have them come and just feel free to tell me and then be able to say, well maybe you should have done this in that situation, than them not telling me anything and then winding up in the gutter somewhere. So, I think just always keep the communication free and open, for them to say pretty much anything that they feel they need to say, encourage them to talk about it because it's only through that that you're going to get them to try to enable them to start thinking about why they're doing it and focusing a bit more on that. Because it gives you windows of opportunity*.

These are narratives of *care*, similar to parenting discourses: a good worker is someone who knows what's going on with clients, even if or *particularly* if the worker does not condone what they are doing. Many workers feel responsible for making sure clients are looked after, whether within or (but rarely) outside professional boundaries. One of the most important tools for engagement, however, is *flexibility*, as counsellor Theda illustrates:

> [Theda] *...you know all these things mean that as a worker I have to be flexible, changing, updating. [..] I used to do woodwork years ago and I sort of compare it to that in that you've got a toolbox, you've got to have all your tools in the toolbox, it's no good going to fix a chair and only having a hammer because you might need a chisel and saw, a nail and on it goes. I just never know when someone comes in what their preference is so I have favourite ways of working with people. I like to use a lot of analogies and discretely talk about… it's almost like storytelling but parallel with things that happen in life in a sort of anecdotal [style]… It's like giving them an image for what they're experiencing and they can identify it more sometimes with the image*.

In Theda's account, the toolbox is her way of flexibly adjusting to each client's personality or preferences and to choose a learning style fit for the 'target group'; The worker is considered to be a life-long learner, identifying with her '*workerhood*' and needing to create a new 'mould' for every client and remodel herself in order to work 'effectively'. Such manufacturing of *idiosyncratic responses* is a skill workers are selected for.

In summary, engaging and staying engaged with the drug user is of utmost importance for human service work to be possible and 'successful'. Clients who are constituted as challenging, resistant and needing to find themselves demand many tools of engagement that rebuild their identity, make them likely to disclose and be open for change. As the service system run in a competitive environment with scarce resources, workers make judgments about which clients to '*invest*' time, effort and commitment in.

## 4. Trafficking meaning in relationships

Re-stating a meanwhile familiar theme: no client exists without his/her counterpart, the worker; I have borrowed the phrase '*trafficking in meaning*' from Teoh, Laffer, Parton and Turnell (2003, p. 147), not only because of its wonderful analogy to drug trafficking but because meanings are being trafficked most intensely at the *relational* level, exchanged and renegotiated between the client and the worker. Trying to capture the relationship between worker and client, the *dance* metaphor is useful, as it makes the *mutual dependencies* between them obvious and

illustrates the alienated '*helping stage*' on which both have to perform. The dance is pre-conditioned and pre-staged and not all tunes are available to draw on at all times (the service type - emergency relief, counselling, housing - and the knowledge and experiences of client and worker). Dances are known as 'addiction', 'client-centred approaches', 'alternative- or cognitive-behavioural therapies', 'life-space crisis intervention,' etc. and workers choose them like a 'bag of tricks': strength-based, solution-focused, motivational interviewing, '*going to Maccas*' (taking clients to McDonalds and working 'on them'), '*taxi therapy*' (working on clients whilst driving them somewhere), using '*windows of opportunity*' when the client is perceived to be ready to change, and '*working with people where they are at*.'[126]

Achievement is measured by finding the right dance technique (helping), the right melody ('*treatment plan*', client goals, achievement of a '*diagnosis*'), both partners following the steps in the prescribed order (policies, procedures, eligibility criteria) and dancing well with others (referral system, '*advocacy*', presenting well in court). Some workers and clients dance well together (called '*successful engagement*', 'establishing a relationship/trust') and they negotiate what is *really* at stake and how they will perform their roles (subversion of roles, discretionary practices). Other workers dance while judging *desert* and tracking down the lying and cheating ways of their clients and letting them know in no uncertain terms who '*the boss*' is.

If the dance doesn't 'jell', they will step on each other's feet, they'll cut it short, citing the interventions of the '*hosting*' agency (accountability, managerial influence, treatment effectiveness), rendering the *client a rather conditional dance partner*, as the threat of non-compliance, eviction or breaching is ever looming. Social *performativity* is situated in this dance: the worker and the client decide who '*the other*' is and how/whether the dance can be put on stage. Drug use narratives are drawn on and co-produced by the client and the worker; a client able to *navigate the service system* is the desired goal, whether any '*help*' is received is an entirely different matter and often incidental. The worker is required to see the bond as *temporal*, not 'cling' to clients or exercise ownership of them and pass the clients on, to 'themselves' or other services. Clara, working in a youth residential setting, knows when a relationship is built:

> [Clara] *The first thing we do is try and build a relationship. I think relationships are very important and working with them in a positive way and not exactly ignoring the drug use but not making that a main focus: talking about them, their likes, their self-value in a way of not putting the young person down, building their self-esteem. When you get to kind of*

[126] The idea of locating people on a scale of (readiness for) change, the 'stages of change' model – also known as the trans-theoretical model (TTM) of behaviour change – is associated with the phrase 'where people are at' (see DiClemente 2003).

*a bit of a relationship going, encouraging them to access the specialist services and sometimes with young people it has to be in a manner where they don't feel like they're going to a drug and alcohol counsellor. It may mean that the counsellor comes there and is part of our group and builds a relationship again and you'll know when they're kind of connected because they'll say... "my worker" or something like that*.

Clara also mentions the direct or indirect 'marketing' of services to the clients: the fact that they may like to talk to a generalist rather than to a specialist worker, who may or may not be introduced as such. Workers decide from case to case if the relationship is more 'effective' (achieving the service's goals) when 'performing' as a specialist or a generalist and they employ tactics as to when it is '*appropriate*' to address drug use or not. Karl, a worker with the young homeless, had a clear idea what exactly a 'good worker' is: not someone who is a 'pushover;'

[Karl] *We had someone come up a while ago interviewing some of our clients and they asked what they thought made a worker a decent worker, and they stated straight-out that someone who occasionally wasn't scared to have a rip at them, someone who wasn't a pushover, someone that wasn't simply someone picking them up, taking them to McDonald's, patting them on the head saying you're a good boy. We'll try this or you've got to do this and you've got to do that… it doesn't work. It doesn't work for them and they just see that as an easy mug. At the end of the day we're still going to get the odd one who knows that if they come and I'm on duty, they come in the next day and try another worker and if it's another worker they know of, they'll check out who's on duty again and they'll just work it. They're not silly, they're pretty smart, they're manipulative... but they're also desperate. It would be easier, though, if we had a uniform response but it's very difficult to have a uniform response when you have five workers and you have individual clients with individual needs and individual backgrounds*.

Karl would like to see uniformity in workers' responses within his organisation; he views workers as '*easy targets*' for clients who are scheming to get what they want. '*Individual clients with individual needs and individual backgrounds*' become an obstacle at the relational level and the agency becomes vulnerable to '*clients' manipulation*'. He goes on to complain about his co-workers who are '*givers*':

[Karl] *They'll only come to a certain worker because they think that worker's going to be a giver. Now maybe as a non-giver, it may be someone else… in our agency is a non-giver so they work out which ones they reckon are easy marks. I don't think it's that difficult. If we all work on the same page it would be a lot easier but sometimes we're all different too, we all have different days. If we're all having a good day it might be easier to say yes, if you're having a bad day it might be easier to say no but one problem I've found that we have is because we have five different workers on intake, you have five different responses so that makes it hard*.

Karl goes even further: not only clients' individualities but workers' individualities can be obstacles as well. Workers and clients are matched with each other as much as clients are

matched with different programs; however, providing a *consistent response to clients* may be at odds with the practice of matching or 'fitting' workers with clients, the service system priding itself in delivering '*effective matches*' between clients, programs and workers. Inconsistency is interpreted as both counterproductive for workforce cohesion and as giving clients the power to manipulate 'the system' to their advantage, which must be avoided. It is this inconsistency that Karl objects to, but this – paradoxically - might be required for the service system's functioning and stability: the workforce should be sufficiently individualising to (at least *seem* to) be able to accommodate differences between workers and between clients and thereby allow flexibility and discretionary practices. The workers' level of 'comfort' with drug use, for example, can be translated into different relationships with clients and their drug use:

> [Clara] *I mean, some workers are quite comfortable going out and popping their bag [for volatile substance use] so they'll cop a load of abuse or something from the young person, but they're confident in doing that and other people aren't, so I think that kind of sets some workers up... Like, "so-and-so's on, I'm not going to chrome because they're only going to pop my bag... but so-and-so's on, so I can chrome all night because they won't do anything about it."*

Once the person has started to regard him/herself as a *client*, the task becomes making the client '*service ready*', '*service competent*' and versed in the service system's language of entitlements and accountabilities, providing careful induction to assessment criteria, ways of complying with policies and procedures, so that the person is 'enabled' to mould itself into the client subject position:

> [Fred] *We link them into the relevant agencies, but we don't leave them there, though; we provide ongoing support, we quite often provide them with transport to the initial appointments just to help them sort of ease into the system and get used to it, it's amazing how many people you come across who still have not had access to any of the services and if they've spent a couple of years in prisons, accessing a service like that can be a bit daunting to them, so we will often go along and 'hold their hand' a little bit, if you like, initially just to give that extra support until they start to feel comfortable and then they get to know all the people and they start to become confident or competent at using the service and make sure that they follow on as well.*

Of course, for most workers there is not just one relationship with a client but many; workers said relationships varied from non-existent to very productive, some having lasting contact with clients beyond service provision, mostly for those working with young clients. Truth detection and truth telling are essential techniques of building trust and rapport; in the parenting advisor's account, drug users cannot tell the truth because their social context '*makes*' them a '*pretending persona*,' affecting the sort of relationships they had with other people and workers:

[Hannah] *They've all been very, very different, you know, whether they've been open, closed, prepared to talk, not prepared to talk. Although I think maybe one theme is that you feel that you're not really getting to the truth in the way that you often do with other clients. I think and usually the way that you know that you're not getting to the truth is that there's just gaps and inconsistencies and things… sometimes it doesn't matter, so you just don't even worry about it, you just let it wash over but never having any money even though it's Friday and yesterday was money day…. I know one woman said she hadn't been out of the house all week yet I'd seen her when I went down to [suburb name] to buy my lunch one day. Now I'm not trying to find times when she's not telling me the truth but they just jump up all the time. I think the person who's using puts a lot of energy into trying to keep a certain persona and I think that also means that if they come into [parenting] group work, they often can't be honest the way … say someone's in a domestic violence situation. If they feel comfortable enough they will talk quite a bit about it, right, but if someone's using they're not going to be talking about it in that same setting, well that's my experience*.

Quite a few workers found textbook knowledge potentially detrimental and useless, only a few finding it preparatory; working with clients was all about the *skills of engaging*, *being able to relate* and *learning from the clients* – these helped the worker to play '*truth games*', i.e. eliciting *performative* truth in the encounter:

[Vera] *… just think if you're open you just learn so much and I did, I learnt lots and all through my working career. I've done so many different courses and things like that but you can throw that all out the window and it means nothing if you don't relate to the people you work with. I've worked with qualified psychologists when I had nothing behind me and the people I worked with seemed to relate to me better than that person because they sometimes you know, you've got to have a combination of both, you just can't have a qualification and not have the skills to carry that through. If you're just talking about text book stuff and you're just saying stuff that you've read, especially working with drug addicts, they're just going to think you're an absolute wanker and they will. That's probably about the honesty, like addicts will be honest with you too. If they don't like you, they'll soon tell you, or they will give you an incredibly hard time*.

Vera, working in a domestic violence service, juxtaposes lay and professional notions of expertise; as to everyday knowledge and truth games, being skilled and being professionally trained are two things. Honesty and authenticity of a worker is quickly detectable by clients who can tell who is genuine. Isaac illustrates a tension a worker constantly faces: '*accepting*' and '*respecting*' a client and not being *offensive* and *prescriptive* in one's approach, whilst at the same time using subtle techniques to *guide*, *model* and *prefigure* ways of living and relating to and with their clients:

[Isaac] *Well I guess I would see myself as someone that can help them achieve their goals. I wouldn't like to see, you know again it's that non-coercive stuff, I don't think I would want to influence… I don't see my opinion, my morals, my beliefs as any more righteous*

> *than theirs for them. So I think it would be offensive of me to try and influence them to come around to taking on what I think is best for them. Look, I guess in a roundabout way that's what we **do**. But I think the influence I can have is by being there, by forming that relationship and using that relationship as a, I guess, an example. So the relationship becomes a way that we model how you can relate to the world*. (my emphasis)

Interestingly and paradoxically, Isaac seems to not have noticed that every 'client' already relates to the world a long time before assuming clienthood; the worker *wants the client to problematise* the way in which the latter relates to the world (deemed to be '*an issue*', risky, destructive, immature, counterproductive or in some other way '*not healthy*'), in order to relate to the world *differently*.

Summarising, a central prerequisite for assuming *workerhood* is the ability to both *other and same* the client, who is the same or equal to the worker (and deserves respect) but also different and alien. One can relate to the client (*empathise*) and one cannot *understand* or *condone* his/her actions, strategically divorcing subjectivity and practices from each other and then reunited again: *what is problematic with clients is not who they **are** but what they **do***. Once a relationship is established, the worker can identify with the client which sides of her/him are '*worthy*' and which are somewhat '*faulty*' or mistaken, thereby problematising the person as simply engaged in a problematic practice.

Any *expert* regime cannot really problematise the practice (drug use) without problematising the person (drug user); the worker subject position needs to employ sophisticated 'professional' tools that validate a person whilst invalidating the practices of that person. The balance between problematising practices and people remains shifting; the worker subject position is obliged to seek what makes a client 'tick' and how change can be brought about, change usually being synonymous with *conformity to dominant social values*.

The next chapter will investigate the constitution of clienthood and workerhood on the institutional level, mediating between the individual/relational and the political-economic levels.

# Chapter five

# The art of dealing with frozen meanings:

# negotiating with the instituted

In Chapter One I posited that discourses had created the human service worker as a historically partnered subject position to the client subject position: client and worker are in a *dyadic relationship*. Discourses had worked to influence, if not structure the parameters in which the client and the worker could '*become*'. The previous chapter illustrated how clienthood and workerhood were constituted on *individual* and *relational* levels, problematising assumptions and dynamics within the client-worker relationship and emphasising how both were encouraged to use their *selves* as a resource. The present chapter addresses the *institutional* level, defined in Chapter Three as mediating between the individual/relational and political-economic levels. I seek to answer the following research question in this chapter:

***Which practices and discourses constitute the drug user and the human service worker in the drug welfare service system and how do workers reflect on the service system?***

Exploring the ways in which the *helping culture* unfolds, influences and constitutes client and worker subject positions, part one will be concerned with describing the *institutional context*, using current literature. First, I characterise the service system; second, policy analysis as pertaining to harm minimisation policy and, third, I use an example – the supervised injecting room – to illustrate how difficult it is to make drug policy and judge the different influences that come to bear on it. I also use this example to show how clienthood is constructed differently within the 'same' service program. Part two discusses the data thematically, relating them to the above research question.

# 1. The context

## 1.1. The drug welfare service system: treatment, services and harm governance

Chapter Three provided a basic outline of the Australian welfare state; here, I will concentrate on the policies affecting drug welfare, its agencies and the service systems, the institutions of employment (regarding *workerhood*) and treatment/service provision (regarding *clienthood*). Economic deregulation had a profound effect on the welfare state, which previously relied on a wage and employment-based '*safety net*;' it effectively dismantled employment-based guarantees, leaving Australia '*with a residual welfare state in the liberal mould*' (Shaver 2002, p. 339)[127]; family and market are now the preferred institutions for social support (2002, p. 331), whilst fiscal responsibility was equated with minimal welfare spending.

The employment world has undergone major changes: economic deregulation and industrial relations reform, decreased union membership, disappearance of standard working hours and polarisation of high and low levels of weekly working hours, increasing participation of women in the labour force and increasing casualisation, underemployment and job insecurity (Broom & Feyer 2001, pp. 179-184).

Interestingly, agreement and data on exactly who constitutes the community services labour force are lacking (Vaughan 2006, p. 10);[128] five broad categories for community service workers are current: child and youth services, family services, disability, aged and disabled care and other community service workers (including as a subcategory 'drug and alcohol counsellors') (Vaughan 2006, p. 62-63). Community service sector qualified hourly pay/wage rates are $17.34 per hour for a full-time non-managerial adult male worker and $15.32 for a similarly employed female worker (unpaid and paid work/care are statistically accounted for by using the same rates) (AIHW 2003, p. 122).

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[127] Shaver in fact argues that the welfare '*activation agenda is designed less to increase the overall rate of economic activity and sustain generous social support than to reduce the welfare rolls and reduce their burden on a limited tax base*.' (2002, p. 339)

[128] Vaughan writes: '*One of the major data issues stems from the lack of agreement as to the constituents of the community services sector and hence the lack of clear methods of identifying the community services workforce in data collections*. […] '*Further investigation of possible means of data collection is required for those subsectors for which national information is patchy or non-existent: child protection services; juvenile justice services; other children, youth and family services; disability services; housing; supported accommodation and crisis services*.' (2006, p. 10/13)

The drug and alcohol treatment workforce[129] is predominantly staffed by nurses, followed by general AOD workers, psychologists, counsellors and social workers (Wolinski et al 2003, p. 66), indicating the discourses dominating the AOD sector: medical knowledge (nurses), '*hybrid drug knowledge*' (AOD workers), psychological knowledge (counsellors) and social work knowledge (social workers). The proportion of drug and alcohol counsellors employed in community services increased by 45.4 % between 1996 and 2001, whilst the overall community service workforce increased by 26.8 % in the same period (AIHW 2003, p. 146). In a survey of drug and alcohol treatment agency managers, the overwhelming majority identified insufficient funding as an impediment to their agency's work and difficulty recruiting staff; most agencies supported harm minimisation, including abstinence (Wolinski et al 2003). Until 2005, Australia's drug treatment capacity was not known (Miller S 2005).

A nation-wide structural shift from employment in manufacturing to the service industries and community services labour forces has increased significantly, whilst remaining largely female (Saunders P 2002a, p. 89/90). The community service sector is comprised of '*not-for-profit, non-governmental bodies, of which there are over 700 000 in Australia*' (Hancock 2006, p. 42). Non-governmental community service organisations (NGCSO) remain largely dependent on government funding (AIHW 2003, p. 128-129);[130] according to David Crosbie, the AOD sector faces '*a key not-for-profit dilemma, achieving efficiency while striving to achieve the mission*.' (2007, p. 28) He explains:

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[129] The Department of Human Services has introduced a minimum standards qualification strategy for workers in the AOD field, resulting from findings that the AOD workforce is rather diverse in its specialisations and training backgrounds: '*The data found that 83% (618) of registrants had one or more relevant qualifications such as a TAFE or university certificate or diploma, bachelor degree or postgraduate qualification. Of workers that held relevant qualifications, 49% (301) had one qualification, 36% (224) had two qualifications, 12% (76) had three qualifications, and 3% (17) had four or more relevant qualifications*'. (DHS 2004b, p. 3) However, while the sector is highly qualified, '*only 8% of qualifications held are specifically in Alcohol and Other Drugs Work or Addiction Studies*.' (DHS 2004b, p. 4) Trevor King (2004), for example, finds it problematic that we do not know more about non-specialist workforces working in the AOD field or with AOD clients: '*Even less is known about the 'non-specialist' workforce engaged in drug and alcohol work*.' (2004, p. 196) Whilst minimum qualification strategies can be useful, they always can also mean that the workforce is trained to think and react in a certain way. These strategies can also re/produce 'specialised' and 'non-specialised' workforces and tensions between them. From a workforce point of view, qualification standards might mean that professions or sectors can lobby for 'parity' of status, pay and conditions and can mean that clienthood can expect to get a standard of 'care'. But these very same strategies can produce specialist mentalities and 'silos' and train workers into accepting a particular view of drug problems and people who use drugs. Training and education can also be useful ways of explaining the implications of policies, of disciplinary knowledge and contradictions. Therefore, it would be useful to think of training and education as offering the potentials for resistance and the potentials for conforming.

[130] '*In 2000–01, governments in Australia contributed $9.6 billion (70%) of the funding for welfare services (Table 4.5). The remaining 30% came from the non-government sector, comprising NGCSOs and households. Households paid $2.5 billion in fees to service providers (both government and non-government) for some welfare services, while NGCSOs contributed $1.6 billion (11.6%) from their own (non-fee) revenue sources. The amounts do not include health-related expenditure*' (AIHW 2003, p. 128-129).

> This dilemma has been compounded by the policies and practices of governments and other funding bodies. For over a decade, NFPs [not-for profit organisations] have been under relentless pressure to provide 'more for less'. The performance emphasis has been strongly upon reducing service costs and increasing outputs. Governments in particular, seek increased efficiency, not in the way the organisations run, but in the cost per unit of service. [..] Staff in NFPs are generally paid less and are often expected to work longer hours in more complex roles when compared to staff employed by government and business. There is much less infrastructure and support for management and organisational operations within most NFPs. (Crosbie 2007, p. 28)

Crosbie points to the '*new*' governance regime for community and drug welfare services, including '*relationships and networks between public, private and not-for-profit sectors; it includes formal and informal means of policy persuasion; and the creation and use of policy-relevant knowledge*' (Head 2005, p. 44). The new and by now firmly established governance of community services is characterised by the following: an environment in which competition between non-governmental organisations is sought and encouraged and the split between funder/purchaser/provider of community services is entrenched; a '*rising influence of economic regulators*' (Dufty 2004, p. 53); the advent of horizontal *and* vertical accountabilities of organisations (Considine 2002); the audit explosion (Head 2005, p. 48); '*the problem of self-referential policy knowledge based on the dominance of functional and managerial expertise – the creed of rationalist expertise*' (Adams 2004, p. 29) *and 'the adoption of managerialism in the public sector*' (Scott & Wanna 2005, p. 20).

The effects of competitive tendering and contractual arrangements on the welfare sector have been identified as detrimental: a reduction of choice of services which can be offered to clients; reduced the autonomy by confidentiality clauses or restrictions on public comment; reduced collaboration and information sharing within the service system as agencies compete against each other; administrative costs to competitively tender higher than grant submission writing; and, finally, funding regimes do not cater for complex and diverse clients' needs (Nevile 2000, p. 21-22). Considine explains that the new governance assumes exit options for clients of quasi-markets, but this choice is not often available as there are not enough services to choose from, nor does their exit exert any pressure on the service system to change (2005, p. 182). Clients of community service organisations cannot rely on governments to protect their interests:

> Instead, we have tended to use the government purchaser as a stand-in for a kind of collective consumer interest. This is totally inadequate. Government agencies responsible for establishing contracts or regulating them have their own axes to grind and cannot be entrusted with the protection of individual citizen interests. (Considine 2005, p. 182)

Whilst not suggesting that governments per-se cannot or should not be entrusted to enact the 'public good' or clients' rights, Considine points to some of the complexities of operating quasi-markets and alludes to governmental shortcomings. The changes in governance regimes mean that outsourcing[131] services can equate to outsourcing risk *and* responsibility[132]:

> More broadly, the outsourcing of service delivery to non-government organisations implies that rising demands for services and the consequent unmet needs become the problem of the sector, rather than the government. Partnerships become a risk-shifting strategy for the state. (Hancock 2006, p. 58)

This role reversal forces the community sector to 'lobby' the government to take on the public responsibility that it already has; the sector with its peak bodies, research and policy capacities tries to mediate the adverse effects of this new governance by issuing policy and budgetary advice and by engaging in policy advocacy, but exactly how successful it is to influence public policy is difficult to determine (Casey 2002). Mowbray has termed governments' delegitimising 'public choice-based' rhetoric against NGOs or the '*third sector*' as the '*war on non-profits*' (2003)[133], summarised by Lyons and Passey:

> Since the late 1980s, many of the contracts by which governments subsidise the provision of services have been written in such a way as to prevent nonprofits from drawing the public's attention to the inadequacy of government policies (McGregor-Lowndes and Turnour 2003); some ministers seem keen to use charity law to silence organisations with which they disagree (Maddison and Denniss 2005). Yet this mixture of piecemeal support, confusion, ignorance and hostility is not the only possible government stance toward the third sector. (2006, p. 92)

An effect of political-economic level processes is not only the increasing hostility to '*social causes*' like wealth or income redistribution or alleviating poverty, but even a simple fact

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[131] Outsourcing services to non-governmental agencies is not per-se problematic and in the state of Victoria, community services have historically been provided predominantly by non-governmental agencies. However, outsourcing has been associated with less governmental accountability for public services (although governments refute this and argue accountability has been improved) and '*an increasing incorporation of private contractors into the overall structure of government*' (Mulgan 2006, p. 48)

[132] Furthermore, the rise of the idea '*of communities as co-producers of outcomes with government*' (Adams 2004, p. 37) may not simply be 'empowering' for clients but may simply shift the responsibility of government elsewhere.

[133] Furthermore, conservative rhetoric has recently viewed (some) non-government organisations (NGOs) with increasing suspicion in terms of their representational legitimacy in the policy-making processes and this resulted in reduced advocacy (and democratic participation) for disadvantaged groups (Maddison & Denniss 2005, for further analysis of the contradictory relationships between government and the community sector see Casey & Dalton 2006). The federal government's attack on not-for-profits' legitimacy is apparent in its spin when for-profit organisations are never questioned for their self-interest in the policy debates as the 'welfare industry' is; there are also trends towards the de-funding or poor resourcing of advocacy groups, threats of withdrawal of tax-deductibility and demands to prove 'authenticity' by sharing characteristics of the advocacy constituency (having a disability or an HIV virus) or the explicit exclusion of political activity from funding regimes for organisations who engage in advocacy work (Maddison & Denniss 2005, p. 383-384).

like the higher and more complex reporting requirements of not-for-profit compared to for-profit organisations[134]. As the welfare state has always been a battleground for class-conflict and compromise (with periodic strengthening for either side),[135] hostilities are not new phenomena among the various policy players. The assumed inefficiencies of welfare spending, however, have been an achievement of sustained political argumentation, trying to divert public attention and public opinion from the fact that there is little evidence for the association '*between the conditions of competitiveness in an ever more open economy and the necessity of labour-market flexibilisation and welfare retrenchment*' (Hay 2005, p. 203).

It is at the *institutional level* where struggles take place to shape what the institutions of welfare, employment and treatment look like and which programs, practices, discourses and agencies attach themselves successfully to such institutions. The institution of treatment can bring into being agencies, policies, procedures and processes and multiple discourses can create and attach themselves to this institution. Analogous to Foucault's discussion about the '*birth of the prison*' (1991, p. 239), an image of discourses emerges which compete over and establish treatment rationalities:

> *therapeutic* (Is 'addiction'/drug use treatable physiologically, neurologically, neuro-scientifically, psychologically, pharmacologically, phenomenologically, behaviourally and/or spiritually?);
> *sociological* (Are treatment and 'rehabilitation' producing coping (integrated) individuals?);
> *religious* (Is faith (in the ideology of life) restored?);
> *spiritual* (Is treatment methodology creating a sense of belonging, meaning-making and 'recovery'?);
> *administrative* (Are treatment agency and clients accountable and auditable? Is the division of labour optimal?);
> *economic* (Are the treatment costs bearable and 'effective' for the benefit of society and the economy? Are labouring and (legally) consuming individuals regained?);
> *political* (Is the treated person committed to maintain social peace and democratic citizenship?);
> *legal* (What is the likelihood of future lawful conduct and are laws (and by-laws) in combination with treatment effective in steering conduct?).

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[134] Interestingly but not surprisingly, a recent study found that it takes only two days to set up a business but it may take more than 200 days to set up a not-for-profit organisation because of the regulatory and compliance pressures forced onto them (McGregor-Lowndes 2006). There is also evidence of '*multiple and irreconcilable differences in the reporting requirements of government funding programs reported by non-profit accounting practitioners*' (Ryan & Flack 2005, p. 74-75).

[135] The welfare state has had a contradictory history since its inception: '*It is exactly its multi-functional character, its ability to serve many conflicting ends and strategies simultaneously, which made the political arrangement of the welfare state so attractive to a broad alliance of heterogeneous forces*. [In the last decades, however] *[t]he machinery of class compromise has itself become the object of class conflict*.' (Offe 1984, p. 148-149)

To date, there has been little critical analysis in Australia, ethnographic or otherwise, of service or treatment encounters where drug problems are constituted.[136] Treatment rationalities always express a particular social relationship and aim towards societal and political-economic targets. They cannot do so, however, without to some extent targeting the individual level, which is why the institution of treatment is pluralised to produce a closer fit between individual and political-economic level dynamics and still be somewhat accommodating of individual differences within the manufacturing of conformity. Cruikshank expresses this need for a balancing act between individual and political-economic interests as a problem of '*government*': '*To balance the subjectivity of citizens with their subjection required an innovation of political rationality*' (1999, p. 75). She is interested in how participation of clients in the very programs that constitute them as poor (and drug using) was politically manufactured. This innovative political rationality of ensuring the individual's participation in treatment or service programs was a neo-liberal one, argues Bunton, achieved through the '*pluralization of technologies in Western and Antipodean drug care systems*' (2001, p. 229)[137] and power relationships are decentralised and multiplied across sectors and constituents (Cruikshank 1999, p. 75). In the *Victorian AOD sector*,[138] many different types of drug using clienthood can be assumed; clients can *choose from* but also have to *choose within* the following instituted treatment forms:

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[136] What we know about Australian treatment approaches is limited. As change and motivation are central concerns in drug 'treatment', cognitive-behavioural approaches are dominant treatment 'modalities' (Keene 2001, p. 190). Yet, Ritter et al. claim that the Australian '*substance abuse field has been slow to embrace research into the impact of the therapeutic relationship on treatment outcome*.' (2002, p. 261). Gossop even calls for the addiction field to learn more from psychological discourse: '*In social psychology there is a vast literature on how to understand, measure and change attitudes, and the links between attitudes and behaviours. In the 'addictions field' we should learn more from this vast body of work*.' (Gossop quoted in Allsop 1999, p. 95) By contrast, social work has been described as *indirect* technology: '*In social work noninfluential influencing is its communicative arts, its speciality*.' (Epstein 1999, p. 8) The political dimension of treatment, needs to be seen in the context of liberal individualism, as Lichtman explains: '*In reality, our society "individuates" us as isolated, hostile, deprived and curtailed and then redefines and sanctifies us as autonomous, self-reliant and independent. Simply put, the realm of the private is the result of a particular social formation in which alienation is presented and accepted under the rubric of liberal individualism*.' (2004, p. 89)

[137] Bunton goes on to characterise drug care regimes: '[…] *adoption of a multi-sectoral approach; the increased range of therapeutic options available; the use of local and community knowledge and expertise; the shift to incorporate different and more ambitious prevention strategies; and the use of notions of the management of "at risk" populations*.' (2001, p. 229-230)

[138] The definition of the Victorian AOD treatment sector is provided by the Department of Human Services: '*The Stage Two Report of the Drug Policy Expert Committee defined the AOD treatment system in Victoria as comprising "several interdependent components…including the primary health system (general practitioners and hospitals); the broader service system (mental health, juvenile justice, homelessness, corrections…and other services) and the specialist drug treatment service system." The Department of Human Services (DHS) directly funds over 100 specialist drug and alcohol service agencies with many operating services from multiple sites. Services are provided by a variety of agencies including charitable and/or non-government organisations (NGOs), Community Health Centres (CHCs), hospitals and local governments. There are also a small number of targeted services that are delivered through specialist agencies such as Aboriginal Cooperatives, telephone helpline services such as*

> The general service types that may be accessed by clients in each DHS region are (Victorian Department of Human Services, 1997, revised 2002): • Residential Withdrawal; • Home-based Withdrawal; • Outpatient Withdrawal; • Rural Withdrawal Support; • Specialist Substitution Programs – Specialist Methadone, Buprenorphine; • Counselling, Consultancy, and Continuing Care; • Residential Rehabilitation; • Alcohol & Drug Supported Accommodation; • Peer Support; • Aboriginal services; • Mobile Overdose response; • Mobile drug safety; • Continuity of Care; • Extended hours support; • Methadone outreach; Youth services types that have been made available in each region are: • Outreach; • Counselling, Consultancy, and Continuing care; • Supported Accommodation; • Peer Support; • Withdrawal; • Aboriginal services; • Residential rehabilitation; • Day programs; In addition to the regional services, a number of state-wide services provide specialist assistance to complement the regional services: • Youth Substance Abuse Service; • Ante and Post-natal Support; • Specialist Family Programs (Family residential rehabilitation program); • Family drug information and support information Helpline; • Parent Support Programs; • Dual Diagnosis services; • Homelessness and Drug Dependency Trial; • Treatment programs for offenders (DHS 2003, p. 16-17)

This plurality is meaningful at the political-economic (returning people to normative social lifestyles) and individual level (individually tailored treatment regimen); treatment '*modalities*' had to become innovative, knowledges and practices are constantly (re)made and 'transferred' in an endless 'development' of more or less 'mobile' institutional and policy responses[139]. Simply producing scientific evidence for the varieties of treatment rationalities was not sufficient (apart from the continuous contestation of '*evidence*' and '*effectiveness*' within scientific and policy communities[140]); much work was done to encourage '*uptake*' of evidence-based research by governments, professionals and lay-people (called addiction knowledge or '*technology transfer*'[141] from the 1990s and the International Harm Reduction Association (1996)

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*Directline and prison and community based services as part of the criminal justice system. The Government also provides support to community pharmacotherapy services and Needle & Syringe Programs (NSPs) delivered in a range of sites across Victoria*.' (DHS 2007, p. 53) However, when using the term '*Victorian AOD sector*' I refer to all the non-governmental organisations that are directly or indirectly related to AOD treatment and harm reduction services.

[139] Caulkins, describing the difficulties of modelling drug epidemics and waves of drug use, has pleaded to make drug policy more responsive and dynamic to drug use cycles but, whilst drug researchers understand that '*policy ought to vary over the course of a drug use cycle, [..] drug policy debates have not yet internalized this perspective*.' (2007, p. 4) Policies ignoring drug system dynamics (market, use patterns, etc) suggest that '*mental models guiding policy discussions implicitly superimpose a static framework on an intrinsically dynamic phenomenon, akin to popular nostrums for get-rich-quick investing that never vary even as economic conditions change over the business cycle*.' (Caulkins 2007, p. 4) Caulkins speculates why dynamic policies are missing: '*It is not clear why policy is not discussed more often in dynamic terms. Perhaps disciplinary boundaries and stove-piped bureaucracies create single-issue advocacy. Perhaps both the health and criminal justice perspectives favour individual-level analyses. Whatever the reasons for their absence to date, dynamic perspectives on drug policy are, in fact, possible*.' (2007, p.4)

[140] For critiques of evidence-based policy making see Marston & Watts (2003) and Gibson (2003).

[141] The Workforce Development Glossary defines 'Technology Transfer' as *'[t]he systematic process through which skills, techniques, models and approaches emanating from research are delivered to and applied by practitioners (CSAT, 2001) Transforming what is useful into what is actually used. (CSAT, 2001)*' (NCETA, no date) Behind the idea of 'addiction technology transfer' is that knowledge can travel from site to site and be valuable. Whilst it is worthwhile to seek dissemination of knowledges and practices that have been deemed '*effective in reducing harm*',

made this part of its business). There is, however, an acknowledged tension between lay, peer, professional and scientific knowledges of drug problems; Kalb and Morton described such conflict as one between the craft (based on paraprofessionals) and the science approach (based on professionals) to (alcohol) addiction more than 30 years ago, the two approaches being incompatible (1976). Addiction discourses relegate addiction experiences simultaneously to the 'everyday life', peer, autodidactic, non-specialist or specialist knowledge realms of 'the social'.

I will now outline some uniquely Victorian service system characteristics through which clienthood construction is constituted.

### 1.1.1. Recognising connections: drug and social policy in Victoria and its clienthoods

I will outline some of the dynamics that are particular to the Victorian service system and its construction of clienthood. Political-economic pressures[142] can mean reduced funding for community services; increasing pressures on generalist providers of family and welfare services to help people who use drugs have been recognised since the year 2000 at least, a Drug Policy Expert Committee report emphasising that such pressures and the changing client profiles must be dealt with '*as a matter of urgency*' (DPEC 2000, p. 62). Six years later, some parts of the service system in Victoria and elsewhere are even in greater crisis,[143] with pressures on the non-AOD-specific service sector increasing. The estimated percentages of '*drug-using clients*' throughout Victoria's service systems are as follows:

> Of the total Victorian population of 4,753,900, it is estimated that 370,804 people (7.8%) of the total population) have a substance use problem. Mental Health Services (registered user) 80%, Specialist Drug Treatment Services 100%, Supported Accommodation 10.6%, See a General Practitioner 7.8%, Inpatient Hospital Admissions 5.4%, Adult Corrections 74.8%, Juvenile Justice 91%, Child Protection 58%. (Goldsmith 2001, p. 2)

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from an actor network theoretical perspective (which recognises the 'free' movement of knowledges and objects) it is more helpful to think that it is the network into which the object is placed or in which it finds itself that makes the object work or not work '*effectively*'.

[142] The Department of Human Service itself uses social democratic discourses to explain such effects: '*Economic and social trends often favour advantaged groups in society who are in a better position to manage their own health and wellbeing. However, disadvantaged groups will tend to depend more heavily on a wider range of health, welfare and housing services. It will, therefore, be crucial that people experiencing disadvantage receive integrated, appropriate and accessible human services. […] There is recognition that disadvantage needs to be tackled at both systemic and individual levels – a 'multi-layered' approach where sustainable and effective public services like health and education are recognised as necessary but not sufficient conditions for the enhancement of the life chances of disadvantaged individuals, families or communities*.' (DHS 2006, p. 7)

[143] Dorothy Scott has called for urgent action to save Australia's fostercare system: '*The fostercare system is under enormous pressure by increasing numbers of children coming into care*,' she said. '*We have to tackle the problem at its root cause and two-thirds of the children currently in care have a parent with an alcohol or drug dependence. We as a whole community must really face the issue of parental substance dependence*.' (ABC News Online Friday, September 29, 2006)

These numbers from the Drug Policy Expert Committee are stark and offer evidence of the entrenched *drug using society* that we are and how it pervades the service system even more deeply than society at large. The major social policy blueprint addressing social disadvantage in Victoria, *A Fairer Victoria* (Victorian Government 2005), – a very worthwhile initiative after the assault on community services during the Kennett years in Victoria – has missed the opportunity to link social and drug policy: '*any policy to address disadvantage that fails to recognise and respond to the harms caused by alcohol and other drugs, is missing a significant piece of a complex picture*.'(VAADA 2006c, p. 1) On the other hand, a 2007 discussion paper to develop a new AOD service sector blueprint, for the first time claims that the '*Government's Social Policy Statement, **A Fairer Victoria**, underpins the Victorian Drug Strategy*' (DHS 2007, p. 6) and commits the service system to implementing a '*no wrong door*' approach to service provision and developing stronger linkages and partnerships with welfare, health and other services (DHS 2007, p. 8). It remains to be seen how Victorian drug and social policy will be set into relation with each other.

An indication of the significance of the AOD sector can be gained through the budget: the Treasurer's budget report outlines that Victorian drug and alcohol services (roughly $110 million) represent 1/7 of the budget of Victoria's mental health services (roughly $732 million), the second smallest budget in the human services area (Treasurer of the State of Victoria 2006, p. 81). The Victorian peak-body of the non-government AOD sector, the Victorian Alcohol and Drug Association (VAADA), complains about years of increasing demand on services being met with undersupply:

> The Government has again failed to address the disadvantage associated with substance use in the Victorian community in its 2006-07 budget announcement. The budget contains virtually no money for the alcohol and other drug (AOD) sector, after years of increasing demand and shrinking funds. (VAADA 2006d, p. 1)

The Victorian Council of Social Service (VCOSS), the peak-body of Victorian non-governmental community services, urges in its 2005 state budget submission[144]:

> A state-wide, integrated system of universally accessible services, linked to a range of specialist supports within the secondary service system, including mental health and drug and alcohol services, is key to promoting and supporting the wellbeing of all children, young people and families. To ensure an integrated service system is able to respond

[144] VCOSS 2007-08 State Budget Submission welcomes a new focus on drug and alcohol services: '*VCOSS supports Labor's commitment to prioritise mental health and drug treatment services. In implementing this commitment, VCOSS calls on the Government to take a comprehensive approach and invest in drug and alcohol treatment in prisons, increased non-custodial programs and better community-based drug and alcohol services*.' (2007, p. 11)

> effectively to the varying needs of children, young people and families, urgent additional investment is required across universal and secondary family support services. (2005, p. 29)

Investment, price indexing and workforce issues are just some of the contemporary pressures on the community sector, as is the absence of comprehensive data on its paid (Victorian) workforce (Barraket 2006, p. 2). Odyssey Institute of Studies found that barriers and fragmentation existed across the servicing agencies for substance using parents who access drug treatment:

> Due to the complex nature of these families and the multiple problems they present with, the knowledge and expertise of workers in specialist child, family and parenting services, mental health services, family violence, and health services needs to be linked with drug treatment services so that these resources and supports are available to all families. In this way, workers from generalist services need a diverse range of additional skills, collaboration between drug treatment services and other sectors needs to be enhanced, and some additional specialist workers that provide this linkage work, training, and back-up for difficult cases need to be employed. (2004, p. 87)

The necessity to innovate and cross traditional funding lines and training boundaries are highlighted throughout the report and Odyssey Institute of Studies also recommends that cross-sectoral worker collaboration needs to be facilitated (2004, p. 112). Establishing a recognition or even a link between different service systems is, however, not enough as highlighted by VAADA's submission to the White Paper *'Protecting Children – the Next Steps…'* and the Children's Bill:

> The fact that these services are not adequately resourced or designed to work with children and families often means that AOD services need to link these clients with family services for their parenting issues or children's needs to be effectively addressed. Often, however, these families won't accept referral to other agencies, yet AOD agencies do not have the capacity to respond holistically to them. The outcome of this situation is often not conducive to furthering the best interests of the child. (VAADA 2005, p. 5)

Responding holistically to clients and involving children and families in alcohol and drug service provision requires flexibility of funding regimes, which is closely associated with struggles over defining an '*episode of care*' (EOC),[145] the '*currency*' by which Victorian alcohol

[145] Episodes of care are a contested unit: '*Most of those involved in the consultation process identified the EOC as a very 'insensitive' quality/outcome measure due to its subjectivity and variable application – other indicators of outcome/quality are seen as more important than those related to stated goal attainment. More appropriate indicators of service quality and outcome were offered by a number of consultation participants. These included: • client satisfaction • client attendance (within treatment cycles and multiple treatment cycles) • reductions in drug use • improved health status • reduced crime and enhanced legal status • improved family and social relationships •*

and drug services providers are paid. Service providers '*do not feel that the unit cost accurately reflects the level of resources required to attain an episode of care*.' (DHS 2003, p. 5) Reviewing '*episodes of care*' takes on a life of its own in the service context, as they define what *in* and *of* clienthood is serviceable and therefore payable in purchaser/provider rationalities[146].

Whilst many service sector peak-bodies have lobbied for service system integration, '*joined up*' services and a '*whole-of-government*' approach, the recent merging of the mental health and the alcohol and drug portfolios in Victoria has elicited strong responses, with VAADA seeking assurances from the government that the latter will be recognised in its own right, status and specialist knowledge (VAADA 2006e, p. 1). 'Joined-up' or integrated service systems are, therefore, not necessarily or in themselves solutions to complex social drug policy problems; they also do not necessarily relate to the different knowledges which drive sub-sectors; AOD services, mostly operating on *cognitive-behavioural* approaches, will potentially be at odds with services in other sectors, working on the basis of other assumptions, including dealing with other '*psychic dis-order*' conditions or with cognitive disabilities.

The *client-centric rationales*[147] of the individual and relational level, also reverberating at the institutional level as '*client-centred system*' (DHS 2007, p. 29), are seriously weakened by their *non-client centric rationales* and I will problematise client-centricity further in Chapter Six. Multiple discourses, practices and interests are to be accommodated and – occasionally - opposed that service integration and client-centricity represent difficult, complex and contingent processes[148]. As stated earlier, the plurality of institutional arrangements (if not forms[149]) is a

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*employment status. It was reported that these indicators are not compatible with the current EOC concept, as measurable differences in these spheres often require much more time than is allowable in order to meet episode targets in service agreements*.' (DHS 2003, p. 42)

[146] There have been public disagreements between VAADA and Turning Point, a Victorian research and treatment agency contributing to the design and evaluation of Victorian alcohol and drug policy, over what constitutes 'treatment goals' and whether they should be focused on reducing drug use (VAADA 2004, p. 11) and other service providers have found there to be a conflict of interest when a service delivery agency also does a major review of the AOD service system (VAADA 2004, p. 28).

[147] Readers of educational literature will find strong similarities to the '*learner-centred approach*' here, which, according to Usher and Edwards, is marked by cost-efficiency and adaptation strategies, whilst 'empowering' the learners by '*making decisions about their own learning, actually works to increase the efficiency of the 'learning system*'. (1994, p. 45). In fact, concentrating on the client as learner '*brings out more and more dimensions of the learner and in so doing expands the space for educational intervention and the exercise of power*.' (Usher & Edwards 1994, p. 51) Usher and Edwards argue that humanist psychology (especially the client-centred approach, inspired by the work of Carl Rogers, with the claims of providing a more humane, progressive and empowering way of working with clients) amounts to a different way of regulating people rather than a way of distributing more power (2005, p. 398-399).

[148] The more data we gather about clients, their needs and service gaps, the more likely it is that we could close these gaps with funding and planning regimes (by targeting and individualising) but at the same time we increase the governance regimes that totalise/subjectify the client even further; Foucault: '*But I'd like to underline the fact that*

*necessary result* of the function played by the institutional level: *mediating the individual and the political economic levels*.

Having established the systems of governance, service provision and coordination underpinning the Victorian AOD welfare sector, based on Jessop's definition of welfare governance, I will now briefly outline how *harm production governance* could be circumscribed. *Welfare governance* is defined in three dimensions:

> Three main forms of coordination are usually distinguished: the *anarchy* of exchange (e.g. market forces), the *hierarchy* of command (e.g. imperative coordination by the state), and the "*heterarchy*" of self-organization (e.g. networks). […] [W]elfare regimes can help to secure some of the key conditions for capital accumulation. For they are implicated in governing the economic, gender, ethnic, intergenerational (and many other) aspects of the division of labour and indeed themselves contribute to the "labour of division", that is, the classification and normalization of individuals, groups and other social forces as a basis for differential treatment in the division of labour and for social inclusion-exclusion …. (Jessop 1999, p. 351)

Applying this to *harm production through drugs*, the

***anarchy of the drug market*** influences and produces drug availability, drug use and drug '*harm*' (legal poppy production in Tasmania, alcohol outlets, pharmacies, street-based drug trade, etc.) and the ***anarchy of the service systems' quasi-market*** influences which problem representations are constituted as *legitimate* needs, with some *not legitimised* needs including current inadequacies of funding, scarcity or absences of pharmacotherapy subsidies, family-inclusive treatment services and culturally and gender-appropriate services;

***hierarchy of command*** influences legislative and regulatory frameworks, such as drug laws, drug scheduling, patents, public health, Occupational Health and Safety Acts, international treaties and conventions, taxes, excises and tariffs, health, drug and social policy (budgetary) decision making, advertising codes, voluntary, compulsory or lacking industry regulation, all working to define '*harm*' and restrict or expand *harm production*;

***heterarchy of networks*** influences who are the '*partaking and invited stakeholders*', heading organisations, giving 'evidence' to inquiries or sitting in expert committees struggling to

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*the state's power (and that's one of the reasons for its strength) is both an individualizing and a totalizing form of power*.' (2002a, p. 332)

[149] Political-economic relations can produce isomorphic organisations, however. DiMaggio & Powell argue that we can call coercive isomorphism – that is the organisations adopting equal forms or becoming homogenous – such processes in which organisations adopt similar shapes and structures to ensure their own survival due to governmental, societal (normative) or regulating pressures (1983, p. 150). Furthermore, *'[o]rganizations compete not just for resources and customers, but for political power and institutional legitimacy, for social as well as economic fitness*.' (DiMaggio & Powell 1983, p. 150) Neo-institutionalism suggests that these pressures may make organisations commit to actions that are in contradiction to their mission or their constituencies' interests.

delineate (if not expand) their impact territory and contest the objects, subjects and types of knowledge/evidence used for policy-decision making (AOD welfare sector organisations, public service management, party-political policy-makers, senior bureaucrats, lobbyists, professional and advocacy groups, peak sector and industry bodies, 'consumer groups,' etc). Networks can build up vastly different agendas and bring local Council, State and Federal policy priorities to clash, because they have heterogeneous interests and views to enforce[150].

Community service organisations are governed guided by a variety of paradigms, including rationalist and managerial approaches in combination with '*less for more*' outcome-based government funding regimes in a competitive environment which, at times, has strained relations between government and community sector(s) and led to demand of services always outstripping supply. The institution of treatment has been *pluralised*, largely due to individual and political-economic requirements of tailoring programs to the individual and ensuring socially acceptable lifestyles. Governance of community AOD welfare agencies and, particularly, the division of welfare labour Jessop referred to, are dependent on *broader drug and social policy settings*, necessitating a critical review of the *policy of harm minimisation*.

### 1.2. Harm minimisation as instituting power

Victoria's alcohol and drug sector is underpinned by a '*harm minimisation framework that focuses on minimising both individual and community harm related to problematic drug use*' and a *whole of government* approach to service provision (DHS 2004a, p. 1). Whilst Victoria firmly supports harm minimisation, the federal drug policy is far less stable[151] with regards to harm minimisation support (see Chapter Three). The definition of harm minimisation '*is not universally agreed upon*.' (Hamilton 2001, p. 105) A Victorian Inquiry attributes misunderstandings of harm minimisation to the fact that '*harm minimisation would appear to mean different things to different people*' (DCPC 2004, p. 496). Ritter and Cameron are surprised by the '*absence of a definition of harm minimisation or harm reduction*' and reason that the '*difficulty in defining harm reduction is that it refers to both a philosophical approach and specific types of programs or interventions*' (2005, p. 5). These claims are especially surprising

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[150] Zajdow detects conflicting interests within the illicit drug policy arena: '*But illicit drugs do have well-organised groups like politicians, law enforcement agencies, mass media and health and welfare professionals which have often conflicting interests to enforce*.' (2004a, p. 73)

[151] This is public knowledge since at least 2002, if not since 1997, when bipartisan support weakened (see Chapter Three): '*Since the redefinition of harm minimisation in the last National Drug Strategy, our common language has splintered. While the policy community and the system underpinning it have successfully established themselves, the policy framework is not perceived to be so stable*. ' (Fitzgerald & Sewards 2002, p. iiiv)

from a theoretical perspective: how could we expect the possibility of a clear definition or that it was indeed desirable and enforceable? Is there *any* phenomenon or policy '*universally agreed upon*'? Let us, therefore, first engage in a brief excursion into recent approaches to *policy analysis*.

### 1.2.1. Advances in policy analysis

What the above statements illustrate is a lack of theoretical sophistication in (drug) policy analysis; policies cannot be 'misunderstood', but the problem representations, course of actions, targets and methods can be contested and usually and continually are. Recent approaches to policy making and analysis can assist us by showing that they *can* be understood in more adequately complex ways.

In a *principles-based* policy analysis, we would seek to analyse *objectives* and juxtapose them with '*reality*' or '*policy implementation*'; for its operations, the Victorian Department of Human Services set itself six objectives:

> Building system capacity • building sustainable, well-managed and efficient human services. Delivering services Victorians expect • providing timely and accessible human services; and • improving human service safety and quality. Shifting our focus • promoting least intrusive human service options; and • strengthening the capacity of individuals, families and communities. Making a long-term difference • reducing inequalities in health and wellbeing. (Treasurer of the State of Victoria 2006, p. 80)

In a *principles-based* analysis, such objectives would then be further specified and brought to bear on practices, seeking to discover whether they are congruent and, if not, concluding that this is unsatisfactory. Theoretically (even epistemologically), however, this is problematic; in Chapter Two, we found that discourses are '*not all there is*' and that they do not *saturate practice*, Foucault, in fact, arguing that practices '*possess up to a point their own specific regularities, logic, strategy, self-evidence, and "reason"*' (Foucault in Chambon 1999, p. 56). Juxtaposing policy *principles* '*against*' *practices* will find only a *theoretical* incongruence, because practices and ideas/principles have their own '*logics*'.

By and large, the policy realm has until recently been considered as a '*Cartesian **space**, objective, boundless, homogeneous, isotopic, measurable, and co-ordinate*' (Goux 1990, p. 177, my emphasis), due to the dominance of *rationalist knowledge* in the field. '*Rational-choice theory*' and '*bounded rationality*' dominate understandings of individual behaviour in public policy institutions (Jones, Boushey, Workman 2006) and cost-benefit analysis is still the dominant tool of policy analysis; '*[D]espite progress in the decades since then, **paradigms for***

***practice*** *remain largely implicit and uncoordinated in the policy movement*', summarises Brunner (Bryner 2006, p. 135, my emphasis).

Considerable advances in Australian and international theorisations of policy making have been made, however, Gill and Colebatch arguing that we need to move beyond the '*policy cycle approach*' featured in influential Australian policy analysis books; they define this cycle as presenting the '*policy process as a succession of logical steps beginning with the identification of a problem, and leading to the cabinet decision for its solution, and then implementation of that decision*' (2006, p. 242). Thinking of policy making as a *process* of *identifying problems* is problematic; Bacchi identifies the importance of policy-making in the fact that it *constitutes the problem itself* in the very process that is *portrayed* as the technical and objective identification of problems for which solutions need to be found in a functionalistic-utilitarian way (1999). Instead, she suggests '*a What's the Problem? approach*' (1999, p. 20) or a '*What's The Problem (represented to be)? analysis*' (1999, p. 16), from which perspective policy identification is a *result of active and argumentative contestation* which shapes what the policy problem is (meant to be) and this *act* of '*constituting the policy problem*' discursively narrows what can be debated and, indeed, addressed in policy formation.

Bacchi's approach is well in line with *argumentative policy analysis*, which '*links post-positivist epistemology with social theory and methodology and encompasses theoretical approaches, such as discourse analysis, frame analysis, and interpretative policy analysis*' (Gottweis 2006, p. 461), illuminating how policy problems are constituted through rhetoric and argumentation. Similarly, Turnbull identifies the elements of hermeneutics, dialectic and rhetoric as central to questioning policy logic and policy politics (2005), arguing that we can improve our understanding of policy making by using '*problematology*', the philosophical approach which '*defines policy inquiry in terms of questioning rather than problem solving*' (2005, p. 227). Gill and Colebatch, Bacchi and Turnbull all view policy as a dynamic and socially constructed process and problematise the very foundations upon which policy solutions have been claimed to rest.

Until now, drug research has been very selective in who and what is being researched in terms of policy; internationally we know more about the 'hidden' drug user than the policy makers, as Berridge explains:

> […] the real 'hidden populations' are the policy-makers, the civil servants, and the members of organisations and interest groups who have a key influence on the definition of acceptable science and its policy application. They, too, should be under the qualitative microscope. (2000, p. 46-47)

In late-2005, the *Drug Policy Modelling Project* (DPMP) suggested the need to improve the evidence-base of drug policy making and cited as one of the barriers to sound decision-making *'[o]ur limited understanding of how policies are made*,' (McDonald, Bammer, Breen 2005, p. 1), an extraordinary admission of the biased interests and funding regimes in drug research after *two decades* of harm minimisation as Australia's national drug policy (Hamilton & Rumbold 2004, p. 137). Furthermore, the DPMP still treats policy as an '*elevator word*' in Ian Hacking's sense: a word that is assumed to operate on a different level (such as truth, fact, reality, etc.) (1999, p. 22), as occurring when frontline workers are only perceived to act and influence policy at the *level of implementation*[152]:

> As the policy literature makes clear, however, this pragmatic approach to setting boundaries for this study needs to be seen in the context of how policy implementation sometimes becomes policy making, e.g. when *front-line drug workers implement policy decisions* of governments or others in a manner quite different from that *intended*. (McDonald, Bammer, Breen 2005, p. 8 my emphasis)

Similarly, Hancock's view of unintended 'outcomes' of policies:

> Social construction analysis steps back from the action and analyses the underpinning value base and assumptions that guide and mediate policy work, actors and action by both government and external stakeholders. It directs attention to the *unintended consequences of policy choices* (for example, high effective marginal tax rates as a consequence of welfare to work policies) or clashes of values (when policies shown to be unfair on particular groups challenge claims to equity and fairness or when policy aims, such as empowerment of the disadvantaged, are not fulfilled). (2006, p. 49 my emphasis)

I concur with Hay's proposal that a theoretical view which assumes that '*strategic action almost always includes unintended consequences*' (Hay 2002, p. 382)[153] would be more useful and with Gill and Colebatch's suggestion that the term '*policy-worker*' may be more useful than '*policy-maker*,' implying unconstrained agency, and '*policy-implementer*,' implying persons simply acting under instructions by authorities (2006, p. 241)[154]. We are reminded here of '*street-level bureaucracy*,' a term coined by Lipsky to define frontline public service work and its

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[152] Even '*implementation analysis*' is still undecided whether it should be studying policy outputs, outcomes, performances or processes (Winter 2006, p. 163).

[153] That policies would only occasionally produce unintended 'outcomes' presumes a perfect information flow, a 'saturated' knowledge-base where all effects can be known or at least estimated in advance and a possibility of knowing how a diverse range of actors will react to and interpret the policy.

[154] In their comment, Gill and Colebatch talk here in direct reference to policy-workers as people who work in an education department of a state government. Therefore they do not talk about frontline workers' role here (either).

dilemmas (1980) and I will show later that reducing workers to *policy-implementers* denies the complexity of practice and the negotiable spaces that (still) exist in human service provision.

A post-positivist stance towards policy analysis assumes that there can be '***no*** *neutral position from which the truth of drugs can be found*' (Clemens & Feik 1999, p. 18), nor would a '*congruency and compatibility assumption*' that policies will work equally well on many or all levels be acceptable. The flawed nature of this assumption is succinctly put to rest by Zajdow:

> What has been missing has been the bleeding obvious, people's voices. They are not considered scientific, but anecdotal and they are much more difficult to include in bureaucratic outcomes report. They are also varied, contradictory and confusing. Policies need to operate for everybody, but that does not mean that the same policy will benefit everybody. It also does not mean that what looks like it works on a population level, works equally well at an individual level. This is part of the complex and contradictory mix that is drugs policy. (2004a, p. 80)

Talking about *policy practitioners* (a bureaucrat, lobbyist, Head of an agency) and *practitioners of policy* (a human service worker, a drug using client)[155] would possibly help differentiate and link the basic assumptions and preferences of these subject positions with (what could be called) their *policy habitus*[156]. Policy habitus expresses the basic policy standpoint (and preference) of an (organisational) actor, structuring the field of *policy action possibilities*. Policy habitus changes or stabilises policy action and two actors may draw completely different practice-relevant conclusions in their beliefs about harm minimisation from the same event; Fitzgerald describes how the heroin-related death of a friend's son rendered Police Commissioner Neil Comrie more supportive of progressive policing in Victoria, whilst the drug-related death of former New South Wales Premier Bob Carr's brother diminished his support for harm reduction efforts (2000, p. 313). Policy habitus not only varies over time but across agencies[157] as well,

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[155] We do not know much about either; seldom do we know exactly what conflicts, secrecy and deliberations policy practitioners engage in. We know a lot about more about drug user and workforce characteristics than about the policy preferences of the practitioners of policy. Put differently, we know about all these subject positions only as much as we care to ask about them.

[156] Policy *habitus* draws on Bourdieu's (1977) habitus and applies it to policy dynamics. The policy habitus is open to change (people learn, people change their mind, etc.) but it may also stay stable over the years. Which attitude someone takes with regards to welfare retrenchment or neo-liberalism and globalisation is of utmost importance if we are to understand the actions within social policy settings. Colin Hay makes exactly this point: '*Whether actors believe the globalisation thesis or not may be a more significant determinant of their behaviour, than whether they are right to do so. Policy makers who embrace and internalise its assumptions may well serve, in so doing, to bring about outcomes consistent with the thesis, irrespective of its veracity*.' (2002, p. 380)

[157] Paul Pierson (2000) argues that there are long-term and short-term implications on how institutions operate over time, that institutional origins and change remain little investigated (p. 475), that we need to take into account that organisations are made '*up of overlapping generations of short-lived actors*' (p. 481), that the '*relations of interdependence – among actors, organizations, and institutions – expand geometrically*' (p. 483) and that there are competitive relations between nations, states, parties and other political institutions (p. 488). He concludes that:

particularly in those from which one would expect ideological uniformity, for example, churches. David Marr finds that Melbourne's churches are sceptical about the war on drugs, whereas Sydney seems to be the warriors' home, its churches advocating for '*no safe injecting rooms, no drug trials, no talk of legalisation*.' (Marr 1999, p. 6)

One of the most instructive ways of studying and questioning how drug problems are constituted are drug budgets; at the institutional level we can detect how political-economic interests are translated into money spent in drug policy:

> The 2004/5 federal budget confirmed this: $470 million allocated to a National Illicit Drugs Campaign over 4 years, $4 million to an Alcohol Harm Reduction Strategy and *$360 million given back to wine producers in tax exemptions*. (Stockwell 2004, p. 1091, my emphasis)

Collins and Lapsley estimate Australia's 1998-9 total social costs for tobacco to be $21.1 billion, for alcohol $7.6 billion and for illicit drugs $6.1 billion; costs of loss of life is estimated for tobacco at $13.5 billion, for alcohol at $2.0 billion compared with illicit drugs at $969 million (2002, p. 59). The legal and illegal drug costs vary significantly and expose government's political-economic bias in favour of illegal drug intervention; the disproportion between spending and the burden of harm becomes apparent when exploring the actual drug policy mix in terms of spending estimates by Australian federal, state and territory governments for the period of 2002/03. The order of spending from highest to lowest is law enforcement (more than $550 million), prevention, treatment, interdiction, followed by harm reduction (roughly $55 million) and research (Moore 2005, p. 9-25)[158]. In terms of the constitution of the drug problem, law enforcement remains the dominant construction and harm reduction (being only a tenth of government spending) is marginal.

Concluding and before moving to a closer analysis of the reification of harm minimisation, it hopefully has become clear why Australian drug research still displays a poor understanding of the socio-political manufacturing of drug problems at the institutional level.

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'*Causal chains between actions and outcomes are often very long. Politics is simply a far, far murkier environment*.' (p. 489)

[158] Moore found that school-based drug education dominated prevention spending (TJ 2005, p. 9), treatment spending was dominated by drug treatment services (TJ 2005, p. 12) and harm reduction was dominated by needle and syringe programs spending (TJ 2005, p. 16).

### 1.2.2. The reification of harm minimisation

In Chapter Three, I briefly suggested that harm minimisation has been *reified* and I will now attempt to show why this may be a useful to understand Australia's national drug policy framework. Harm minimisation ***is*** nothing; we make it ***some***thing; it is a social-imaginary signification, one idea among many others about how to conceptualise and respond to drugs and their use. Although there is considerable overlap, numerous diverging definitions of harm minimisation can be found; as well, the 'idea' is often simply treated as a given and not defined at all. Rather than being concerned with definitions, at least eight *reifying moments* of the idea of harm minimisation can be discerned, allowing us to analyse the institutional dynamics with more depth; they are not discreet but should be thought of as overlapping, stabilising and destabilising dynamics:

> (1) *political program or policy goal* (party policies on drug use and 'stakeholders' positions);
> (2) *policy* (mix);
> (3) *set of knowledges, experiences and conceptual tools for thinking about drug use and drug interventions* (personal-political, communal etc)
> (4) *policy community of a vast array of stakeholders and lobby groups* (including industrial and professional (agencies), researchers, parents of 'drug users', community service and drug user organisations)
> (5) *social movement* (committed political activist, volunteers, professionals, families, bureaucrats, academics etc);
> (6) *professional discourse of engaging and working with 'drug users'* (professional and sectorial peak-bodies and organisations)
> (7) *service paradigm or set of interventions*
> (8) *an assembly of practices*.

All these moments shape how harm minimisation is instituted and interpreted; for harm to be diminishable or reducible, we contest and negotiate at the *institutional* level what could constitute 'harm' by defining and redefining it. '*Minimising harm*', however, becomes a rather fuzzy idea when looking at how treatment '*outcomes*' in the AOD sector are stipulated:

> The DHS paper titled "*Successful Outcomes of Drug Treatment Services*" indicated a range of outcome variables that may guide the development of service-specific refined treatment goals. Broadly categorised, treatment objectives include: i) reduced substance abuse; ii) reduced high risk behaviour; iii) improved physical health; iv) improved social functioning; v) improved emotional and psychological well-being. (DHS 2003, p. 54)

Does '*improved social functioning*' mean a worker having a coffee with a homeless client or is it the right to affordable (public) housing of an acceptable standard? Is '*reduced substance abuse*' smoking marijuana only five times and not seven times a week? Is '*reducing high risk behaviour*' having a better public transport net so as to have less drink-drivers or is it being able

to leave a violent partner? Treatment objectives *only* relate to individuals *receiving treatment*, they operate exclusively at the *individual level* and treatment harm definitions, therefore, automatically exclude the three other constitutive levels. Each treatment objective defines what we think and hope is *socially achievable harm minimisation in the treatment context*; it is set by government departments, no-one else.

Constant attempts at (re)defining occur of what harm minimisation can, should or should not mean *politically*. The drug policy literature, for example, occasionally equates zero-tolerance with abstinence approaches and Zajdow problematises this and detects that, whilst the last evaluation of the National Drug Strategy (NDS) saw abstinence-based approaches as part of the harm minimisation 'continuum', other authors treat zero-tolerance and abstinence as the same, as '*there is an ideological battle being fought between the forces of good (harm minimisation) and evil (abstinence/zero-tolerance)*.' (2004a, p. 77) In Chapter Four, I showed how the drug-using client is made to conform to societal expectations and how abstinence was part of such conformity. Being or becoming abstinent, however, is one of the most effective ways of resisting and escaping prohibition and treatment discourses and equating zero-tolerance with abstinence would deny all such nuances and ambiguities.

The evaluation of the NDS found that, whilst harm minimisation within the '*tripod*' of harm, supply and demand reduction has broad support, most people found the term itself confusing and misleading. (SuccessWorks 2003, p. 46) Additionally, the policy arena is plagued with competition and tension whilst at the same time trying to cooperate and form ongoing partnerships; producing clear and simple policy structures remains a challenge (SuccessWorks 2003, p. 53/4). It should come as no surprise that Trevor King finds the drug policy arena[159] ridden with conflict:

> [The division between elected and appointed officials] has never been more evident than in the area of illicit drug policy where conflict between different levels of government, between departments responsible for health and law enforcement, and between senior bureaucrats and politicians is common. (1998, p. 148)

In Chapter Six I will discuss some definitions of harm minimisation and how they are intended to '*pin it down*' and differentiate it from other approaches to drug use and I will

[159] We also know that there are tensions between the Australian National Council on Drugs (ANCD) and the Intergovernmental Committee on Drugs (IGCD) (SuccessWorks 2003, p. 63) and between the ANCD and Alcohol and other Drugs Council of Australia (ADCA) as to how the non-government sector should be represented (ADCA 2004, p. 2) and that the introduction of the ANCD was a prime ministerial attempt to influence drug policy more directly by bypassing other governmental and sectoral governance structures (Fitzgerald 2005).

problematise current critiques there. Conflict in political deliberations is as common as are conflicts in the helping culture,[160] as the Australian drug research literature – generally speaking – reduces *drug users* to having '*needs*', causing costs and (not) displaying '*help-seeking*' and/or '*drug-seeking*' behaviours; reduces *human service workers* to negotiating the service system '*for*' their clients (imparting knowledges and skills) and using the most '*effective*' strategies in their work; and reduces *policy makers* to needing to be convinced by and open to '*scientific evidence*'. This thesis suggests matters are more complex than that...

The struggle over inadequacies or absences of harm minimisation or its misunderstood status has diverted attention from the more important struggles about its ongoing reification within many socio-political contestations, including struggles about which knowledges and practices should become associated with the socio-imaginary idea of *minimising harm*. Before more squarely addressing the research question heading this chapter, I will illustrate in a short example how difficult it is to fully explain and analyse the workings of drug policy and introduce the diversity in which we have imagined clienthood with regards to establishing supervised injecting rooms in Australia.

### 1.2.3. The supervised injecting room as an example of drug policy and clienthood making

We all operate with certain assumptions and beliefs and with the experiences that have contributed to how we make sense of our world(s) and so it is for the harm minimisation discourse, itself constructed out of many overlapping and intersecting discourses. Applying our *empirical* lens to practices running under the banner of harm minimisation, we discover processes that cannot be deducted from statements of intentions, missions and principles. The attempt to establish supervised injecting rooms[161] in Australia will illustrate this complexity.

I mentioned earlier that Melbourne churches are perceived to be more 'enlightened' than their Sydney counterparts; yet, it was Sydney's UnitingCare, '*the body responsible for the social justice and community services work of the Uniting Church*' (Herbert 2004, p. 94) which came to operate the Sydney Medically Supervised Injecting Centre (MSIC) and remains Australia's first

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[160] Cohen suggested that social problems are produced in noisy (moral panics) and quiet constructions ('*claim-makers are professionals, experts or bureaucrats*'; 2002, p. xxiii). Media and other public campaigns are, however, not opposite to the quiet constructions by professions and social problem constructions are not limited to the institutional and political policy arenas of 'claim-making'. Both constructions occur simultaneously, acting on each other and equally important for drug-using clients, as they encounter both in their social relationships, directly or indirectly.

[161] The terms '*safe injecting facility*' and '*supervised injecting facility*' are sometimes used interchangeably and are both abbreviated to 'SIF'. Lyons-Lee uses 'safe' in his abbreviation (2006) but most other authors use 'supervised'. To avoid confusing further, I use 'supervised' unless it is used otherwise in a quote from a worker or other author.

successful establishment, still operating but on a trial bases dependent on the NSW Parliament's licence renewal. It '*opened on 6th May 2001*' (Herbert 2004, p. 99) after the '*Vatican's instruction to the Sisters [of Charity] forbidding the trial*' (Joseph, cited in Herbert 2004, p. 95).

Whilst Sydney successfully introduced its supervised injecting room, events in Victoria took a different turn; it is not clear, however, which actors contributed in which way to its demise although some research is available as to why that supervised injecting facility (SIF) campaign failed. There will be more than a single reason why it was not instated as a policy under the Kennett or Bracks Governments of Victoria, one study trying to find explanations for the failure:

> The Wesley controversy arguably played a large role in the outcome of the debate. (p. 22) Tim Costello certainly thought it had a lot more to do with 'some key marginal seats more than anything' (2004). Risstrom also thought that 'they [the Government] were worried about electoral implications' (2004). Risstrom also suggested that it was to do with the influence of the Commonwealth Government. He stated 'I think the Commonwealth are a problem, he [Bracks] probably felt pressure there. They [the Commonwealth] have pretty backward views (2004). As stated earlier, the Howard Government was certainly involved in drug policy debates at state level, pushing the Commonwealth agenda of zero tolerance. (Lyons-Lee 2005, p. 46)

One can only guess from a conglomerate of actors (media, government ministers, Premier, parliamentarians, Wesley Mission, etc.) and motivations (the interpretation of SIF's efficacy overseas, voting behaviour, fear of media scare campaign, lack of urgency/momentum after the previous sudden rise in heroin deaths had abated, disapproval of the measure based on reasons including preference for alternative policies, tensions between levels of government, lack of strategic skills by those advocating the SIF, lack of local government support, etc.) which one factor or combination might have had more weight in or explanatory value for the failure of this policy[162]. Blaming the media is always easy (and often right), but it can deflect attention from other actors and agencies and their motivations which are likely to at least contribute, if not cause policy proposals to '*fall from grace*'. Indeed, Lyons-Lee concludes that there is no clear

[162] Fitzgerald & Sewards (2003) provide the following rationale for the failure: They explain that savings in hospital and ambulance costs looked promising and the introduction of the SIF had public support in 1999. Yet, there was '*no scientific basis to state categorically that SIFs would save lives*' (Fitzgerald & Sewards 2003, p. 206) which could be gathered from European SIFs but the public started to demand such evidence. The lack of local government capacity to steer the policy development process and to produce evidence in favour of the SIFs (to be introduced in 5 local areas) coincided with the policy community's (various experts serving on expert council) loss of control over the evidence debate. Community mobilisations such as the 'Resident 3000 report' (influenced by Liberal party interests) and tabloid journalist and editorial efforts opposed to the SIF introduction and only two out of five local governments being supportive sealed the fate of the SIFs by parliamentary defeat of the legislation. The Labor government, initially supportive of SIFs, faced challenges and even rejection of its policy from labor electorates and had become weary of the increasingly volatile local government processes and its problematic governance (Fitzgerald & Sewards 2003).

explanation for the Victorian SIF failure (2005). Even though a '*political-economy*,' a 'public *opinion*' or a '*stigmatisation of drug users*' assumption could be seen to be quickly confirmed by the failure of this attempt at policy innovation, the details deserve scrutiny and hold valuable lessons for future endeavours and political strategies. Talking with those involved with planning or lobbying for the SIF or reading some of the academic interpretations adds up to a cautionary tale against 'ready made' answers for why drug policy proposals succeed or fail; as Fitzgerald and Sewards suggest, a much more complex picture needs to emerge (2003).

Few workers commented on the failed campaign to set up a supervised injecting facility (SIF) in Victoria; Charles, a youth residential worker, explained the failure with public opinion, misinterpretations by the media and the government not communicating the efficacy of such facilities:

> [Charles] *I guess things like the heroin injecting rooms was probably badly done by the government. I think that there's room for that sort of stuff. I'm not saying that everything they put forward was right but the way it was portrayed and everything was more or less destroyed before it had the chance to be explored, explored properly. In that sort of sense, public opinions and that can get in the way of the actual truth of what those things are trying to do. […] It was I guess misinterpreted by the media and not supported by the government in terms of portraying it as what it could have been and how it could have worked*.

A counsellor, Theda, having had other, related policy experiences, described some of the problems she encountered:

> [Theda] *I mean the whole thing about safe injecting rooms is another whole issue which to me is surprising that the community can't support… I mean I went to the one in Sydney […] and it's fantastic what they're doing there. And educating the community, the broader community around these issues I think is a much harder task than working with the client…If people could understand the benefit of a safe injecting room concept across the board… but trying to get people talking about that is so hard. The same thing goes… I was on the [name of committee] and just people's issues, the whole discussion that broken open, it's very, very hard… as soon as you talk about street workers and sex workers or people using drugs and safe injecting rooms, everyone just kind of freezes up or something. So it becomes very illogical*.

Theda refers to the very emotional reactions people have with drug policies, which, whilst not unique, still seems particularly strong. Zajdow has shown that there is significant variation in service provision among services which are known as either '*supervised/safe injecting*' or '*drug consumption*' rooms: Service rules in different countries specify exactly into which body parts clients can inject, whether they can inject other people, whether pregnant or intoxicated people can use them, which parts of the rooms can be used for which drugs and drug use method

(smoking vs. injecting) and the service rules all allow for service exclusion if necessary (Zajdow 2006b, p. 413). The Australian facility in Sydney is explicitly organised around a clinical model[163] (Zajdow 2006b, p. 414), whereas European models have contact cafes, showers, laundries and incorporated health and welfare services, sometimes even provide meals (Dolan et al. 2000) and the Melbourne project followed the latter. A cultural political-economy of treatment provision shows that countries with different institutional solidarities and welfare histories have different interpretations of the '*same*' service,[164] the different conceptions of services carrying with them different assumptions of the capabilities, sociabilities, trust-worthiness and social needs of their '*target populations*' and reflecting what is regarded as '*best practice*'[165] (often determined by professional cultures). Zajdow summarises '*the governance of the drug using subject*' in these facilities:

> They all describe the various technologies of self, designed to produce the "responsible" drug-using subject. Drug users enter the rooms as chaotic, out-of-control subjects (those who are the most problematic) in need of persuasion and education, and exit at the other end as specialists in the harm reduction techniques of safer injecting. (2006b, p. 414-415)

The drug user is transformed during the service encounter and equipped with service knowledge which applies to client conduct, clients' rights and responsibilities as well as contractual arrangements. Whether this transformation is temporarily achieved for and in the

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[163] A social justice discourse, as opposed to the medical-clinical discourse that shapes the Sydney MSIC, would highlight the composition of demographic details that MSIC clients display: 74 % are males, median age 31, 10 % Indigenous, 7 % from CALD backgrounds, 41 % of clients did not complete secondary schooling and only 9 % had entered tertiary education, less than 30 % were in part- of full-time employment and one-third were in unstable accommodation, 9 % involved in prostitution, 23 % previously incarcerated and 60 % had accessed drug treatment programs previously (Van Beek 2006, p. 24/25)

[164] A cultural political-economy can possibly account for the differences between Australian states but may not necessarily be able to explain how the different people/teams involved in the planning of such facilities affect a different approach to such facility. Sydney's MSIC (2004) operates with a '*one-way client flow system*' where clients enter from one street, use a Waiting Room and an (eligibility, statistics and medical history) Assessment Area, are then admitted to the Injecting Room (clinical booths, education and first aid, resuscitation, etc.) when they finally arrive at the After Care Area (observation and referral services) and exit onto another street. Whilst the Melbourne CBD facility (which was completed but never opened) did offer a sanitised and 'clinical' oval injecting space, its philosophy being that the injecting room was incidental to the facility itself. The facility featured a healthy food cafeteria/coffee shop, a shower, toilets, laundry and cleaning facilities, changes of clothes, a library as well as first aid and transport to bring people to detox, rehab and other services. Surfaces and edges were rounded and chairs were sourced so if people slumped when drowsy, they would not hurt themselves. There was a plan to use drug users as volunteers in the service and add massage and therapeutic services over time. This shows that two Australian approaches, one a clinical and medicalised (Sydney) and the other based on European models (Melbourne), had constructed the 'needs' of injecting drug users very differently. (Photos and personal conversation 2007)

[165] I have problematised the notion of best practice in human service work in a co-authored article (see Campbell & Webber 2005).

service encounter or whether this is '*just*' a client *performativity*[166] or both is yet to be established. For services to claim that they impart certain ('*safer use*') education and knowledges 'onto' clients does not mean that they will necessarily perform these ways of engaging in their drug use outside the service encounter, although they would be able to perform service compliant conducts again if they needed or wanted to.

Drug policy problematisations are always local, although they may be influenced by different levels of government or internationally; they are time- and place-specific, meaning that policy-making '*catches up*' with changing local constellations and social struggles which have identified and problematised a drug-related phenomenon. The division of labour in the drug welfare sector and the differentiation of interests amongst policy stakeholders (Councils, law institutes, police force, governmental departments, local action groups, the drug and alcohol sector (in a more or less consultative role), research institutions, professional associations, local businesses and churches, etc.) lead to arguments about the definition of harm, the problem and the interventions.

Returning to the research question for this chapter – '*Which practices and discourses constitute the drug user and the human service worker in the drug welfare service system and how do the workers reflect on the service system?*' – it explicates my interest in exploring the notion of the *institutional self*. The concept is borrowed from Gubrium and Holstein's work on the making of selves and post-modern troubled identities in talk shows, Alcoholic Anonymous, brief therapies, therapeutic communities, in divorce proceedings and domestic violence interactions, etc. (2000). They argue that institutions and organisational encounters provide the resources for and the constraints to achieving selves (2001). The '*self and, indeed, its very availability as a category of experience are increasingly appreciated as a sociohistorically shaped, institutionally mediated, and interactionally realized construction*' (Pollner and Stein 2000, p. 46) and it is with this insight that I will now investigate the construction of the institutional self using my interview data. Whilst this insight seemingly has not reached most Australian drug researchers, I regard the '*unpeeling*' of the making of the human service worker and the drug using client in their *institutional selves* as crucial to achieving change, particularly since we have become aware of the impossibility of escaping our own complicity[167] in drug

[166] The word 'performativity' is borrowed from Judith Butler and understood here as a social performance linguistically and/or theatrically achieved (1990, p. xxv).

[167] Usher and Edward have pointed out, that we cannot escape being more or less complicit actors: '*However, the problem is that in order to see reality differently, in order to see the grand narratives of modernity differently and tell different stories, we have to rely on the 'reality' we have created. We cannot, through an act of analytical will,*

problem constructions, because it is through the self that we construct them or their absence (see Chapter Four).

## 2. Institutional Selves

In this section, I seek to answer the research question for this chapter, first by outlining the constitution of the worker and then that of clienthood in interaction with the former, as it will – hopefully - become clear how the dyadic relationship does not allow us to conceive about and explicate just one of the parties in this relationship and that one always implicates 'the other'.

### 2.1. The creation of versed *workerhood*

The *institution of (social service) employment* shapes the way in which workerhood can be assumed; the term '*human service worker*' is, of course, an abstraction and is only useful as such, as discourses of *generalised* and *specialised* 'human service work' create not only different workerhoods but tensions between them (in their approaches, knowledge regimes, assumptions, etc.). Human service workerhood is a generalisable subject position but most workerhood is constituted around task- and service-based rationalities and particular '*skill sets*'. If and when identifying oneself or being identified as '*human service worker*,' one is governed by and can resist discourses.

In Chapter Four, it was established that the worker is predominantly constructed as a *professional* and I will, first, outline the constitution of workerhood with regards to being subject to professional duties and follow that with a discussion of two prominent dynamics present across the interviews: '*resisting*' and workers' *habitus*.

#### 2.1.1. Professional duties

The concept of *professionalism* and what it means in practice and to participants is contested; the academic literature treats professionalism in relation to human service work as an ambivalent term. Historically, tensions have existed between occupational, organisational, political and professional allegiances for front-line workers (Jones & May 1998) and

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*free ourselves with one bond. This is where the postmodern scepticism of emancipation through knowledge that uncovers 'truth' comes into play. We are always complicit in that which we struggle against*.' (1994, p. 28)

professionalism can present multiple dilemmas for human service work and for workers' positions 'between' their agencies and clients:

> Professionalism is often associated with elitism, exclusivity, monopoly on skills, and domination of consumers, and it has been argued that there is a need for new forms of professional practice that re-emphasise accountability to consumers (Weeks 1988, pp. 33-36). […] The issue of professional status thus presents social and welfare workers with a paradox. They may need to de-emphasise (or re-interpret) their professionalism in their relations with consumers, while using strategically whatever professional status they have or can muster in their relations with most other organisational participants' (Jones & May 1992, p. 291)

Professionalism can, therefore, be strategically helpful *and* unhelpful to achieve desired effects as will become clear from what interviewees associated with 'professional duties.'

#### 2.1.1.1. Knowing the problematic drug user

Workers described themselves as more or less effective when having knowledge about drug use and users; scientific-professional communities have always had a keen interest in understanding drug users and the language used by them. As early as 1928, we can find references to a scientist who is keen to develop a *psychological thesaurus* of *drug-speak* after having observed that '*the drug addict is "hooked" by "dope" talk as well as by the "dope" itself*' (Paynter 1928, p. 20). This was not just a disinterested enquiry into 'drug cultures,' but a way for professionals to gain the trust of their patients, to alienate patients or clients as little as possible and to access their most intimate thoughts without being exposed as blissfully ignorant, and, of course, survive as professionals as they could claim to 'know' the drug user:

> Tramping on the drug addict's code of honor, or even attempting to violate it will set him against the psychologist who is in ignorance of it: being ignorant of the drug addict's slang the psychologist was shut out from his intimate beliefs. (Paynter 1928, p. 20)

Knowing the *'peculiar language activities of drug addicts is perhaps the first step to be undertaken in the understanding of their well-defined though elusive and strange personalities*', urges Paynter (1928, p. 20) and till today, many publications discussing '*professional issues*' feature glossaries, the most benign exercise of staying '*up to date*'[168]. It is true that professionals

[168] For example, Dietze, Lanagan, Thornton & Gardiner state: '*Professionals need to be aware of how language influences perceptions of drug use in the community. [..] This glossary also includes the language that users employ to describe some of these terms. As such, this glossary is an important update of existing dictionaries of drug-related slang. This is significant because the street language of drugs is by no means static: it evolves along with the emergence of new drugs, new users, and new user behaviours. In order to relate well to clients, professional need to be aware of the language that clients use to describe their world*.' (2004, p. 259) The discursive construction locates

do not know what their clients are talking about if not acquainted with their vocabulary; nonetheless, it is *also* a political act of knowing or getting to know the drug user and, most importantly, be able to establish and maintain a *professional relationship* with the client[169].

Workerhood puts 'professionals' into a position of privilege - which can be abused:

> [Theda, counsellor] *I've had clients who, not only were they abused as kids but they've been abused by professionals in some way or another, some sexually some in some other way… so it's frustrating for me when I hear that people have breached that power imbalance*.

At present, it is often asserted that the binary constructions of drug users have been overcome and this is celebrated as a success:

> The simple dichotomy of the alcoholic and the social drinker or the addict and the non-drug user has been abandoned and replaced by the concept of a spectrum of use and misuse, with an array of modulating factors influencing whether harm occurs and what forms it takes. (Saunders J 2002b, p. 3)

The question remains whether by switching from addict to '*problematic user*' or to '*dependent user*' we have achieved that much; another possible interpretation is that the '*strength*' of changing from '*addict*' or from '*alcoholic*' to '*drug user*' ('addict' and 'alcoholic' being construed as derogatory terms, whilst 'drug user' thought to be neutral) consists in broadening the range of interventions. Indeed, the subject position can now be ascribed varying characteristics along the '*continuum of drug use*' and *multiple technologies* can be deployed. A further interpretation is that discrimination and stigmatisation have not stopped, nor have '*deeper*' understandings of drug use been established, simply because we use words like 'problematic' rather than 'dangerous', 'dependence' rather than 'addiction' and 'risk'/'harm' rather than 'anti-social'/'unhealthy' behaviour. The seeming neutrality of scientific discourses (and its juxtaposition with lay discourses) *is itself discursively produced*.

'*Knowing the drug user*' both enables the delivery of a service that is (potentially) meaningful to the client and the professional surveillance and control to do so '*effectively*'. Prevention, early intervention and voluntary services have a greater capacity to '*seduce*' people into *clienthood* than more interventionist and statutory services; initially, the client is a '*misfit*' to

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drug use firmly on the street [not in middle-class houses or pharmacies, pubs or offices] and the professional is juxtaposed with 'the community' and its 'perceptions'.

[169] This need to learn (the language) is in no way unique to the worker-client encounter. Any immigrant, child or person who changes jobs or encounters people from different 'lifeworlds' is confronted with the task of having to comprehend a 'new' language and become acquainted with different experiences and assumptions.

the service system (Chapter Four) and in order to attract them to assume clienthood, services need to *market themselves to the 'users'*:

> [Fiona] *So as a result of that fear they avoid using mainstream services. So the biggest challenge for an agency like [name of agency], which is a mainstream service, is to promote ourselves as a universal, family friendly service. So in the way that we conduct ourselves, we try to present not as your sort of official social worker with the language that we use… We don't call ourselves "social workers", we don't refer to the time that children spend with our caregivers as "placements", we don't even refer to ourselves as a "fostercare agency". So the message we're trying to get across to families is that we want to share the care of their children. So the philosophy of the agency is about working in partnership with parents and sharing the care of children and so we're constantly looking at this issue of engagement and try to develop trust and trying to get to a stage where drug using mums will feel okay about using [name…] and won't feel afraid to use [name…], knowing that there are nice people at [name…] who are going to treat them with respect and who are going to look after their children and the people who are going to look after their children are volunteers. They're not doing it because they want payment and nobody's going to judge them and nobody's going to treat them as though they're bad or neglectful parents when it becomes known that they have a drug problem. As an agency that we're not automatically going to notify the Department of Human Services and that if we do become aware of the fact that maybe their drug taking is overtaking their lives and that the children are suffering as a result, that we will raise these issues with them in the first instance and we will express our concerns and we will tell them that we want to help them to make sure that their children are safe*.

> [Hannah] *And it's really interesting actually, because when we were first negotiating it, the children's worker and the coordinator said that if we said 'parenting', the women would immediately feel that we were judging them and would really not attend. So we thought, well OK that hasn't actually been my experience. I think all parents want to talk about their kids. If you frame it right I reckon you can get anyone there. But I said 'oh OK then'. So what we did was we started it more as a playgroup and said it was a playgroup where you could come and talk about your kids and blah, blah. Anyway, you know, they attended every single week without any trouble at all. And they actually got into more issues around parenting than a lot of our other groups*.

Fiona, a fostercare worker and Hanna, a parenting group coordinator, offer examples of how services, workers and language are employed to adapt the style of 'service delivery' to the drug user; workers have come to understand their clients, their preferences and hesitations. Workers' knowledge of clients is always instrumental to a 'working' service system that adjusts itself in the most subtle *and* the most apparent ways to the ecology of people who potentially can assume clienthood. Services are delivered in a carefully crafted combination of *guided persuasion/coercion and client self-actualisation*.

The idea of the '*continuum of drug use*'[170] is observable in this youth drug and alcohol worker's account when asked to define what drug use is:

> [Adam] *I see it pretty broadly. I see it as basically all use of substances that give people a change in their outlook, the chemical substances that give them a change in their perception and outlook. Everything from a cigarette through to LSD and through to ecstasy and heroin and back down to benzodiazepams, alcohol, is what I think is drug use. […] Yeah, it could be mind altering, in cigarettes, it could be just blood alcohol changing, it's fairly subtle, people don't talk about the mind altering behaviour of smoking cigarettes but it is. I mean some elements of food like mushrooms, magic mushrooms in particular*.

Workers who had received some drug and alcohol training were more likely to view a range of substances as 'drugs'. The 'from/to continuum' and 'back down' always implies that cigarettes/alcohol/medications (legal drugs) are at the '*low end*' of drug use, whereas illegal drugs are at the '*high end*' (even though legal drugs are at the '*high end*' of harms/death). Many workers also identified drug use *rituals* and *lifestyles* as being significant for their clients:

> [Theda] *I do know that there are programs where they take people who have, not while they're drug using, but once they've recovered, they take them like abseiling or something thrilling. Often people who love, as I said, that rush, that thrill, excitement… and often with that drug use goes a street life which is very exciting… you're on the run, you're scoring, it's all hype… so there's an addiction, not only to the drugs, but to the lifestyle and people often talk about that [...] there's also that common thing is an addiction to the needle going in which is why, say with methadone, it's always taken orally to try and break the addiction to the injecting as well*.

Theda, a counsellor, describes here the human/non-human relationship between a person and the needle; 'habits' are not just broken with a substance but with physical and emotional objects, drug users being portrayed as living in a physical and emotional world of (past) '*drug effects*' and associated '*lifestyle patterns*' which will have to be provided *in other outlets/ forms* to the drug user after recovery. They are portrayed as '*hooked*' on particular feelings, the *drug-seeking* discourse coexisting with the *feeling-seeking* discourse. Feelings are not just something

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[170] The classificatory discourses of non-use to addictive/compulsive use are a readily available resource for people to place their (non)identities along the continuum. For example, I could not say I am a teetotaller unless it was in juxtaposition to some other form of use. Our position on the continuum is also judged by the governing discourses of 'social functioning', 'health', 'capacity to act rationally', attending agencies (rehab. programs, workplaces, hospitals) etc. In short, they enforce what is seen as socially 'productive' time spent. Most workers identified drug use as some sort of continuum, meaning that 'stages' within this continuum are thought of as 'windows of opportunities', drug use can be prevented or intervened 'into' but for most workers the question was not whether to intervene (unless it was or they regarded it to be not part of their job) but *when* to intervene and *how*. The continuum is also prevalent in thinking about policy tools, education and prevention where 'early' and 'late' interventions are forms of governance of the drug user. All prevention is already an intervention, socio-politically or otherwise and clienthood has become thinkable along a continuum: '*from*' drug education, detox, rehab, court-ordered, '*to*' involuntary treatment).

workers need to be able to read and relate to '*in*' their clients if they are to be '*effective professionals*', they are also what the '*reflective practitioner-in-and-on-action*' (Schön 1983) needs to be aware of and able to cope with. Professional duty comprises not only knowing the drug user but knowing *yourself* (professionally) as a *worker* and feeling as a worker (identifying with a given task, status, etc.).

#### 2.1.1.2. The professional as (balanced) emotional worker

One central finding emerging from the interviews was the *emotional* work that workerhood demanded and implied, particularly in workers' descriptions of their interactions and feelings when working with drug users:

> [Roslyn] *With drug using clients you're aware from day one that they may die of an overdose or whatever and that has happened to me more than once. So there is an awareness of that, therefore I think you tend to put a boundary up and I don't think that's a bad thing in itself, we need to have that, but I sometimes wonder whether one does that subconsciously [...] I wonder whether there is, well there's an inevitability that this particular person is really on the path to self-destruct and the frustration of not being able to really do much about that. It's a frustration more than anything that here you have a valuable human being that no matter what path we take we don't seem to be able to just click that magic moment when something changes. It's probably a mixture of frustration, a mixture of the value of our client and just feeling what else can we do, where else can we go for this person… I think maybe it was in the early years for me, I can remember getting to work at times, and I'm going back to when I was in the correctional setting, that there were times when I would just be so angry because I couldn't get what I needed for this person and of course sometimes down the track they were found dead and I guess it's the same with anyone that passes on for whatever reason, it's 'if onlys' or 'what ifs'. [...] it's a philosophical thing that there are a lot of marginalised people in our society, in our system, our system doesn't help them and those who can get on with the job and do it*.

In this family worker's account, frustration and anger are not simply related to drug users but also to a '*system*' that does not help them; Roslyn expresses a sense of powerlessness to make a difference in clients' lives, particularly pronounced when the dangers of drug use, such as overdose, are present. Other workers, by contrast, expected clients to get a '*handle on their drug problems*', like Karl, a worker with the homeless:

> [Karl] *I'm not comfortable in handing money fist over fist when I know it's going to go in their arm or down their throat. I talk to them like I talk to anyone, try and explain to them that until you get a bit of a handle on your drug problems and your drug issues, coming back here for a handout each week isn't going to be a solution and I suggest that they have to find other solutions before they come back for more money. I'll suggest that if they're not doing a detox or a D & A program of some description, that if they come to me with the exact same request I will have to say no. They accept that usually*.

Karl is concerned that clients will 'use the system' to support drug habits and uses emotive '*tabloid newspaper*' language to make his point: '*it's going to go in their arms or down their throats*'. Drug use is portrayed as somewhat dehumanising, not a practice but a compulsion of the physical body and until their '*free will*' is exercised, workers can and should reasonably hold back support, according to Karl, who portrayed his saying '*no*' as *emotional strength* compared to other workers. Yet, others objected to certain workers' '*patronising*' conduct; saying 'no' was interpreted as not appreciating the complexities of someone else's experiences by this youth worker:

> [Isaac] *People that I work with have talked about other workers, other human service workers that they've had contact with that have been really inappropriate and insensitive to their experience. […] Well I guess offering suggestions and strategies for change which are fairly patronising to the complexity of someone's experiences, that whole 'just say no', demand reduction stuff, people find really offensive and patronising because there's a lack of understanding about why they might be using drugs in the first place. The level of anxiety and internal pain that they may be experiencing that the drugs are really serving a purpose for and sometimes they really work. They can, short term, while they're intoxicated make people forget, feel better*.

For Isaac, saying '*no*' related to the anti-drug messages which prevail in drug education; he belongs to a group of interviewees that saw drug use as perhaps not a long-term solution but rather as a strategy which clients used to deal with and even address their problems short-term and, therefore, regarded drug use as somewhat functional. Giving clients credit for trying to address a problem was worthwhile and respectful towards their experiences.

Workers had disagreements over the most appropriate way of responding to drug use and the strategies to deploy in working with drug users and many warned that the workers' '*self*' can become jaded or exhausted, also described as '*burn-out*'. Workerhood demands employing technologies of taking '*care of the self*' to stay the course:

> [Vera] *I just love it. It is a passion for me. Sometimes I get in my car and go 'I'm never going back to that hell-hole again'. I've had a shit day, but you just work through it. And even like the majority of workers that hang out for their holidays because you do, you run at a certain level, especially in crisis accom[modation], residential is a lot more intense than outreach work… and sometimes four weeks a year just doesn't cop it with your holidays. You have to learn really quickly how to look after yourself outside of work. [...] to have a balanced life, like it's really difficult to do that too sometimes because sometimes you get home and you're stuffed, you're so stressed and you're tired because it's been a full-on day or you've been yelled at all day or you've had to evict people… It can be a nightmare working here sometimes and you go home and you might have something social planned but you just don't have the energy to do it so you cancel it.*

> *You've got to be careful that doesn't become a pattern so that you just live for your work and it's very tricky because I think it can happen very quickly. I think a lot of people burn out in the field and continue working in it even though they don't have it anymore. They don't have the patience to work with people with needs*.

Vera, a domestic violence worker, describes the pitfalls of workerhood and the special requirements of workers to be emotionally balanced, look after themselves and continue to be patient in working with '*people with needs*'. The worker, with his/her personal attributes, is utilising her/himself to become an efficient human service worker by 'exploiting' his/her emotional and social skills to relate to clients; at the same time, workers are always to be able to divorce themselves from their personal preferences, particularly when faced with *institutional expectations* about their work:

> The humanist demand that one deciphers oneself in terms of the authenticity of one's actions runs up against the political and institutional demand that one abides by the collective responsibility of organizational decision making even when one is personally opposed to it. (Rose 1998, p. 35)

Such tensions were particularly noticeable when workers talked about the contradictions between professional and communal approaches to and professional and governmental/bureaucratic expectations of their work.

#### 2.1.1.3. Negotiating the 'catch 22' situations

Whilst the worker is commonly constructed as task-based and -focused, *workerhood* is not *only* obliged to fulfil the tasks that job or program descriptions outline; the notion of *institutional selves* can illustrate one of the central findings emerging from the interviews, i.e. the *tensions* workers experienced between what they considered effective help and support and the projections and actions of co-workers, governments, the media and, particularly, the 'wider community' on how this help should be delivered and/or curtailed. The workers' use of the phrase '*catch-22*' demonstrates the discrepancy and ambiguity that has arisen between workers' '*coal-face*' assessment of what clients need and other expectations they were confronted with. Fred, a bail advocacy worker, found government *funding* did not amount to government *support*:

> [Fred] *Support our work? That's a hard one. I don't see any government policies that support our work. That's a bit of a catch 22 really, isn't it? We're funded by the government. If they knew half the stuff I did I'd probably be the first one they put in jail! They support in a way, because they fund the programs but I don't think government policies in general support, really support*.

Fred's identifying the difference between receiving government funding and support was shared by many workers; most found that, whilst government rhetoric sometimes acknowledged the need for action, budgets were generally unsupportive of their work and funding came with too many strings attached. Many also expressed doubts that governments understand the complexity of their clients' lives in any depth.

Interestingly and in contrast, the majority felt *supported* by their employing *agency* as much as they felt *unsupported* by the *government* (and its policies); clearly, workers' *institutional selves* were in conflict with the *service system as a whole*, but not with their employing agencies. They regarded the latter as being subjected to the same pressures of resources they experienced and lack of governmental will to make a difference for their clients, placing the blame for failures, inadequacies and lack of commitment squarely on the government, its funding decisions and policy directions. Here are just some of their comments:

> [Roslyn, family support worker] *Government policy is supportive of our work, but government budgets are not supportive of our work. We're very, very poorly resourced, we're very understaffed.*
> [Nora, family support worker] *I don't think a lot of the people who make the policies sort of understand the depths of a lot of the issues that people have. And a big problem is the waiting list to get people into resources, most agencies, including ours, have huge waiting lists. It can take months for people to access services that they require and I believe that's a result of government policy.*
> [Olga, family intake worker] *There're not enough resources for us to actually do our work effectively and we're always needing to meet expectations of government departments so we have to have so many bums on seats that month to actually justify our funding. It doesn't take into account that we're actually over-performing in terms of what we're meant to have but we can't actually build relationships or do good work with the clients. And each budget, the budget comes out and there's hardly ever anything about families or welfare or young people, it's always about what's going to get votes, so it's pretty frustrating really.*
> [Hannah, parenting educator]*...a drug paper that was released not all that long ago and Bracks didn't even go to it. He said he had two other more important things on that day and I think that is complete and utter crap. He probably did have things that he thought were more important, that's exactly right. But I just don't think he's prepared to accept that it's an issue in Victoria and Australia and the world and really do a lot about it*.

Without making it explicit therefore, the *institutional selves* that workers had adopted were *not* to expect their agencies to perform or operate in any other way, but the government *was* expected to, accepting the idea that agencies do 'what they are told to' and that there is not much

they can do about that[171]. The only time employing agencies were more critically assessed in the interviews was when workers talked about their access to training, professional development and external supervision.

For *workerhood*, service systems create a huge challenge in themselves, a fact continually problematised by the workers. Isaac, working in a multidisciplinary youth team, described the task as *negotiating with different parties*:

> [Isaac] *In this particular job, probably negotiating the many different players, the case management role, well it seems you're often juggling a lot of different priorities, a lot of different perspectives from protective concerns to the child's family to fellow workers and colleagues to juvenile justice. There're always different players involved and then trying to marry some of those perspectives is a bit of a challenge sometimes and mediate them, try and make sense of them*.

Youth residential worker, Angela, used the phrase 'catch-22' in relation to community expectations:

> [Angela] *I'd say it puts us a bit in a catch-22 situation because we try to do right by the kids but it's not always right by the community, or as they'd like to see things because we work under a harm minimisation policy which, I feel, is the most effective for the kids, which is probably why I still work with the agency that I'm working for. But the community doesn't always see it that way and that was obvious when the chroming scandal come out and hit the papers and everything. [I was] pretty angry because it was sort of like ... people have no idea, absolutely no idea yet they're so prepared to say that we're doing the wrong thing. But yet if they put themselves in the same situation I'd like to see them do better [pause] I don't see how they could do anything any better*.

Angela defends and justifies her work whilst describing her reaction to the tabloid affair, sparked by a human service worker, leaking information about supervised inhalant use in a youth residential care facility at Berry Street in 2002. A government minister lost her post over the '*scandal*', making Angela angry; however, she seemed to conflate government and media reactions to supervised chroming with communal expectations. She was one of many workers commenting on being poles apart from bureaucrats', government and communal expectations of how young people's inhalant (or volatile substance) use should be managed. Angela, like other

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[171] These findings are congruent with what neo-institutionalism claims: in doubt, institutions follow what is expected of them or what they are pressured into doing by external forces (rather than following the experiences and expectations of internal actors or the tasks they were set up to deliver) to ensure their survival/viability: '*…DiMaggio and Powell (ch. 3) both argue that organizations adopt practices or structures mandated by their environment, even when these elements are poorly suited for the task at hand. The reason for this conformity to external demands, however, is to ensure organizational survival, because these external agents are typically suppliers of key resources. […] DiMaggio and Powell contend that organizations are rewarded for being similar to other organizations in their fields because it makes it easier to conduct exchanges, to attract personnel, to maintain a good reputation, and to be eligible for contracts and grants*.' (Powell 1991, p. 190)

workers, felt betrayed by the government's decision not to back the agency's supervision practice; bureaucrats are *clueless*:

> [Angela] *I think it makes our lives harder; it makes life hard for the kids. I mean, I can understand some of the things they do but… I just don't think they give us enough credit for what we do do. Because I mean they'll all sit there up in their happy little offices and say "well we should do this and we should do that" and yet they've just got no idea what we're actually dealing with, no idea at all. Yeah, that kind of annoys me*.

A few workers explicitly problematised their co-workers' attitudes and how they disadvantaged their clients; a particularly prominent illustration of clashes between *institutional selves of workerhood* and *workers' selves* was the supervised chroming incident mentioned before. Adam, working in a multidisciplinary youth service, was most concerned about what happened at that time:

> [Adam] *That was one of the dilemmas, it pretty well polarised a lot of people. It polarised even agencies. We had criticism directly after the media announcement that we were supervising drug using on the premises. We had other agencies who were religious- based come out also disagreeing with our methods without really understanding them. And then inside our organisation of course there were workers even in our own residential units also had beefs about… that we would allow that, and didn't quite understand the harm minimisation elements involved …they had more personal problems with what they were seeing and they want simple solutions. I mean a lot of our residential workers when they see a client chroming they want us to lock him up. They just want that solved. They don't realise that by locking someone up, you really breed a lot worse kind of outcome. It did polarise people into their value-base about no drug use is best. … What's a normal level of drug use? What level of experimentation is normal for teenagers? And that's taken a long time to settle down. I mean I do understand some people like when they see a 12, 13-year-old kind of going for drugs as a way out, the temptation is to physically restrain them but you can't do that forever and what benefits are you getting from it when you are doing it? Now we do do it when we believe they're in extreme danger but in fact it can be abused. We've seen it being abused by multiple lock-ups of clients who chose to take inhalants. I had no impact when I constantly complained and they thought that by multiple lock-ups they could actually change their behaviour. It's actually got human rights issues attached to it. I was appalled but it's been done. People are fairly good about harm minimisation in relation to adults but it challenged people in relation to harm minimisation among teenagers and younger people. They thought parental authority or state authority could tell young people what to do*.

This demonstrates that harm minimisation discourse not just co-exists but is confronted with all sorts of other discourses, from authoritarianism to human rights. Harm minimisation discourse is *institutionally* and *personally* interpreted and assembled by workers with a variety of practices and rationalities. Harm minimisation practices, such as supervised drug use, co-exist with a variety of other practices, such as lock-ups, and their combination generates its own

conflicts. When workers query drug use based on *age* (this '*ageism*' finds (problematic) drug use by older people less 'objectionable' than that by younger people), harm minimisation discourse is modified by workers' locating of '*their value base*'.

### 2.1.2. Resisting pressures

Whilst most workers '*resisted*' in one way or another what they were meant to do with or about clients, resistance took very different forms, from knowing what to say to get a client accepted into a different service or program, encouraging clients to talk to the local member (of parliament), trying to maximise client's rights and entitlements or simply defending them, to downright disobedience. One counsellor refused to accept the logic of high client turn-over and time limits:

> [Kirsty] *When I was hired here, the general rule in the organisation was that you were supposed to see clients for six sessions and then maybe a few more if necessary and unless there were exceptional circumstances, you were really basically supposed to do brief counselling and stick them out through the door and have another one through. So the statistics look good if you've got lots and lots. I said in my interview I was not prepared to work that way. I need to see a client for two to three years. I would see them for two or three years and if they didn't want me as a counsellor then they didn't have to have me. I'm old enough and experienced enough to be able to say that. Many people wouldn't be able to say that. I have a very supportive boss who happens to agree with me and she will take the chop for me. In fact, in this organisation, there are a number of counsellors who see clients long term. I refuse to see clients short term and that's what they want. I just refuse. So the pressure on the organisation from government to push through the numbers is appalling. In my opinion, it does not solve the problem long term – you just see the same clients coming round and back.*

Kirsty explained her principled refusal to see clients for short-term counselling, particularly for drug users, because she regarded them as long-term clients; her age and experience supported her in this, making her less vulnerable to unrealistic work conditions and expectations. Resisting can take on other forms when it comes to systemic failures: 'child protection' and its resulting placements, according to Uma, a family and personal support worker, have become so abusive to children and their families that she was very reluctant to send any of her clients into a system, where abuse in the home can be traded for abuse by the state/carers. She had to make a dreadful '*choice*':

> [Uma] *Then it becomes a referral thing for Child Protection and before you know it they've gone into fostercare and they're being abused in fostercare so then you've now got the same problem at the other end of the scale. You've got them at the home where they're supposed to be protected, you've got them in the Commonwealth where they're supposed to be protected. Neither's happening. Then you have to have education to the*

*child about what's good and what's not. So that's missing. So sometimes you just have to play the system so as they don't go to the Department of Human Services, because in the past they've been there and were abused. So you might say I don't want to know, don't tell me. If you don't want me to act on it, don't tell me. At the end of the day, if you've got a feeling and people are at risk you need to do the right thing and you need to fill out your forms. That's the way it is, you just have to do it. I'm not here to sail on my boat, I'm here to help clients. That's what I have to remember all the time*.

Uma explains what positions workers find themselves in when they can '*choose*' between locations of abuse, rather than for the absence of abuse. Her option was to tell her clients to make a choice about whether or not she *should be told*; resistance here is both *passive* - as the worker cannot really do much about the failures of the service system - and *active* - she can tell clients about its shortcomings and the dangers of using it. The way services are now administered leaves workers with the following '*rationale*' when trying to 'refer' their clients:

> [Roslyn, family support worker] *I would be ringing, contacting people that I know in the system to see whether we can get some special consideration here. That's different to bending rules, it's just using contacts and I mean some would say, well that's not fair, but for me that's the name of the game, that's what it's like now. The more risk factors the better. So it's not a case of just hiding the facts, it's a case of saying look, we have an enormous lot of risk factors here and this just has to be addressed. [...] In fact that seems to be what is asked: if you want some action I usually get asked that, well look the more issues the better, and there usually are plenty of issues with our people*.

Social services thus seem to prioritise potential clients with the most/highest risk factors, whilst – contradictorily - also choosing to select people who are easily serviceable, or 'creaming off,' as it is known; few workers also recounted that certain resources only became available once the level of intervention was increased. Workers who wanted access to more resources for their clients as a *preventative* measure sometimes had to *increase* interventions-levels by the service system to make them available. '*Social actors as active exploiters of institutional contradictions*' (Seo & Creed 2005, p. 236) seems a fruitful way to characterise workers' search for places and spaces to resist dominant understandings and framings of drug and social (service) problems, *helping the client* being paramount for Uma and for most workers. Exactly what 'help' means, however, differs from worker to worker, often to be explained by differences between a *generalised* and a *specialised* human service worker *habitus*.

### 2.1.3. The workerhood *habitus*

In Chapter Three, I discussed Bourdieu's notion of the *habitus*[172] as allowing us *to think* the *transition* between the relational and the institutional level; it is useful to demonstrate which kinds of '*field effects*' on workerhood we can observe. The *generalised* habitus I found in my interviews is as follows:

- workers are '*people people*';
- they are '*anti text book*' and '*anti-red tape*';
- they prefer '*mini-theories*' that '*theorise*' engagement and (motivational) change,
- they treat clients as '*experts of their lives*' (a technique rendering clients governable and reflecting the real learning workers do about a client's lifeworld, because of their social distance to clients);
- they pretend the *non-existence of a class habitus* or at least try to make the class habitus shrink (by being non-judgemental, not mentioning their (overseas) holidays, houses, cars to '*facilitate engagement*', employing '*narrative*' techniques that build on client's stories and preferences);
- they adhere to '*professional boundaries*' as much as possible;
- they have either a rudimentary or an '*experience-based*' social justice/community development commitment (the older the worker, the stronger that commitment).

The ideal *worker* is an *information gatherer* who is rendering the client *governable*, showing genuine interest in clients' lifeworlds and '*colonising*' it for the sake of relating to the client and gaining influence. S/he modifies and tailors approaches and treatment according to the client with '*fluid*' professional tools, cares (but not too much) about clients, effectively judges their stories and desert. S/he delivers a diagnosis or plan and distributes resources faithfully as intended by the (welfare) state and program design, '*takes the crap from the clients*', establishing an emotional buffer-zone for the '*disaffected*' and '*marginalised*' and reins in their emotions whilst presenting the client to the 'outside' world as deserving of a 'break' or willing to better their situation of their own free will. S/he temporarily suspends atomised social relations during '*episodes of care*'/service provision, without establishing dependencies or making clients '*too*' knowledgeable about the welfare system. S/he has a *resilience* to go through the ups and downs with clients and is reflective about work practices. Workers need to become *well-versed in the service system*: flexible, knowledgeable, adaptable, accountable, efficient, committed and ethical.

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[172] Bourdieu illustrates how society is '*lived through*' the socialised body: '*The self-evidence of biological individuation prevents people from seeing that society exists in two inseparable forms: on the one hand, institutions that may take the form of physical things, monuments, books, instruments, etc. and, on the other side, acquired dispositions, the durable ways of being or doing that are incorporated in bodies (and which I call* habitus*). The socialized body (what is called the individual or the person) is not opposed to society; it is one of its forms of existence.*' (Bourdieu 1993, p. 15 his emphasis)

The worker is meant to '*discover the therapist in him/herself*' and subscribe to dominant discourses about client transformation whilst exhibiting loyalty to the agency (employer), pledging allegiance to the welfare state and law and order, identifying and supporting his/her profession (against others) and not questioning organisational policies (duty of care, debriefing, (external) supervision, etc.). Various institutions, in particular the delivering of training, education and professional development with a life-long learning undercurrent, create a *versed workerhood*, ready to take on whatever task they are given with strategic sophistication, refinement and emotional investment. Workerhood requires a commitment to be the '*punching bag*' for their clients, the defender of the status-quo, the skilled '*underminer*' of the institutional logic and whatever else is required by policies, the agency, the law, the statutory requirements and the client's and worker's quest for understanding and authenticity in the service encounter.

*Workerhood* thus seems predominantly constructed in terms of *professional conduct* but requiring *knowing* the drug user, being able to *emotionally accommodate* clients', organisation's and service system requirements and *negotiating* 'catch-22 positions' between all of them, often using discretionary and resisting practices, built on a common *workerhood habitus* that strengthens their resolve to '*work for the client*'.

Workerhood is a very *vexed* subject position, located at the intersection of the wills of government, civil society, the service agency (employer) and the client – not forgetting the interfering demands of 'private' life. This location is ridden with discursive contradictions and persons assuming workerhood need to activate their own governing capabilities to be fit for service. Individual and collective dimensions of workerhood, however, muddy the waters and render service system '*outcomes*' much more *contingent* than bureaucratic measures could ever capture or pretend to know. The dilemmas between personal and institutional preferences also express themselves in conflicts between workers and their institutional selves and it is the more or less immediate *feeling of wanting to make a difference* that keeps many workers at work in a service system that forces them into compromises and a more deep-seated complicity.

## 2.2. Diagnostically achieving and selecting for genuine clienthood

I will now elaborate the constitution of clienthood by workers, first, analysing the *diagnostic achievement of clienthood*, second, debating *addiction* as an *institution* prevalent in workers' accounts of clienthood and, third, highlighting how, according to the workers, the service system constitutes clienthood.

Many workers were reluctant to generalise about '*drug users*;' recognising that this can be dangerous, most nevertheless had descriptions, generalisations and classificatory ways of evoking '*drug using clients*':

> [Fred] *There's no such thing as an average client because they've all got their excuses and they've all got their crutch that they resort to as an excuse. For some people it's quite genuine, for others it is just an excuse, and there's a lot out there that just refuse to take responsibility and just think well, it's the easy way out… then again you've got the fair dinkum crim who is going to be a career criminal who will make no excuses about it whatsoever, this is what I do… so they're all quite different…. The ones who are victims, the ones who are victims of their own doing and the ones that really don't give a shit and as I say they're career crims. But even them, they are all different too, there's no standard sort who you could generalise but that's a dangerous thing too*.

Employed in a bail advocacy program, Fred had worked out how to identify where he could most make a difference and detect those whose lives he could '*turn around*' ('*trigger change*'). In his account, '*the career criminal*' and '*the victim*' are exclusive positions with no overlap between them. His task became one of '*efficiency*,' detect the '*genuine*' cases, motivate those clients and get them referred to other services. The role played by assessment, diagnosis and selection in constituting clienthood will be examined in the next section.

### 2.2.1. Diagnosing and assessing clienthood

Just how assessment and screening tools are elementary to the operation of the service system is obvious by the sheer mountains of treatment literature; without diagnosis or treatment plan, no action can take place which is why arriving at a '*label*' or assessment is the first step to establishing clienthood. Once accomplished, action on the 'drug user' (or any other *categorisable* person) is possible.

The workers insisted that telling clients they were 'drug users' is '*counterproductive to their engagement*' with them; whilst labels *are* used to assess and intervene, they should not be invoked or talked about in client encounters as they should 'choose' how they would like to view and name their own condition[173]. Client labels are primarily useful for accountability and audit-ability of community service agencies and are essential for treatment and intervention *measures*,

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[173] Usher & Edwards, who draw on Foucault's work, describe this storying of the self as '*confessional*' practices: '*It has become central in the governance of modern society, where externally imposed discipline has given way to the self-discipline of an autonomous subjectivity. […] Here, the purpose of confession shifts from one of salvation to that of self-regulation, self-improvement and self-development. In other words, confession actively mobilises a productive and autonomous subject but one who is* ***already*** *governed and in this way there is no requirement for externally imposed discipline and regulation*.' (Usher & Edwards 2005, p. 400)

but they are often useless for the (initial) client encounter where they are always more diffused and '*smudged*', turned into '*appropriate*' words, phrases and 'respectful' suggestions. In other words, labels are *watered down* into '*digestible*' units of pathology and *social deficits*, addressing *and* legitimising clients' '*issues*'. The label '*works*' when the client has 'accepted' his/her condition and can now use it to gain acceptance, lobby against stigmatisation and be *deserving* of (labelled) help associated with the (diagnostic) label. Whether the latter is a 'diagnosis', 'disease'/'disorder', a 'need', a 'right' or a diffuse 'issue' depends on which discourses are at play or utilised[174]. Clara, a youth residential service worker, objected to the *fancifulness* of labels.

> [Clara] *I'm talking about our clients who are with us because of underlying issues and family related issues, disorders of some kind, and if they're not using drugs it's going to come out in another way. Maybe we'll label young people ADHD, autistic or this or that... we've all got these fancy labels for kids. There's always underlying issues for young people there and I think the breakdown, it always goes back to the family unit: the breakdown of that family unit and the structure of the family unit*.

The utility of labels is that they can never fail to diagnose; when one behaviour/practice is non-classifiable, it simply proves the diagnosis by providing an a-typical example of something typical and/or the non-classifiability leads to the creation of new labels, which is why assessment discourses and screening tools are forever updated and technologies 'improved' (witness the 'mother of all' diagnostic kitbags, the DSM4; see note 50). For quite a few interviewees, '*specialised*' diagnosis, labels or categories did not mean much, because these workers were 'working on *the social*,' where *relationships* matter and for them, specialist knowledge is only part of the 'puzzle' of trying to make sense of their clients. For a few experienced workers, assessment knowledges posed a real dilemma:

> [Cora] *I actually think it's really important to know that we can have our professional opinions and our professional judgements and they can be based on extensive experience and we can always be wrong. I actually think within the drug and alcohol sector and I actually think it's also happening within the homelessness sector, there is a pre-occupation with assessment, and I actually think that the helping field in general draws too much of a link between 'if you do a thorough assessment' – which in fact really is about information gathering – 'if you do a thorough assessment then you will be able to work out an effective treatment plan for the client to follow'. I think that's naïve. [..] Because I think one can't always predict the future. People are individuals. People change. I think the risk of that is a medicalising of a human condition. […] [Assessment] is over-professionalised. […] I often make a bit of a tongue in cheek joke about this*

[174] The *family* is the ultimate institution to call into question if labels do not suffice to explain a 'condition,' because almost every client has one and all families and human relationships are problematic, or at least potentially so in some regard. The family, by individualising its members or problematising particular kinds of family relationships, can be made accountable, particularly in absentia.

*place... 'let's get a great assessment worked out, a great plan, the only thing is the client buggered it up because they didn't follow the plan*'.

Working with the homeless, Cora was the most critical of assessment technologies, disavowing the supposed professional sophistication of information gathering and trying to raise workers' awareness of the deployment of assessment logic in service institutions. Assessment logics responsibilise the client and his/her actions and efface the workers' deployment of professional knowledge and the service system design from its discourse. She was, however, not the only one who thought professional tools are somewhat vulnerable to 'real life' situations and complexities. Adam, working in a multi-disciplinary team, saw professional tools 'flying out the window' when clients are intoxicated:

> [Adam] *I would use some of those professional tools that I'm aware of. But then we are dealing with young people in very vulnerable positions, so it goes sometimes a bit beyond that… sometimes it's a bit more personal and empathy has to come into play, and I guess that's the area that one needs to be a bit more careful about. There are tools that I can minimise my more kind of personal involvement. I can be a bit more professional and solution-focused in relation to the dilemmas of the clients that we've got. But as I say when they're highly intoxicated they tend to go out the window, the professional tools* [laughs].

Clienthood is almost always discursively and institutionally *pre-figured*: it is conceived of and made *before* the future client enters into contact with the service. Whilst there is scope to 'adjust' to a client in the choice of technologies used to change the his/her perceptions, hardly any service has the ability to configure the client position outside pre-formulated parameters, service designs, job descriptions, etc. There are few technologies (such as *brokerage funding*) constituting clienthood *after* the person has become a client, which is why *referrals* are common in the service system, the only difficulty being the '*appropriate channelling*' or matching of the '*right*' drug user with the '*right*' service system '*clienthood factory*'. This is where the *specific power/knowledge nexus* of the human service worker and the drug user comes into play: they are doing the matching, together! There are no 'wrong' *fact*-ories, only wrong matches; in the service encounter, the question is not *whether* but *how* to treat a client, the challenge being *how* to 'make' clients 'opportunity maximisers' in '*socially acceptable ways*'.

This 'making' relies on *knowing* the drug user, as I established earlier; the *pin down* metaphor, describing the elusiveness of the drug user was explicitly used by a worker, Henry, when trying to depict what 'makes' someone a '*drug using client*':

> [Henry] *I think initially people who use drugs if you look into their family background and history you'll find that they had a very sort of probably rough upbringing, their background could be slightly different, maybe they had a sort of broken home situation, they didn't experience stable parenting, maybe their parents were drug users, maybe they didn't have sort of adequate social networks, they were very sort of isolated, that's my experience having been working with drug users and they seem to be unhappy in general, they seem to be living in isolation away from their friends and families, minimum contact with their family, not very good relationship with their own family and they may become unpredictable and sort of have this way of going up and down all the time and you can never pin them down*.

A fostercare worker, Henry projects the (stereo)typical drug-use career: a state of limbo and unpredictability[175], social disadvantage, broken home and 'the roller-coaster rides' of dependent drug use. Without debating the veracity or their 'truth,' how can such discursive constructions of the drug user be achieved? There is always a '*range of factors*' that make the drug user thinkable, the 'social blueprint' this worker juxtaposes the drug-user with being the non-nomadic, Western, industrialised, urban living condition, the nuclear family providing 'biopsychosocial' stability and predictable life-patterns of education and employment. For decades, precisely such descriptions served as the basis of social interventions on *individual* and *relational* levels, interventions, however, which were also formed at the *political-economic* level, focusing on making the individual *accountable, predictable and responsible*, without focusing on helping and improving living conditions of people with insufficient income and alleviating social harms. Henry's depiction of the drug-using client is closely associated with one of the workers' strongest identifications of problematic drug use: the *addiction* concept which will be discussed in the next section.

Much treatment literature about the '*nature*' of addiction is, in fact, designed as *conduct guides* for worker subject positions; for example, Jarvis, Tebbutt, Mattick, Shand suggest to the worker to '*foster your client's self-confrontation through open-ended questions and selective feedback*,' (2005, p. 4), instructions which have a political effect[176] on the constitution of

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[175] At a parent support group meeting similar words were used: the drug user is a hologram, said one parent, the person is there but not really there. In other words, the drug user cannot be made accountable; his accountability is fuzzy and unstable. Everybody [every body] must be accountable. Parents talked about their drug using children as having a relationship 'with an object', the drug, and as missing the needle the most. The idea that the drug user is 'slippery' is a re-occurring theme in the workers' accounts.

[176] Cultural dimensions create the very 'knowledge' that diagnostic tools rely on (Room 2006a). For example, the Australian classification system of substance dependence and addiction relies on the DSM-IV (Diagnostic Statistical Manual from the American Psychiatric Association) and the ICD-10 (International Classification of Diseases) from the World Health Organisation (Hamilton & Gape, p. 6). Not surprisingly, the DSM-IV is '*"atheoretical," positivist and politically conformist*', writes Lichtman (2004, p. 93). Valverde summarises the attempt to define substance-related disorders in the DSM-IV: '*If one takes out physical withdrawal from the list just quoted, what is left is the*

clienthood: zeroing into the therapeutic aspects of the client-worker relationship, it is apparent that '*[t]herapy does not 'copy' social life; it completes it in its own domain. Social structures provide imperative, restrictions and possibilities*.' (Lichtman 2004, p. 93)

Emphasising the *process* of therapy, Usher and Edwards state that '*counselling is deployed within a power-knowledge formation which constitutes the subject as an individual with needs which can only be articulated through a process of counsellin*g.' (1994, p. 97). This is the *political sphere* of counselling and treatment; the therapy process constructs drug users who are *not* in treatment as '*other*' drug users, as '*addicts who remained "out there" as oblivious to their own self-interest*' (Weinberg 2000, p. 610). In the therapeutic dynamic, 'the drug user' begins to identify himself as a *particular* drug user, constructing positive and negative self-imagery (Rødner 2005), often interactively achieved by forming an *active relationship* with addiction, whether in its rejection or acceptance.

### 2.2.2. Addiction as an institution

Displaying a lack of *critical* analysis of the *institutional* pressures of harm minimisation policies, Australia's drug research literature often treats the service system as a mere '*executioner*,' not problematising the compromises that make matters so much more complex. This leaves some defenders of harm minimisation overly optimistic about what can be achieved (or even what they have achieved), construing conflicts as more-or-less consisting of '*ideological*' preferences (in dealing with drug problems, such as zero-tolerance '*versus*' harm reduction[177]), rather than the messy practice of achieving social change and the institutional 'bargaining' that is employed to achieve it.

In the interviews, it became clear that clienthood is set up in such a way that 'addiction'/'problematic' drug use may not be '*disclosed*' or '*discovered*' until *after clienthood has been assumed*. The service system has *narrow* entry criteria, is designed for '*target groups*'

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*fuzzily defined, non-medical, primarily social terrain of collateral damage – legal problems, disruptions in relationships, and so on*.' (1998, p. 26) Richard DeGrandpre found that the DSM is expanding its diagnostic entities rapidly: from 106 in 1952 to 307 in 1994. (2002, p. 93) This means, as society changes (and new drugs become available), we observe a proliferation of new diseases, more and more differentiated ways of classifying 'the social'.

[177] For example, in a recent article, Dr. Alex Wodak, head of the Australian Drug Law Reform Foundation, is quoted as saying to the Howard government: '*You can't keep on saying irreconcilable things for ever … It will either switch sooner or later to consistent harm reduction … or to consistent zero-tolerance.' Whereto Christopher Pyne, Minister for Ageing, reportedly responded: 'The Government, of course, does have a zero-tolerance approach to drug use, but for those people who make the mistake of getting caught in the vortex of drug abuse, we have an approach to treat and rehabilitate them, because we're capable of walking and chewing gum at the same time.*' (The Age 2007) In this case, although one can disagree with Mr Pyne, he does acknowledge that discourses co-exist and even need to co-exist depending on which 'group' one may want to target with educational messages and service responses etc.

and to '*cream off*' 'easy' clients, those that can be 'helped'. This is the systematic production of '*lying*' clients:

> [Vera, domestic violence worker] …*quite often when women say or anyone with an addiction says they've got this addiction, they'd normally be evicted from the majority of services, whether it be a women's refuge or whether it be other services. So it's almost like that's something that other services have set people up to do anyway, just not be up front about it*.

The client is now in a catch-22 situation: not receive the service or confirm the stereotype of '*lying addict*'. Addiction experience from the institutional perspective is often seen as a *uniform* experience, something 'addicts' have *in common*,[178] but it is *the experientially and inter-subjectively formed meanings workers ascribe to addiction discourse* that form the basis on which clienthood and workerhood *project onto each other* what their encounter and addiction is about.

> [Marc] *I tell all my clients that drug use is a choice initially. It can move through the nature of just being an addiction, it can move into different areas, but initially it is a choice. Everybody uses drugs at one level, whether legal or illegal. It's always been in every society through the history of mankind, it's been around in one level or another. It can be very dangerous. It can be brought under control and it can be brought back to a choice level too at some stage depending on where they are at*.

Marc, a youth outreach worker, explains drug use as a *staged process model*, a continuum along which people travel 'up' and 'down,' whilst Vera, a domestic violence worker, finds that addiction takes choice away from the affected person:

> [Vera] *Like the madness in thinking no one's going to see that you're stoned and just the crazy things you do to keep your addiction going. It's just madness for someone to be in a full blown addiction – just is so difficult for them. And I think that's the thing that some people miss if you've got a full blown addiction, it's quite often not by choice the things you do. You do some awful things. But it's kind of like you do what you need to do to keep your addiction going*.

Roslyn, a family support worker, made the connection between addiction and the different responses and reactions to it by her co-workers as based on missing links in training curricula for human service work, amounting to addiction being used to stereotype drug using clients:

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[178] This is perhaps because of particular elements of the addiction and recovery discourse in which the '*addict identity operates as a master identity which comes to explain everything about the subject, not only his inability to control his alcohol or drug use, but all his past failures and disappointments, his poor relationships, his lack of self-esteem, his career difficulties and so on*.' (Keane 2000, p. 342)

> [Roslyn] *And I think even people often will say marijuana's okay, that's the soft option. I don't think it is, no. But by the same token I'm not a believer in the Alcoholics Anonymous approach where they've all got a disease. They've all got the addiction gene in their system and they have no control at all, I don't go along with that either. [..] I don't like the word 'addictions'. I don't like any of the descriptions, dependence, abuse… it's all very relative. But needless to say, since I've been working here, overall I think that it probably is an issue that needs to be looked at for workers in this field, just sort of from observations and hearing. ...I think workers… I don't know whether this [addiction] is covered in, say, social work and I think… I doubt that it is, it certainly wasn't in my day and I doubt that it is now because just sort of overhearing conversations and throw-away lines, that there is still that stereotype. It can even be with a lot of workers in the helping profession, in our area. Well, they are just drug users! What would you expect, they're drug users! Useless anyhow, why do I waste my time? I have come across that in this agency*.

Addiction is both a product and a producer of discourses. Vera, a domestic violence worker, illustrated how harm minimisation policies (when intertwined with cost/benefit and other calculations) can be translated into a service system that is not willing to treat addiction as a long-term problem and that bans those who are '*too entrenched*', '*too difficult*' or any other 'rational' expression that the client is not worth '*our service* (yet or again)'. Vera also gave a direct comparison with domestic violence:

> [Vera] *He'd been through like 50 detoxes and you would not tell. You would not be able to even tell that he used to have a drug problem. But he said they didn't give up on me, it's one of the things he said to me: just don't give up on the clients you work with. Quite often workers give up on them and then they don't have a lot of choices. It's kind of like women that get black banned going to refuges because they've been into too many. Like, who are we to say it's too many times to leave your husband. Some women have to leave them many, many times and it's like some people need to go into detox many, many times to get clean or to be able to manage their addiction. I'm not saying that people can't have social addictions because lots of people do and they're managing fine but it's people that have full-blown addictions that don't manage it that normally need a detox and a rehab*.

I mentioned earlier that Fred had carefully chosen his '*worthy*' or '*genuine*' clients; the service system itself also makes those choices by way of funding and eviction regimes. Vera and Fred were workers who portrayed themselves as '*hanging in there*' with their clients when times get difficult or when confrontations with the service system occur. It hopefully has become clear that addiction discourse is not just something that is played out at the individual or relational level but also at the institutional level where it is directly confronted with political-economic rationalities; however, the recognition of such political problems was absent from workers' discourses and, therefore, from their perceptions of their clients' situations (and constitution as clients).

### 2.2.2.1. Addiction as disease: the absence of political dimensions in workers' interviews

Whilst psychological and therapeutic discourses focus on what makes the addiction experience unique for the individual[179] (or at least the projection of their uniqueness), institutional discourses seek to produce '*the generalisable*' in addiction,[180] because they establish relations and services based on their production of *generalisables*, one of these being the *addiction-as-disease* discourse. Yet, this discourse is largely avoided by the Victorian AOD service language, which adopted a seemingly more neutral phrasing: '*harmful substance use can be (or become) a 'chronic and relapsing' condition for clients*' (DHS 2007, p. 8).

There is an abundance of literature arguing both for and against the disease concept of addiction and it continues to be contested; Reinarman provides us with a map of how different institutions, such as the World Health Organization (WHO), defined and redefined addiction, describing addiction as institutionally '*accomplished*' (Reinarman 2005). It may be more useful to step *outside* of the discourse of '*addiction as disease*' and of the dichotomous 'fighting' over its disease/non-disease status; without having to position ourselves in relation to the *disease* status, we can concentrate on *the effects* that either position can produce. For example, a recent successful campaign against a Federal Government proposal to remove drug addiction from the disability discrimination list (Disability Discrimination Amendment Bill 2003) utilised the disease concept of addiction to mount its claims, arguably using the discourse in a politically effective way to keep in place (workplace) discrimination protection for people with addictions. Biologists seeking the addiction *gene*, 12-step groups espousing the disease program, lawyers effectively exploiting the poorly defined state of the addiction concept to create a '*lawyer's breakfast*', public health advocates being confused about whether it is useful to call addiction a disease, and a mother being able to forgive her child because the child is *sick* with a disease rather than *bad* with an addiction – all of these constitute effects of addiction-as-disease discourse.

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[179] A different way of understanding addiction is as a '*process*'. I follow Dollinger's (2005) suggestion to explore the intersubjectively achieved meanings of addiction and the process-nature of addiction in the sense of assuming great variability of consumption patterns and the effects of changes in intersubjective and subjective meaning-making of consumption during 'addiction' processes. In my view, this is what Weinberg (2000) shows: addicts, a subject position created by addiction discourse, become addicts in a complex relationship with their environment (peers, etc.) and learn for therapeutic purposes what it means to them to be addicted.

[180] For example, Gould describes just some of the complexities of the addiction concept: '*But when the concept of addiction is examined we find that medical people cannot agree on a definition; that many controlled drugs are not considered addictive, that addiction does not occur in most cases of drug-taking; and that many psychiatrists have thrown doubt on the validity of the concept, referring to the 'myth' of addiction and the 'myth' of alcoholism*' (Davies, 1992; Fingarette, 1989)' (2001, p. 221).

I stated before that the harm minimisation discourse consists of *assembly work by actors*, which allows me to unpack which effects are produced by the deployment of the disease discourse of addiction. I may ask what people associate with *addiction* and *disease*: is *disease* a useful label for them to understand what is going on with a fellow human being? Does *disease* mean one is entitled to social support and understanding? Does *disease* mean it is '*beyond your control*' and being placed in the medical realm, managed and cared-for by *health* professionals? Does *disease* mean people can seek company and create 'patient' groups, overcoming social discrimination or does it mean we are dealing with *pathologised* behaviour? Does it mean that the government has an *obligation* to act and *help* the '*diseased*'? Can the idea of *disease* carry the *only socially acceptable* strategy of lobbying for '*addicts*' in a prohibition culture and can it channel more resources into the AOD sector? How would the idea of *drug* treatment survive *without* the disease concept?

The question is not anymore whether we should or should not regard addiction as a disease, but what kind of *collector of symptoms, behaviours, meanings and explanations the label 'disease' represents to people, institutions and in social interactions*. The point is thus *not* to prove the '*conceptual acrobatics*' (Reinarman 2005, p. 311) of addiction or the incongruence of the disease concept, but to explore what exactly such conceptual acrobatics *do* for the continued relevance and, indeed, survival of addiction-as-disease – a vivid and continually redefined idea by each of us and the *denial* of which produces effects just as lasting as the *insistence* on it. In addition, being '*politically smart*' would involve the active exploitation and utilisation of all sorts of existing discourses towards the re-configuration of current 'drug user' and 'clienthood' subject positions, whilst simultaneously trying to produce new discourses without seeking in any one discourse the '*answer*' to the situated contexts of drug use (i.e. human rights, drug lifestyle 'diversity' or egalitarian discourses *in themselves* will not hold 'the solution' to drug problem constructions or put an end to them). How addiction as disease has been used politically can be derived from Reinarman's observation:

> Addiction-as-disease, then, is something of a double-edged sword. When attached to sympathetic (Betty Ford) or well-connected (Rush Limbaugh) individuals, it becomes part of the larger, positive gestalt surrounding them. But when addiction-as-disease gets attached to less reputable individuals (''street junkies'', ''ghetto crackheads''), it becomes part of a larger, very negative gestalt. Thus, the disease concept sometimes serves as a humane warrant for the right of access to services, but it also serves, paradoxically, as a key justification for punitive prohibition. […] The discourse of disease may have potentially progressive effects insofar as it has helped trigger a shift of gaze in which drug use comes to be seen as properly belonging in the realm of public health rather than criminal law. But addiction-as-disease has just as often been a discursive weapon wielded

> by a state that has declared war upon citizens who ingest disapproved substances. (2005, p. 317)

*Positive* or *negative* gestalt is obviously produced by the logic of the treatment system as *worthy* (based on the strength of medical and psychological discourses) and the drug market and its customers as *unworthy* (based on the strength of the prohibition discourse). What Reinarman suggests is that addiction as *disease* can be charged with *serving multiple purposes*, but discourses of any kind cannot be controlled as to their purposes, intentionality, effects or interpretation by players. Their very *contestability* represents their strength as organising principles. Addiction as *disease* produces and establishes relations with other discourses, such as public health or prohibition and we should not be seduced into believing that services operate in a humane or progressive way *by default* or that addiction '*properly belongs*' in the domain of public health. Harm minimisation discourse not only builds on moral panics to influence policy (Zajdow 2006b, p. 407); it is placed within the rationalities of cost-benefit reasoning and, indeed, its defenders explicitly engage in *political lobbying* based on *the economic evaluation of current policies*, such as the costs of drugs to society, business[181] and the community, as governments are sensitive to (health) costs. People who 'carried' the harm reduction discourse could successfully lobby for health interventions for people taking certain drugs and whilst this was a useful strategy for the health needs, it addresses the *health* needs (at best) but not the many social aspects repeatedly identified by workers and in the literature. In Chapter Six, I will further discuss how workers thought about harm minimisation discourse.

Every addict learns to narrate his/her story within the '*institutional self*' they adopt (Weinberg 2000) and which s/he *continues* to form in relation to addiction discourse, often throughout the life-course. Whilst the sciences go round-about, taking all sorts of different roads and shortcuts, I argue that only a *discursive and relational understanding of addiction will expose the institutional manufacturing of addiction*. Individuals, lay-people, professionals and scientists all manufacture it within the discourses that (they) operate and addiction continues to exist because it occupies a site of contestation and 'the will' to govern ourselves and others. It allows for a plurality of practices and diverse 'lay' and 'expert' knowledges that co-exist and struggle for domination and if we are to discover its *situated context*, we have to learn how to step outside

[181] For example, the Australian Drug Law Reform Foundation sought to mobilise businesses' self interest by commissioning economists to measure the drug costs businesses are bearing (see Collings, Lapsley & Marks 2007).

of (addiction) discourses. Next, I will discuss the constitution of clienthood as it is linked to the service system and experiences of it.

### 2.2.3. Service systems, discrimination and class war

As mentioned in Chapter Four, the drug using client is constructed as marginalised and disadvantaged by the service system; however, to any construction exist counter-constructions. One worker was particularly concerned with '*pushy*' drug using clients who make other people miss out:

> [Karl] *Your so-called average, off-the-street person without the drug issues often misses out on our service at the expense of the drug user because they are so demanding and they're so in your face and they're so constant and repetitive with their demands. And I think actually a lot of clients who are starting to fall through the cracks but haven't got to the real bottom are missing out on our service because of the high numbers of D & A clients we have and I think the number of D & A clients we have, have really jumped up since the new D & A workers have come into town – there's been a shift in the last 12 months. Last year the main worker there was probably more of a 'hanging in, give, give, give' mentality, hoping that by hanging in they could change. The new worker has an expectation that these guys and girls do something, as in a direct D & A program or something. […] Just basically working the system, going around everywhere they can to get their needs met, and usually it's always money that they're after. Some come, they're desperate, they want money and I think as a result a lot of our less critical clients if you want to put it that way, are missing out badly*.

Karl, working with the homeless, did not question the capacity and funding of his service that seemingly could not cater for all the clients who came to it, instead singling out the drug using client as an *opportunity maximiser*[182] who would selfishly '*try to get needs met*'. The '*irony*' is that, at the individual and relational level, the drug user is described as '*un-pin-down-able*' but at the institutional level, the service system seems equally '*un-pin-down-able*': the definition of drug problems (addiction) as a '*relapsing condition*' shifts *all* the responsibilities to the drug user-as-client because *how can the service system fail someone who - by definition - 'fails'*? Whilst administrative (public administration) discourse constitutes clienthood as (needing to be) accountable, social discourses constitute drug-using clients as unaccountable, transient, manipulating, slippery, unable to commit and undeserving. The prohibition discourse (the

[182] This is based on Mitchell Dean's argument describing the governance of the welfare client who is unemployed: '*The mode of obligation for the jobseeker is less of a grateful beneficiary of the state's concerned tutelage and more an enterprising consumer of services exercising the best choices possible for him or herself. The jobseeker is an active subject not only in undertaking agreed activities but also in the very process of gaining access to the services they require*.' (1998, p. 97) In this formulation, self-enterprising 'job seekers' (not 'the unemployed' anymore) are 'opportunity maximisers'.

illegality of (some) drug use) and the ideology of '*they chose to use drugs*' and its variations ('*just say no*') place the drug using client firmly at the bottom of the '*ladder of opportunity*' in the service system. This family support worker described that the drug user is discriminated in the general community *and* by the service system:

> [Roslyn] *I think the general consensus that I pick up just as a general everyday person or maybe even the odd neighbour of a client that I might meet, it's oh look they're scum anyhow, they use drugs, they're scum, best thing if they overdose then we're well rid of them and they shouldn't have children and they should all be sterilised and they're bringing kids into the world. I constantly hear that. And I'm not sure that it's improved over the years. I don't think it has. [..] The difficulty is getting suitable programs up for them. We've got a drug and alcohol agency task force which is just up the road there and they're tremendous and very supportive of our clients, but there is still a long waiting list for assessments. Then we get the assessments, we have a look at that, we decide, well these are our goals here, but there's nowhere we can go with it. There are not enough community groups, community support groups around. Naturally, we don't have a budget to pay for them to do things, they have no money, so there's a lot of areas that we can't link them because there's no money, there're fees, fee for service is the big thing now*.

Clients can also be directly and personally banned from services in which case the service system perpetuates and compounds the disadvantages of clients:

> [Adam, working in a multidisciplinary youth service] *Like a lot of D & A solutions are community-based, activity-based, drama or kind of hobby-based, recreationally-based, they're what I see as scenarios for solutions of drug using problems. A lot of the clients I have are banned from almost all those community possibilities for misdemeanours, or people find them difficult to deal with, so what's required is a more open-hearted kind of response… opportunities from all the kind of non-specifically, kind of community-based organisations to allow people back into activities they see as hobbies or choose to do. I mean it's schools that kids are getting thrown out of. I mean most of my kids are pretty well banned from almost every activity and it's hard for me to find avenues to get them back into things. Like quite often we're working with one-to-one. I have to find one- to-one tutors in recreation, one-to-one tutors in education, pretty difficult things for a young person to deal with. […] While I can do my job, the young people when they choose to make some changes have still got a lot of resistance like from organisations to re-engage with the community which would help solve some of their alienation*.

A useful strategy for clients in trying to cope with this kind of service system is to, at least, exchange information about the '*service*' they are getting, as Uma observed:

> [Uma] *They talk a lot about poor hygiene, poor health, feeling bad about themselves, alienation from their family and friends is very strong, also they know about a lot of the drug clinics to go to. Well they'll go there and if they don't like it they'll go to the next one and they'll talk amongst themselves, don't go to that place it's crappy and they treat you like shit... once they've gone to a place and they've been upset they find it hard to go back. Sometimes to any service if they have a bad experience, if they feel judged or if they waited forever and they didn't get listened to*.

Uma, a family and personal support worker, describes a reaction to receiving poor service that would be shared by most: you do not return to such services and drug users are singled out as particularly vulnerable and facing compounding problems. The 'welfare' service system has proven itself untrustworthy to some drug using parents, as outlined by this fostercare worker:

> [Damon] *They have to agree and so often the worker will refer, come along with the parent to meet us and we'll engage with the parent but often somewhere along the line and they'll just drop out for various reasons... Often they'll say there's another family member who can vouch for the children, but our belief is probably often the only people they trust are other users because they know those people won't dob them in to anybody. They basically trust other users more and obviously then there're issues about the other user's lifestyle and whether they can adequately care for the child, given their addiction as well. But still I think a lot of the mums who have had previous experience with welfare professionals who have notified the Department and they just are very suspicious, which if you put yourselves in their shoes is probably very understandable... you wouldn't trust anybody really*.

The tensions between AOD services and child protection matters have become widely acknowledged; the service system has created clienthoods in different sub-sectors of the 'system' and instead of a '*AOD client*' and a '*mental health client*,' we have created '*dual diagnosis clients*' and those who are somewhat 'unclassifiable' are called '*complex clients*' and on it goes. The service system creates situations that are unbearable for clients and the '*no way out*' scenario produces violent effects, which help to further problematise clients. Zahra illustrates one of the client-worker encounters at Centrelink – a statutory agency providing Commonwealth services including social security payments – where she had worked before becoming a youth homelessness worker:

> [Zahra] *A couple had come in. I mean they were only young, probably 22-23 but still classed as adults and you just knew that they were on something. They started screaming and yelling and just like probably a 5 year-old child would do. It was just really hard, not just the customer service, they were upset but also the rest of the customers that were in Centrelink were upset as well. I think he wanted a form. All I know is that they weren't going to give him the form and he screamed and yelled and carried on and then he left. Then I think it might have been his girlfriend or it was the girl that he was with walked in, and she actually jumped on the table and kicked the customer service offer in the chest. I mean if you're angry you might raise your voice or whatever, but you don't normally act like that. Even though I know that the customer service officer was trying to talk to them and trying to calm them down, it just didn't seem to work. None of it worked, even when the support come over, they were just too angry to stop and calm down and talk. I mean he never came back to work the whole time I was there, the officer that was kicked, he never ever came back to work. With customers like that they should be banned and do their dealings over the phone and whatever forms they need get send to them. But as far as I know it was just like a warning on the [computer] screen about the customer and that they were allowed to still come in. There is like a warning on the screen to just be careful*

*of this customer, violent, whatever, just a brief sort of thing, there'll just be a brief thing on what they've actually done and just be careful when serving them. There's no protection, if a customer wants to get to you, they're going to get to you. I mean it is hard too with Centrelink because a lot of people don't work and that's all they're getting is that money and when you've got to cut them off and that you're taking away their bread and butter, you understand that they're angry and it is, it's a pretty hard place to work*.

This is the modern-day class-war: Zahra reported on screen warnings about violent customers, video surveillance in operation and staff safety at risk, wishing for protective glass windows too. Workerhood is caught in the '*middle*' when clients (literally) fight for their livelihood. Clienthood and workerhood are set up to confront each other and whilst there are political interests being played out in this conflict, it is portrayed as a conflict between two people: the Centrelink officer and the client.

Summarising, workers portrayed the *ideal client* as able to '*story their way into the service*', willing to retell the story to dozens of professionals and to 'engage'; willing to comply with treatment goals and organisational policies and not questioning rules (or at least break the rules only occasionally); not 'infecting' other clients or 'cross-contaminate' the service with 'bad' behaviour, considering the help worthy of receiving, accepting, trusting and being honest with the worker and employing effective technologies of the self (being hygienic, a good parent, getting job ready etc.). S/he (interested in gaining 'transfer' of goods and/or services) is not alienated by the way the help is delivered, the minimal or no help on offer and is not too complex or demanding or violent; accepting professional boundaries, being appreciative, and not engaging with the service too long as this becomes too expensive. Clients must be compliant; if considered too troublesome to the service, they are likely to be excluded or banned.

In summary, this chapter has attempted to show that it is at the institutional level that the 'drug user' is made '*serviceable*', assumes clienthood and the 'human service worker' becomes *employable* and bound by intervention discourses. As the institutional level *mediates* between the relational/individual and the political-economic levels, it necessarily reflects both in its dynamics and considerations, even though these reflections might be partial and implicit. They are mostly observable in the way *policies* are made and service sectors constitute *clienthood* by *devising service standards*, outcome measures and accountabilities. Any policy which seeks to constitute an individual (a subject position) or a population has at its core assumptions about a 'problem', a problem 'possessor' and a problem maker (or at least *addressee*, like a worker, doctor, prison officer) and drug services necessarily reflect the politics of these core assumptions.

Institutions offer various relationships and we *relate* to them in various ways (as volunteers, bystanders, participants, consumers, partners, members, etc.). As they are historically formed entities, they rely on diffuse technologies and interpretation by '*institutional selves*' to survive. This is what I would term the '*art of dealing with frozen meanings*': what institutions offer are frozen meanings, historically handed down, that need to be dialectically '*de-iced*', re-formed and sometimes '*re-frozen*' and it is the art of dealing with frozen meanings that is demanded of us as social actors, making sense of or rejecting those meanings and interpreting them as they fit with our own senses, experiences, set of principles, values and ethics. In this chapter, workers and clients have been seen to be struggling with and re-interpreting the meanings of institutions, organisations and sectors and in their relationships with other institutional selves.

# Chapter six

# Harm minimis*ing* as peace-keeping:

# A cultural political-economy

In Chapter Four, the practices and discourses constituting the drug-user and the human service worker in the service relationship stood central, whereas Chapter Five dealt with their institutional constitution through the drug welfare service system. I now move to the final part of the research question posed at the beginning of this thesis:

***Which practices and discourses constitute the drug user and the human service worker in the political-economy - particularly in the war-on-drugs and harm minimisation - and how do they change within the helping culture?***

Trying to 'respond' to this question, all the threads from my engagements with the workers, their interviews and the literature will converge towards a (however tentative) conclusion for this work. I shall have to return to the political-economic level, reflecting on what the workers and I learned from our respective journeys. The chapter has three parts; first, I discuss the arbitrary fault-lines along which harm and expertise in harm minimisation discourses are located; second, I portray the missing links in harm minimisation and war-on-drugs[183] discourses, as they relate to morality, ideology, harms, choices and the market; and, lastly, I briefly demonstrate how workers perceived change in themselves and their environment. For the purposes of extrapolating the political-economic elements in both discourses, the subject is both 'decentred' and 'centred,' as the political-economic elements revolve around this dynamic rather than around the worker-client constitution.

[183] The ***war-on-drugs*** is a phrase that is deliberately deployed by the federal and state governments although differences exist between them in how they interpret harm minimisation which includes 'war measures'. Federal and state governments assume roles that relate to both harm reduction and war-on-drugs elements in their budgets and responsibilities.

### 1.1. The locus of harm in The Australian Alcohol and Other Drugs Charter

The Australian National Council on Drugs (ANCD) *draft* proposal for the Australian Alcohol and Other Drugs Charter (AOD charter) – intended to be a set of overarching principles to guide people affected by and involved in drug issues from community to industry – includes the following passage about 'drug users':

> People should not suffer discrimination based *solely* on their use of alcohol, tobacco or other drugs provided that use is lawful, is respectful to community wishes, and results in no physical, behavioural or emotional harm to themselves and others. (ANCD 2005, p. 5, my emphasis)

The notion '*solely*' discursively constructs that discrimination based on other 'characteristics' than 'mere' use may be acceptable; 'stigmatisation' may be included in the notion of 'discrimination', but it also may not. The statement only accords the status of acceptable activity to *lawful* drug use and what exactly '*community wishes*' and '*being respectful*' would mean and what workers, clients, police officers and others might understand by '*physical, behavioural or emotional harm*' are, as we have seen before, rather contested objects of drug policy. The *final* version of the charter, released in 2007, however, featured an amended version of the passage: '*Drug Users: 2.9 People should not suffer unlawful discrimination based solely on their use of alcohol, tobacco or other drugs*,' (ANCD 2007), meaning that only *unlawful discrimination* is unacceptable,[184] but we know that drug users are discriminated against in lawful *and* unlawful ways and the *variability* of courtroom-achieved decisions of (un)lawful acts and events is all too-well known.

Interestingly, the AOD Charter expects parents not to harm their children/young people by their own drug use, but it is silent on the reverse possibility; as well, health and welfare providers (presumably workers and agencies) should work with drug users '*without risk or fear of harm or discrimination*' (ANCD 2007), but, again, the reverse is not included. Yet, we know that discrimination is not limited to an actor, place, group or the 'wider community', employers, or landlords, but also present in the service systems which are meant to cater for drug users' 'needs'. What both statements discursively construct is that harm (potentially) originates from parents and drug users, but not from children/young people and workers/agencies.

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[184] If reminding people to abide by the law is all this Charter can achieve and it has no other social aspirations for the status of the drug user, it only serves the status-quo. Whilst the Charter spells out that the drug user should reach his/her '*full human potential*', the law is not considered to play a problematic role in achieving or not achieving one's full potential.

The novelty of the Charter is that it recognises the unequal distribution of harm across different social groups, the impact of marketing, advertising, promotion and sponsorship by drug companies and – in an Australian first – acknowledges the relevance of the Universal Declaration of Human Rights, the Ottawa Charter for Health Promotion and the International Covenant on Economic, Social and Cultural Rights (ANCD 2007) for work in the sector(s).[185] Whilst the Charter identifies the unequal burden of harm in different social groups, including '*Indigenous communities and other disadvantaged groups*', it is concerned about the '*disproportionate impacts of use experienced by some groups including Indigenous Australians and young people*' (ANCD 2007). The discourse never identifies gender,[186] other ethnic dimensions or other 'social status' groups, like homeless people, prisoners, older injecting drug users or the unemployed.[187]

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[185] It is never quite clear how many sectors and where their boundaries are/should be drawn, who/which agencies belong to the 'alcohol and other drug sector', to the 'HIV sector', to the 'Hep C sector', to the 'drug policy sector' etc. I would see these demarcations as more or less arbitrary, context-dependent, permeable and contested.

[186] This is despite much research showing and problematising the gender-specific nature of drug use: one of the best policy studies examining the gender dimension in US drug policy is Nancy Campbell's (2000). In Australia, it has been found that the National Drug Strategy '*addresses women only if they are mothers or smokers*' (Rice 2005, p. 6). Similarly, women as mothers (are made to) carry the primary responsibility for social reproduction, yet treatment services do not acknowledge the gendered nature of society nor of drug use practices per se: '*Women wishing to seek treatment may be hampered by a lack of childcare, unsupportive or abusive partners, and/or a fear of having their children removed*.' (Rice 2005, p. 5) An ANCD recently found that *'[w]omen drug users who are also mothers typically experience marginalisation and discrimination due to their parenting status. This dynamic needs to be acknowledged*.' (Dawe et al. 2007, p. ix) Banwell and Bammer want to encourage discussions on '*whether the management of mother troubles will assist in the management of drug troubles for mothers*' (2006, p. 512). Without acknowledging it they advocate conformism to the dominant '*intensive mothering*' practices by arguing that all mothers (whether they are drug using, mobile (by which they mean mothers who move a lot due to their husbands' employment in the Australian Defence Force), high or low-income mothers) should have the resources to conform to the cultural expectations of being a 'good', 'intensive' mother. For Banwell and Bammer the problem is not that of a hegemony of intensive or 'good mothering' but the inequitable access to being able to conform to these hegemonic values. With statements such as '*some of the time they [mothers] spent with their children was impaired by drug-seeking and drug-use*' (2006, p. 510) and *'[f]or example women who used methadone treatment to repair their maternal identity found their attempts subverted by their heightened visibility and the master status of drug-user (Banwell, 2003)*' (2006, p. 511), the authors confirm dominant values by reproducing the deficit model rather than analyse the cultural conditions under which drug use and mothering practices are juxtaposed and contradicting each other, making them incompatible, alien and placing social responsibilities solely on mothers. Exactly how the authors think a methadone program can/does '*repair maternal identity*' (which presumes that there is something 'to' repair) is not outlined. They also do not critique the fact that methadone programs produce a clienthood that produces a different 'drug user', one marked by a certain interpretation of social 'functioning' but not as a system of government in which abstinence or sobriety feature. A methadone program is a socially sanctioned form of continuing the 'drug user' subjectification with different means. Arguably, conforming to 'society' and dominant values is a rational way of leading life and an extremely workable one but for a *critical* analysis, this type of research is unsatisfactory. As far as the service system is concerned, Banwell and Bammer list a whole array of services that Defence Force families have available to them (from movers and packers to special needs children and boarding school support) but for the 'drug using mothers,' welfare, drug treatment (including home visits from 'outreach' nurses) and parenting services are available. It does not occur to the authors that those different ways of 'servicing mothers' (apart from an inequitable way in which services are distributed across populations) in conjunction with their social position and their embeddedness in social relations produce very different mothering (narratives) and mothering subjectivities.

[187] Low unemployment figures continue to be reported by the media and the government. The real picture suggests that unemployment has not been markedly reduced during the last decade: '*Applying the output and wage principles*

A recent study of 150 injecting drug users in Victoria reveals their mean age as 31 years, mean education as 10 years, 60 % were male, 81 % unemployed, 6 % Aboriginal or Torres Strait Islanders, 47 % had a technical or trade qualification, 53 % had been to prison and 40 % were currently in drug treatment (AIHW 2007, p. 60). In the Charter's discourse, however, the 'politically correct' 'harm groups' continue to be Indigenous populations and young people.

The Charter thus expresses clear biases about the *location* of harm and thereby reflects some of the entrenched dynamics of the political-economic level, such as the still widespread absence of gender and social disadvantage from discursive constructions of drug problems. Another political-economic level dynamic is the question of *client-centred (service)* practices dealt with in the next section.

### 1.2. 'Client-centredness' and expert discourses

Two questions will be investigated here: how can we understand the claim of practices and service systems needing to be *client-centred* and how can we gain a more complex understanding of '*experts*' in drug problem discussions?

#### 1.2.1. Client-centricity led ad absurdum

The idea of client-centred practice[188] is an old one perhaps most dominant in therapeutic (psychological) discourses, going back to Carl Rogers' idea that client-centred therapy '*trusts that clients have within themselves resources to improve their life situation. If this inner potential and ability emerges, the client needs only support, not direction*.' (Coombs, Howatt 2005, p. 104) The Victorian AOD sector blueprint Discussion Paper sets itself a target to become (more) client-

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*to the employment area, when the currently massaged employment and unemployment figures are adjusted to take account of the hours worked a decade ago, i.e. converted to real terms, both employment and unemployment require adjustment. The outcome is that the real rate of unemployment rises from a published 4.6% to a real figure of 8.0%. This means that in spite of all the recurring spin and rhetoric, there has not been any significant reduction in the past decade. What we have in reality is cleverly and well-concealed underemployment, quite a bit of it involuntary, if ABS Surveys are to be believed*.' (Gibbs 2007, p. 26)

[188] Both public health and harm reduction (and wider health promotion) approaches have focused on the individual and tried to initiate behavioural change in identified individuals, at the same time, however, the urban environment has changed markedly by such processes as 'gentrification', social fragmentation and rising health inequalities (Rhodes et al. 2006, p. 1384). Not only have we concentrated our research and intervention efforts on the individual (and not on the 'risk' and the social environment) but what we know about 'drug user' subjectification is heavily skewed: '[…] *by the impossibility of obtaining a truly random sample of drug users. Most studies use samples of convenience (such as arrestees) or ethnographic techniques (such as snowballing sampling) and thus fail to represent the full spectrum of users*.' (MacCoun & Caulkins 1996, p. 184-185) An acknowledgement of the biased efforts of research and intervention towards the 'drug user' is a useful starting point to explore the problem of client-centred practice.

centric,[189] indeed a desirable goal. The question, however, is not *whether* this should be an aim, but *how* this aim is '*translatable into practice*', what *happens* in practice and how do other dynamics support and undermine such an aim. More questions are associated with consumer-driven service systems: who is a consumer? Does the consumer hold the truth? Is the representation of a diversity of consumer perspectives and preferences possible in current structures of deliberation, funding and advocacy? Is there trust and legitimacy invested in consumer representatives (and consumer groups) and the '*policy process*'? Are clients' rights enforceable? Some of these questions will be taken up further in a following section on '*experts*'; they lead us back to how workers described the institutional workings of the service system and their comments - directly and indirectly - express doubt about achieving client-centricity. Adam, working in a multi-disciplinary youth team, contends that the way cases are 'assessed' for action is not congruent with the 'actual risk' for a client:

> [Adam] *If you followed these [inhalant policy] procedures, these new procedures they've got, you'd virtually lock up people once they've been seen to be using inhalants. ...I had a meeting just the other day that I was totally frustrated by – the Department came, the case managers of the client came, and they were really concerned about a client's inhalant use. Now that client lives very effectively in a low-harm scenario in relation to his drug use but because he generated a lot of incident reports and because he's at his unit and he's noticed by the unit to be intoxicated, he's generated say 100 incident reports in 100 days, so they have these big meetings about him and devote a lot of time into… but this boy's… there's no real problem in his drug use, he's actually what I call a champagne inhalant user who uses it moderately, he never runs any risks, he doesn't use multi drugs with it, poly-drug use, he's made decisions not to be an IV-user… but they devote a lot of time and energy because at the moment it's sexy and everyone's concerned about inhalants. Now there's a hell of a lot of clients who run huge risks on a daily basis, near life and death risks, who we don't have these meetings for! So the obstacles are the focus and sexiness and knee-jerk reactions to things. I mean certain things are in vogue – suddenly all the attention is applied there and the eye goes off the general picture. I think they've overemphasised the inhalant problem in Victoria*.

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[189] '*A quality, client-centred service delivery system should be accessible, evidence-based, effective, safe, efficient and flexible, providing integrated service delivery and coordination through holistic and professional case management. Clients should have opportunities to participate in service design, planning and delivery. […] The Department is developing a quality framework for treatment incorporating a standard for achieving a stronger and more regular consumer input to service planning and delivery. […] One of the key components will be a Charter of Client Rights to be developed in association with the Association of Participating Service Users (APSU).*' (DHS 2007, p. 29)

Adam offers two rationales for obstacles to his work: *incident reporting*[190] as a measure based on *frequency* of incidence and not necessarily based on '*risk scenarios*' and the *fashion principle*[191] in responding to the use of certain drugs with more vigour because they are seen as more risky at a point in time. I mentioned earlier how policy and service focus on one drug can have positive and negative effects: for example, it can mean that other drugs lose 'their' funding (funding ice- and not heroin-related interventions) and/or that a particular drug-use pattern, having built up for years, receives recognition for causing harm. Conversely, some 'general picture' drug-use patterns, such as problematic alcohol use, may not receive (enough) attention because it is such a commonplace and culturally entrenched consumption form, making it more difficult to manufacture a 'moral panic' about. The *fashion principle* is, therefore, usually ambiguous. A similar obstacle to client-centredness can be the '*flavour of the month*' response by government departments themselves:

> [Hannah] *Whether it's policy or whether it's just decision making but DHS who funds us every now and then will come up with a flavour of the month. And they'll say we want you to do a little bit more of this and we want you to do a little bit more of that*.

Hannah reported that *flavour of the month* in her parenting group work meant that she was expected to shift priorities from one culturally and linguistically diverse (CALD) group to another or other (newly identified) '*needs groups*'. The *fashion principle* was also one of Clara's concerns amidst identifying some of the pitfalls of the logic of service systems:

> [Clara] *Because each young person is an individual and that individuality creates its own problem in that not everybody fits in these little boxes that policies are made out of. So there has to be room for movement, has to be room for understanding and we need a lot of different types of services for these young people. We've got a lot of similar types: we've got all our drug and alcohol services here with workers attached that come out and see the young person, take them out for coffee, have a little bit of a chat, do a little bit of harm min stuff and try and build up that relationship and all this sort of thing and that works and then the relationship starts to build, the worker moves on. And then we repeat it. And we've got a lot of that... we're not saying that's bad. We've got too much of the same. We need to have a lot of different types of services that kids can link into for their different needs because they are individuals. Some kids really respond to a challenging situation, so you have your outdoor experience, really focus on kids with drug and alcohol problems that don't cost you $6,000 to send a kid there for 2 weeks and I think a lot of these places, some need to be short-term and some need to be long-term and they*

[190] Charles, working in a youth residential service, bemoaned the fact that it is very hard in incident reports to communicate with words the impact and the feelings staff and clients have when they have confrontations with each other and for him this difficulty of expressing the emotions meant that people 'up the chain' can often not assess what conflicts in residential units are really like.

[191] The year 2006 has seen more attention being given Australia-wide to the drug known as 'ice'; in the early 2000s in Victoria it was inhalant use that was 'sexy', in Adam's words.

*just need to be so different because these kids are not going to sit in a classroom. They have to learn completely differently to our normal kids that go to high school, these kids will do that later when all this is behind them and they've started to get a bit of stability in their life, then they'll look at their education. So give them life skills, get them out there, do the nurturing stuff for the kids that need it. […] People just seem like... 'oh, if you build a relationship the kids will start talking to you' – rubbish. They talk to their peers because that's where they've got the common ground. So give them a chance to be with peers, to be with people with understanding. […] We need to break up our current drug and alcohol services where we've got these counsellors who do a great job but get your services focused on different areas to meet different needs. You can turn any corner and find a drug and alcohol counsellor. It's almost like the fads that we go through where we've got too many school teachers or too many social workers... we're kind of big on psychologists and counsellors and things like that, and where I think it's a needed, we don't need an over-abundance of them*.

Clara worked in a youth residential service, pointing at the design of any service having assumptions about the clientele and the type of work that will take place; for her, drug and alcohol outreach work was part of the response but it could not be the only one. If client-centricity is desired, clients' '*individuality creates its own problems*'. Service provision needs to be a '*flexibility game*', employing sophisticated adjustment forms and technologies to produce an individuality that can self-problematise without the service system itself disturbing this 'task' (excessive '*streamlining*' of services cannot pretend to cater for 'individuality' but creates its own '*revolving doors*').

Clara's comments also show that workers operating in 'non-specialist' services, '*outside*' the AOD field, have a different approach to 'specialist' AOD services; specialisation, training and the organisation of the sector into many sub-branches of human service work would also have an effect on how clients' rights and a Charter could work '*across the divides*'. Hannah had her own observations of the 'AOD field':

[Hannah, parenting coordinator] *I also find that the drug and alcohol field is really divided. There're a lot of strong opinions and the opinions can be quite polarised. […] if the drug and alcohol field could get their act together they might be a bit more of a united voice in trying to get money. I don't think any of them are with a very united voice feeding back into policy which I think they probably need to do. I think also people who work in substance abuse [..] sometimes I don't think they recognise the work that other workers do, no, and don't refer on as easily as they probably should. [They] Don't think maybe that other generalist workers are capable of the work. [..] other specific workers probably are a bit better at keeping their families in the mainstream, does that make sense? Like if you've got a mental health worker, for example, they will try to make sure that the client still goes to the maternal and child health centre and still does this and still does that, you know, and really keeps them very much wound in, whereas drug and alcohol… I think the directions it's taking is to really narrow them off. Like for example at hospitals, you've got special clinics for those who are substance users and I think that's positive for them*

*but once again it's narrowing them off into this little section all by themselves. [..] I think it's better if they stay in the mainstream. You know, a bit like mental health too, how GPs [general practitioners] now work a lot more with clients rather than them going to special mental health clinics. They just go straight to their normal old GP who's specially trained. I think it's just a way of keeping people in their community and not putting them into almost a rarefied way of being worked with*.

Specialised and generalist workerhood are really portrayed as *divided* by Hannah, who juxtaposes mainstreaming clients and '*keeping them in the general community*' with '*narrowing them off*' and not referring them on. Other workers said that clients prefer to use ethnically-specific, gender-specific, mainstream or specialist services and they all have their reasons for doing so; some clients' choices relate to the stigma attached to particular services, or knowing others who have used the services. Complaints by workers about '*not referring clients on*' were not uncommon; different service systems have, in fact, *created* a workerhood divided by their beliefs about which service 'types' ought to 'share' their clients with which other service types and by their beliefs about which services are more appropriate for which purpose, workers often identifying with the rationale of the service type they worked for themselves.

Furthermore, service can be time-limited, bound by region or by specific funding sources, restricting how workers can 'serve' a client. There are even certain assumptions, sometimes guidelines about which 'client problem' to address *first*; workers described such prioritisations, at times initiated by the worker or by the guidelines. Cora, who was with an AOD agency before working with homeless people, had pondered over prioritising drug use or housing needs for her clients and concluded that there was no formula to prioritisation:

[Cora] *I suppose it was the order in which things were done that was different… yet I've tried that, I've prioritised the housing needs for another client who was in a similar sort of situation, she wasn't psychotic, hadn't worked, chronic homelessness, facilitated transitional housing and within two months she was evicted. It didn't work. She trashed the joint, she didn't pay her rent, her drug use was out of control, so I suppose there're two examples of where I'm saying there's no formula. There is no linear pathway... and that's how my belief would have changed over time. I think probably in the past coming from a drug treatment agency I would have said that the drug use is the first thing that needs to be tackled*.

Olga, an intake worker, related agencies' guidelines over prioritisation to her lack of training:

[Olga] *Then if they've got a multiplicity of issues going on, which they generally do, there's abuse. There's this and that and there's drug and alcohol and there's mental health and what do you deal with first? Some agencies have very clear guidelines about what you do... you have to deal with your drug and alcohol issue before you deal with*

*your abuse issue but they come hand-in-hand, so I had difficulty with that. So I think it becomes an issue about probably wishing I had more training*.

Olga and Cora both add to our thoughts about client-centredness: formulaic, experience-based or training-based prioritisations can all cause problems, as they all assume there to be a certain relationship between people and 'their' problems and a certain relationship between their *different* problems. Even if client-centredness was achievable in a less-divided and less-streamlined service system, where work was organised around individuals' (all in themselves contested!) needs, would clients be able to access and afford the services they need? The abundance of *referral* services faced a shortage of affordable *delivered* services, as Fred, working in a bail advocacy program, demonstrates:

> [Fred] *But there's a still an abundance of referral services that have a name that you think you could go to. Mental health, good example, you actually try and get something done for somebody with mental health. They keep referring you back to each other. Oh no, we don't do that... well what do you do? Well, we do... good example, [mental health agency's name]. You try and get somebody assessed. When you finally get somebody there, they'll assess them and do you know what their assessment is? Oh we think this person needs help. They do it a little bit more clinically than that but that's basically what they end up saying to you. And I'll say but this is why I brought the person here. You are [mental health agency's name] which means you serve the mental health services in the region. Yes, but we just do a very initial… basically the word should be very shallow or superficial would probably be better... assessment to find out if the person has any problems. But I know that, that's why I brought them here. So what's your diagnosis? We think you should send them off to a psychologist. This person is sick and they need to see a psychologist. Oh great... do you have somebody? No, but we can recommend somebody. But they're going to cost us $350, this is a person who doesn't have a job, doesn't have accommodation, because they're brain fucked. But that's not our problem. I know but you're [mental health agency's name]*.

Fred, less than politically-correct in describing '*psychic order assumptions*', seeks a service for someone who is released from prison and only gets an acknowledgment that further help is required, but his client cannot afford such a service and the service which is meant to provide it has been reduced to an assessment and referral function. Arguably, for the ex-prisoner-client, it is irrelevant whether a Charter of Client Rights exists, because he cannot afford the service in the first place – unless the right to access free and affordable services was granted, a right that may not be achievable with any consumer lobbying, because of competing political interests at the political-economic level.

Client-centred practice *challenges* professional training (specialisations), funding and operating logics of the service system which are deeply entrenched by tertiary training,

universities, government, research and policy organisations. It would be a radical move to completely tailor the service approach to clients' needs,[192] as this would presuppose that client and professional can agree on what constitutes 'needs' and whether they can be legitimately pursued within service system logic. Outlining the difficulties of client-centred practices, however, does not deny that the harm minimisation discourse is not client-centred; indeed, in *therapeutic discourses* and at *individual* and *relational* levels, it *is*.

The next section deconstructs some of the assumptions inherent in advocating with and assuming expert positions, including that of the *consumer expert*.

### 1.2.2. Expertise in AOD practices

*Expertise* is a *contested ascription* at the political-economic level, as there are many more parties, agendas and actors' intentions struggling for definitional power over exerting and being accepted as offering expertise. Chapter Four described how clients are rendered *experts of their lives*: '*In this shift the role of expertise previously held by drug workers in the welfare model of drug services is transferred to the drug users themselves*.' (Zibbell 2004, p. 60) I showed that expertise is not necessarily transferred or simply shifted from one party to another, but rather shared and negotiated in the client-worker relationship and *strategically* deployed. Here, it would be useful not to think about expertise in terms of its *location*, but to study how expert knowledges are deployed across agents, disciplinary and political divides and how they become *hybrid* and relationally deployed.

One of the best-known debates about expertise in the AOD treatment sector is the question of employing '*people with drug problems*' (PDPs) or '*ex-users*': a VAADA discussion paper on employing '*PDPs*' in AOD services concluded that such a practice is both advantageous and disadvantageous (2003, p. 8)[193]. The New Public Health regimes rely on professional surveillance and on governing the environment of populations.[194] (Petersen & Lupton 1996, p. 89/90) It has been argued that harm minimisation policies have served to increase the

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[192] A utopian discourse would seek to imagine a world where people's needs can be met without having to assume clienthood of social and drug services and where society's and individual's aims are co-terminous.

[193] Concerns were raised about 'sufficient' time and distance between someone's past drug use problems and their employment, ex-users' '*rigid views about treatment modalities and recovery, based upon personal experience*' (VAADA 2003, p. 4) and their possible burn-out due to lack of support, supervision and training – overall, however, such workers were welcome and seen as contributing members of the AOD workforce (VAADA 2003, p. 4-5).

[194] The New Public Health explicitly incorporates rationalities of the environment and expertise: '*The environment has become represented as a set of physical resources that requires the rationalised strategies of governmentality, including continual surveillance, monitoring and regulation on the part of experts – just as the human population is conceptualised as a resource that depends on the environment.*' (Petersen & Lupton 1996, p. 89/90)

professional surveillance of the drug user and that it is part of a set of rationales governing 'at risk' populations (including the New Public Health) (Zajdow 2004a). At the political-economic level, definite strategies of professional population management exist, but here it is less useful to juxtapose expert and lay expertise than at the relational level (Chapter Four). Indeed, experts ultimately rely on self-knowledge of *lay* people (patients, clients) to gather information and knowledge that renders them governable; second, experts and clients in the political-economy are both '*conducting their conducts*' (Foucault 2002a, p. 341) and refashion their subjectivities as their subjectivities are refashioned. Experts and clients are *both* subject to the variously intense pressures to exploit their selves: '*Thus, people are being encouraged to drive themselves ever harder, to accept even greater individual responsibility for themselves and their contributions to organisations and the social formation*.' (Usher & Edwards 2005, p. 403)

Further distinctions in the construction of expertise are observable in harm minimisation discourses; *social movement* elements, pursuing harm minimisation strategies and arguing for its political and policy legitimacy, forged links between professional and peer cultures. Indeed, one could argue that the two cultures have a somewhat symbiotic relationship, strengthening each other's legitimacy[195] and appearing '*co-dependent*'. From this mobilisation (assisted by professions and government's gradual funding) developed '*drug user organisations*', as shown in Chapter Three, which sparked and were sparked by '*drug user activism*'. The *consumer perspective* is, however, not a united or homogenous group of drug user representatives:

> At the same time, drug user activists have also struggled with ambiguity when defining drug use and who is and is not a drug user. The transmission of HIV and other viruses via blood-to-blood contact has meant the focus of harm reduction has been on injecting drug use. The drug user movement is, for this reason, best described as an *injecting drug user movement*. It is clear that, in Australia at least, people who use illegal drugs but do not inject, have not formed a significant part of drug user group membership. Membership is predominantly made up of people who use opiates and/or cocaine and/or amphetamine. (Stafford 2007, p. 90)

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[195] The International Harm Reduction Association (IHRA) is closely associated with drug user activism. IHRA has supported and promoted a new worldwide drug user organisation: *'Establishing the International Network of People Who Use Drugs. It has been an extremely busy few months for the developing International Network of People Who Use Drugs (INPUD), under the stewardship of Stijn Goossens, a drug user activist from Belgium. An international drug user activist movement has been developing alongside IHRA's annual conferences for a number of years, and the efforts culminated in the 1st International Congress of People Who Use Drugs - a satellite event in conjunction with the 17th International Conference on the Reduction of Drug Related Harm (Vancouver, Canada; April 2006). This event was attended by over 100 people from around the world. In the Congress, the group wrote and released a declaration describing the prejudice they faced around the world, and their collective goals to overcome this prejudice. This "Vancouver Declaration" has since been translated into 17 different languages*' (IHRA 2007).

Stafford[196] proposes that the activist 'drug user' group is itself a contested and somewhat partial representation of '*drug user interests*'. Further '*symbolic*' political problems are associated with defining the 'drug user': '*However, representing the "drug user" as "drug dependent" continues the prohibitionist practise of presenting all (illegal) drug users as drug addicted/dependent*.' (Stafford 2007, p. 90) The question, however, is not about whether 'drug user' should stand for any group or about any other *attempts to pin down what the 'drug user' does, should or ought to refer to* (injecting drug user, 'all' drug users, dependent drug users); it should be: *what does* the subject position of the 'drug user' *mean in (situated) contexts*, whether implicitly or explicitly identifiable, and how can discourses that construct the drug user be strategically deployed and/or undermined?[197]

*What does drug user activism by injecting drug users mean for a '**consumer expert**' perspective*? A '*consumer*' of drug *treatment* services and *treatment* communities is not perceived (nor treated) the same (equally?) as a '*consumer*' making use of supervised injecting rooms, needle and syringe programs, 'harm reduction programs' or as representing 'drug-user organisations'. Hence, the *Association of Participating Service Users* (APSU) will be involved in developing a Client Charter for the Victorian AOD treatment sector but not the *Victorian Drug-User Organisation* (VIVAIDS). Self-help users, participants of drug-user organisations, different drug treatment and different social service organisations, the 'peer educator', the ex-user, the current user – all these are definable and contestable positions with expert knowledges and competing over status and political influence.

Drug users' stories - in their confessional character - are often used (by others and themselves) to demonstrate that it is indeed desirable to adhere to practices of moderation or abstinence and that addiction is a futile exercise once individuals account for their regret and loss. Whilst this is *one* interpretation and discursive construction of what addiction means, it ignores other perspectives:

- It presumes that addicts have failed (to control their drug use/their lives) - a very selective view of life's struggles.
- It assumes that addiction is a mistake which should be avoided at any cost; that no-one who has 'failed' or made 'mistakes' has anything to tell about or learned from their 'failings' (or re-interpreted life events from a 'recovered', non-using or moderately-using position).

[196] Stafford is the only other Australian author explicitly problematising the drug user construction. We have had extensive discussions on numerous occasions about such constructions and other drug (policy) problems.

[197] As mentioned earlier, Keane identified that a politics based on a broadened addiction concept emphasising similarities (therefore of drug users too) has been missing thus far (Keane 2002, p. 190).

- It discursively excludes that human beings usually experience major life events as bringing both challenges *and* rewards/learnings.
- It locates all responsibility for the difficulty of living in a world which is drug conducive and not drug-free, in the individual.

Expertise has been established by professional, scientific and lay/media discourses, rendering harm minimisation rationales ambiguous in terms of expertise. The idea that '*really*' experiencing something makes one more entitled to speak about this something (parenting, drug use, whatever) or represent as the only 'truth-teller,' results in privileging experience-based knowledge over other forms of skill or knowledge and can result in claiming that no-one knows or has the right to comment *unless* they have '*been there, done that*.' It can be posited that neither science- or craft-, experience- or professionally-based knowledge regimes can necessarily claim to be more representative or 'truer' to a particular life event, feeling or struggle; indeed, all have their deep-seated biases. Neither can be used to claim *authenticity* in discursive constructions of drug use, as they can all be associated with very different and contradictory interpretations in spite of their competing respective authenticity claims. What tries to present itself as unique or different not only deploys an enormous amount of discursive work to establish and maintain its difference, but it can be transcended, subverted or resisted at any time.

Drug users and professional (research) organisations use constituency-based knowledges as instrumentalities to provide harm reduction advocates with 'street cred.' and, hence, 'policy cred.' and drug users and their stories are regularly mobilised to support particular policy-options, including harm minimisation. For many harm minimisation technologies to work, however, loads 'addicts' with the narrative burden of learning about and accepting the problems of their own 'condition' and turning their self into a 'resource'.

An even more complex picture emerges when it is realised that workers – whilst 'occupying' a different subject position to the user-client - are 'drug users' too; this 'overlapping' of experiences brings a new dimension to the worker-client encounter and – at the political-economic level - a degree of 'merging' of experiences can moderate the effects of stigmatisation and othering of the drug user, but by no means always or even predominantly – at least for the workers I interviewed and who had been using drugs, legal or illegal. The workers who had used illegal drugs (no-one mentioned current usage) identified more with their clients' drug use and they portrayed themselves as being better able to relate with their clients, which, however, did not always translate into more solidarian or sympathetic stances towards their clients' drug use. Whilst the partial merging of the subject positions does not produce a particular view of drug use,

addiction or the drug user per-se, '*having been there, done that too*' can bring lay-expert discourses into greater congruence and reducing the distance and the othering between worker and client could - on a larger scale - have liberating effects and increase understanding of the complexities of drug use.

Expert status and knowledges in harm minimisation discourses have assumed contradictory, ambiguous and strategic positions and are not situated in any one actor or location; they are generally contested, particularly when *representative* status is sought.

**2. Harm minimisation discourses and the war on drugs**

In Chapter Five, I argued that harm minimisation has been *reified* and that it would be analytically useful to try to identify different dynamics and elements within its discourse. Harm minimisation can be seen as being deployed as a '*meta-narrative [which] is also a denial of ambivalence*.' (Zajdow 2005a, p. 196) The usefulness of seeing harm minimisation as a meta-narrative depends on how we define 'meta-narrative', particularly in policy terms; whilst post-modern theoretical approaches have associated it with an *all-encompassing view of the world that seeks to explain everything in relation to itself and claim universal status* (Grenz 1996, Lyotard 1997), in policy analysis it can be usefully seen as an attempt to conjure a political narrative into a meta-form, thereby gaining discursive strength and symbolic capital within a polity[198]. Drawing on Gottweis' definition of a meta-narrative as offering '*an imagined collective political identity situated in historical time*' (2006, p. 469), harm minimisation can be described as being such a symbolic meaning-maker and organising principle, but using it in relation to harm minimisation *policy* may be less useful, if suggesting a coherence or congruence it does not have.

Sentences with 'harm minimisation *is*,' or, for that matter, 'harm reduction *is*,*'* should make us weary, as the aim is not to try and 'pin down' what it "is", but to study its strengths, weaknesses, ambiguities, elusiveness and, most importantly, its *situational meaning deployment*. The idea of harm minimisation can also gain strength by its very elusiveness as it '*institutes diffuse, and less visible, forms of surveillance, monitoring and social control*,' (Zajdow 2005a, p. 196) subsuming opposing discourses and reinforcing them at the same time.

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[198] Argumentative policy analysis describes meta-narratives as useful and constitutive for the polity: '*Political meta-narratives describe general concepts and values of social order, and provide for individual orientation and location in the symbolic universe. Meta-narratives offer a conceptual framework that provides a polity and its subjects with an imagined collective political identity situated in historical time. […] Meta-narratives are not simply 'out there'. They are performative practices; they do things with words; they are always written, rewritten, read and reinterpreted. […] The study of political meta-narratives is always the study of interwoven practices taking place in contexts of time, space, and sociality*.' (Gottweis 2006, p. 469)

Approaching harm minimisation as a policy discourse, the next section will outline five aspects which are relevant to the political-economic level: *morality*, *ideology*, *harm*, *choice* and the *market*.

### 2.1. The (a)moral discourses of harm minimisation

A most common claim is that harm minimisation is an approach devoid of moralilty, worthy of its subjects, a value-neutral, unique and *pure* discourse that '*seeks to avoid falling into the snares of moral, legal, and medical-reductionist biases exhibited by other approaches*' (Erickson et al. 1997, p. 6). Stafford is more critical in his analysis of its deployment in health services, yet, he too, accepts that possibility of a neutral position:

> The moral condemnation of illegal drug use and especially drug dependence has become less where health workers have taken on harm reduction principles. However, a *stance of neutrality is a moral stance with consequences*. As a public health strategy it has worked well as a position to advocate for health services like needle and syringe distribution but it has proved less effective in advocating for drug law reform. (2007, p. 88, my emphasis)

'*Purists*,' such as Erickson et al. (1997), claim that harm reduction can steer clear of conceptual muddling and can exclude (or largely avoid) the power/knowledge nexus of other approaches; Keane, on the other hand, illustrates the definitional struggle over harm reduction:

> It has argued that rather than a paradigm which is failing to live up to underlying ideals of freedom and human rights, harm reduction is better viewed as *an assemblage of pragmatic practices and practical goals with varied outcomes*. This is not to say that harm reduction has no role in challenging dominant discourses and practices of drug policy. Its pragmatism, avowed value-neutrality and constitution of drug use problems as *technical rather than moral* are themselves significant interventions in the moralised realm of drug debate. Moreover, its technical approach is a fruitful basis for imagining and working towards a particular style of ethics which supports open-ended debate and respects the freedom and difference of others. (2003, p. 232, my emphasis)

Whilst agreeing with Keane that viewing harm reduction as an '*assemblage of practices and practical goals*' is worthwhile, I cannot see how defining something as '*technical*' excludes its 'moral' dimension; neutral or 'truth' positions from which to talk about drugs do not exist, as mentioned earlier. Keane draws on a distinction between *ethics* and *morality* made by Stengers:

> For Stengers, ethics and morality are significantly different. While 'morality is concerned with statements like 'must one', or 'must one not"', ethics "must, above all else, ask the question, 'Who am I to say to the other 'you must' or 'you must not', and how will this statement define my relation to this other?" (1997, p. 222). (Keane 2003, p. 231)

Intervening into the '*moralised realms*' of drug policy and practice does not make those less paternalistic and prescriptive less 'moral;' a distinction is to be made between moralism (a formulaic code and prescriptions of conduct) and morality ('*a sensitive preoccupation with the whole quality of life itself, with the oblique, nuanced particulars of human experience*,' Eagleton 1992, p. 27) which renders any stance relating to the quality of life a moral one.

Jeanette Kennett, an Australian studying ethics and moral theory, claims that harm reduction is more conducive to '*more honest, respectful, and helpful relationships than alternative approaches and this in itself is a good to people who are too often the collateral damage in the 'war on drugs'*.' (2005, p. 10) The claim for 'superiority' of the harm reduction approach is not only an explicitly *moral* claim to 'defend' a presumably 'a-moral'/'morally neutral' paradigm, but it would be difficult to show how or why it should have a monopoly on respectful practice, particularly as this moral superiority is to be shown in the client-worker relationship. I will return to this claim when looking at what empirical analysis can reveal about this relationship in the context of harm reduction/minimisation. As well, harm reduction is not a *singular* approach and the 'drug user' is not simply *in* the war-on-drugs, s/he also *enacts* the war-on-drugs, as we have seen before.

As Rose pointed out in another context, any protagonist of harm reduction would have to confront its '*history of identification and its ambiguous gifts and legacies*' (Rose 1998, p. 39) – as is the case with a supporter of *any* movement or cause – and problematise their approach admitting its perspectival knowledge is to *sharpen* the knife of critique not to blunt it[199]. Debates and contestations of harm reduction as it coexists with and incorporates other discourses will certainly continue; accepting a Victorian Charter of Human Rights will confront harm reduction much more explicitly with human rights, which have been described as constituting a '*flashpoint for the drug-control system*,' as they juxtapose individual with state rights and challenge the status-quo in the co-existence between 'soft' and 'tough' approaches to drug use (Room 1997, p. 126-127).

The paradigmatic shift towards harm minimisation and its establishment as a national policy always contain an element of 'danger' and the danger changes[200] because policy decisions

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[199] I am paraphrasing Mitchell Dean who expressed: 'To admit the perspectival character of knowledge should be to sharpen rather than blunt our critical stance.' (1999, p. 10)

[200] I am drawing here on Foucault's warning that things need to be considered to be dangerous and to decide which is the most dangerous at a given moment in our activism. Foucault discusses 'danger' with the example of the policy of deinstitutionalisation: '*My point is not that everything is bad, but that everything is dangerous, which is not exactly the same as bad. If everything is dangerous, then we always have something to do. So my position leads not to*

are only ever temporal arrangements that are confronted by contradictions and interests on all four levels, bound to clash endlessly and produce ambiguous subjectifications as 'clients' and 'workers'. Viewing harm reduction as an '*assemblage of practices*', as Keane (2003) suggests, would enable us to build the bridge between institutional and individual levels, as individuals are themselves 'assemblages' of practices, locations, domains and routines *in* connections (see Rose 1998, p. 38, p. 172ff).

Hamilton and Rumbold suggest that harm minimisation '*avoids the minefield of moralistic arguments about whether drug use is inherently 'bad' or 'good'*,' (2004, p. 137) but I have insisted that all responses are moral and that harm reduction/minimisation policies and strategies maybe usefully seen as always containing a degree of *danger*. I will go on to discuss how the '*avoidance of the minefield of moralistic arguments*' is theoretically and practically questionable.

### 2.2. Ideology and appraisals of harm minimisation

Bammer, Hall, Hamilton and Ali claim in Australia, '*an independent humane pragmatism continues to be the overarching approach*,' (2002, p. 92) but many questions have arisen as to the independence, pragmatism and indeed humanism of local drug policy asserted in this quote. Hamilton and Rumbold suspect that some might reject harm minimisation because it is (too) soft on drugs but that the reason for its persuasive strengths is that it '*straddles the middle ground in relation to many key issues and debates*' (2004, p. 143). Another way of expressing '*straddling of the middle ground*'– and I concur with Zajdow – is that, as a policy, it '*is an attempt to come to terms with ambivalence by avoiding the issue altogether*.' (Zajdow 2005a, p. 186)

Harm reductionists have in common that they strive for a '*mosaic of middle range policies*' and are not aiming at '*macro*' policy responses (quoted in Hamilton & Rumbold 2004, p. 136). Its '*pragmatic strength*' can also be viewed as its weakness: it accepts that *harms are being caused* and is less interested in understanding societal *harm production*, because its

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*apathy but to a hyper- and pessimistic activism. I think that the ethico-political choice we have to make every day is to determine which is the main danger. Take as an example Robert Castel's analysis of the history of the anti-psychiatry movement [La Gestion des risques]. I agree completely with what Castel says, but that does not mean, as some people suppose, that the mental hospitals were better than anti-psychiatry; that does not mean that we were not right to criticize those mental hospitals. I think it was good to do that, because they were the danger. And now it's quite clear that the danger has changed. For instance, in Italy they have closed all the mental hospitals, and there are more free clinics, and so on – and they have new problems*.' (2000b, p. 256) Harm reduction might be less dangerous than other forms of governing 'drug users' but it is still dangerous albeit being differently so than other approaches such as zero-tolerance, prohibition etc.

advocates concentrate their efforts on - at best - minimising harms and not (or much less) on avoiding their causation, indeed a *pragmatic* stance, but not an a-moral or neutral one.

As discussed, when Berry Street's harm minimisation strategy of supervising volatile substance users ('chromers') was stopped in its practice by a media induced government response, harm minimisation supporters did *not* demand from manufacturers of chrome paint to use less propellant and make them less '*harmful*;' instead, they claimed the forced cessation of the practice to be a result of *ideological* preferences around abstinence and zero-tolerance. That *supply* policies and strategies *can* be pursued to reduce harmful substance use has been proven by the rolling-out of non-sniffable petrol in some Indigenous communities (Abbott 2006), posing the question as to how harm reductionists choose their political strategies and priorities. A chief '*idea-logue*'[201] of harm minimisation, Alex Wodak, explains the drug policy dilemma like this:

> Why have the health, social and economic outcomes from illicit drugs in Australia continued to deteriorate for so many years? Firstly, there has been a systematic failure to collect relevant evidence (such as would be obtained from a heroin trial). Secondly, policy (including funding) has been based on ideology rather than evidence. If we want to help drug users lead normal and useful lives and offer some hope to their families and their communities, the first step is an unswerving commitment to evidence-based policy and practice without political interference. (Wodak 1997)

'C*ard-carrying harm-reductionists*' (Wodak 1994, p. 147) often lump their '*opposition*' together and fail to analyse motifs and even 'evidence' that run counter to their interpretations of drug problems. To juxtapose ideology and evidence is a typical interpretation of people who want to believe that politics and policy ought to be separate domains and who believe that sciences are non-ideological. Even assuming that evidence about treatment 'effectiveness' and modalities and other drug policy choices could be made in a politically less contested manner, it would still be a huge challenge to devise programs purely on particular types of '*evidence*' because matters are so complex and modes of researching drug issues and users have been biased, as I attempted to show throughout the thesis. Reducing politics[202] to '*political interference*' is theoretically

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[201] Ideology is a term that is perhaps not useful when it applies to false or '*distorted group consciousness*' argues Hoy (2005, p. 200) and he summarises Laclau's suggestion about the use of the term ideology as follows: '*[I]t should be applied to those conceptions that take the social order to be inevitably or necessarily the way it is and that fail to recognize its malleability or its precariousness*.' (Hoy 2005, p. 205) As the notion ideology has such troubled implications of *true* consciousness, I will treat it here in the sense of an '*idea-logy*' – a vision and abstract view of societal processes and their interconnections (and causation).

[202] Two different ways to think about politics have been put forward by Foucault and Cruikshank, the latter arguing that politics ought to be thought of at '*the level at which citizens are constituted as free and politically active subjects*' (1999, p. 44). Foucault suggests that (militarily) politics has functioned as a 'blender': '*Politics, as a technique of internal peace and order, sought to implement the mechanism of the perfect army, of the disciplined mass, of the docile, useful troop, of the regiment in camp and in the field, on manoeuvres and on exercises*.' (1991, p.

problematic and overlooks that harm reduction/minimisation '*believers*' operate themselves with political tools, in the political arena, seeking to use politics to achieve their goals.

Again, Wodak leaves out the institutional dynamics, which are often neglected precisely because they operate on the most slippery level of all. Hall reports on (commissioned) drug research, where industry and government departments try to control the agenda, restrict data access, comment on drafts, control the (timing of) publication of reports, demand advance notice of any media stories and so forth (p. 2006, p. 240). Not surprisingly, he then notes that we do not know about the prevalence of such practices in the drug and alcohol research field. Such institutional '*protectionism*' is a clear expression of the political-economy of doing (drug) research work and the reason why we have yet to see research emerge that problematises and specifies the different positions taken up among harm minimisation supporters and organisations attached to the 'paradigm'. It is somewhat peculiar and particularly contradictory that harm reduction/minimisation supporters, such as Wodak, positioning themselves as '*middle-range*' operators, can be so dismissive of or even ignore institutional dynamics when this is the '*sphere*' they claim to master. Following the logic of the four-level conceptual framework, I suggest it is impossible to *only* operate in any one sphere, domain or level: being a middle-range actor makes one no less an actor in individual, relational or political-economic levels. An institutional analysis only, for example, could not explain why the 2006-07 Federal Budget allocated $5 million to Drinkwise, an alcohol-industry funded organisation, for an education marketing campaign, why *volumetric* alcohol taxation is still not raised based on *alcohol content* or why school-based drug education and other rather less effective measures to prevent drug-related harm are '*perennial favourites*' (Roche & Evans 2000, p. 155) with politicians.

Returning to the political-economic relevance of harm minimisation and to the workers' own voices, I wonder: *What if, instead of asking what 'harm minimisation' is, we ask what harm minimis**ing** is and what '**harms**' **are***?

### 2.3. Workers (and clients) learn what 'harms' are

Darke, Degenhardt and Mattick ask '*Why should society care about drug-related death?*' (2007, p. 135) and they provide the following answers: apart from '*compassion*' for the '*drug user*' – which, according to the authors, includes recognising that they have lost '*control*' over their use (partly caused by '*psychological factors*') and, therefore, cannot be charged with having

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168) Politics thereby becomes of tool of government producing '*indefinitely progressive forms of training, not to the general will but to automatic docility*.' (Foucault 1991, p. 169)

'*freely chosen*' or self-inflicted their drug use – we should consider the *cost* of illicit drug use to society '*through crime, disease, and lost years of productivity*' (2007, p. 135) and be aware that drug users will not stay so: in the end they *will* make a contribution to society. They also urge us to consider the impact of '*drug-related death upon the families of decedents* [sic]*, and increases in the risks of "shattered childhoods" for the children of deceased users*.' (p. 136) What used to be a '*client-centric*' approach at *individual* and *relational levels* and what became a '*smuggle*' pack of all sorts of considerations at the *institutional level*, at the political-economic level takes on an entirely different reasoning towards '*making a difference*': not the user him/herself, but the *impact on non-users* is the primary rationale for '*caring*'.

The police force – having a political-economic mandate - uses the same rationale, as Neil Comrie states:

> Victoria Police considers most drug users to be victims rather than primary offenders, but also recognises that enforcement action often must be taken for health and welfare reasons, and in response to the expectations of the wider community. (1999, p. 51)

This is, indeed, a familiar line of argument: we '*care*' for the impact of drug-use on non-drug users and we '*intervene*' with law enforcement in the '*best interest*' of the user; it also turns client-centredness on its head. *Juxtaposing* the interests of '*the community*' with those of '*the individual*' (drug user) is not helpful in understanding harm minimisation discourse as it intends to work on *aligning* both sets of interests – and thus *produces* its own interests.

The question then becomes how workers (and clients) are *taught* which harms are *considered* '*harms*' and how they are *inducted* to avoid or minimise those harms which can be usefully addressed via established and legitimated *service system* responses (as most other responses are precluded until changes at the political-economy level render them *feasible*)? How do they learn which '*harms*' are harms for them, for the service system and for 'society'?

This worker explains how she learnt what harm minimisation 'means':

> [Dana, foster care worker] *I suppose over time we've understood a bit more about drugs and addiction. I'm talking about drugs, not just heroin or the hard drugs. I'm talking about poppy smoking, alcohol. I think that we understand through research that it is hard to stop doing all those things and the will's got to really be there to be able to stop and I think that the whole philosophy behind harm minimisation, and we talk more about harm minimisation than we did when I was first in the field – those words weren't around basically. I think now if I work in the parameters of harm minimisation I understand it better. In my opinion, I will work more realistically with people who have got drug issues, rather than thinking, 'ah yes, I can make a difference', 'I can get this person off the drugs', or because there are all these other organisations involved we can make a difference. But we can make a difference but it may not be the difference to the point*

*where they get off drugs. So I think it's having just a bit of a broader picture and my framework of working is that it's bigger*.

Dana expresses the common discursive construction of harm minimisation as offering a more '*realistic*' approach to working with drug users, indeed, as the only one accommodating realistic expectations and complexities. Whilst probably more '*realistic*' in that workers learnt to recognise complexities surrounding drug-taking people, it simultaneously often means engaging in '*small target strategies*', labelling abstinence as '*unrealistic*', '*idealist*' and '*disrespectful to clients' lives*' and, hence, inadvertently prolonging drug problems. It may be just as problematic to *coerce* people into ceasing drug use as to enable them to continue using drugs without as much 'harm'. Intentionally or unintentionally, harm minimisation in Dana's context becomes a *rational manager* of drug-use practices within harm production systems and her quote was typical for many workers who had been trained or otherwise acquainted with 'harm minimisation logic': workers learnt that to work '*realistically*' means that they will not get clients off drugs. This family and personal support worker describes how harm minimisation interventions have produced a certain *type* of intervention, the *clinical* one:

> [Uma] *I just think there's a massive health component that has to change around drug users but there's a huge part missing. There's a lot of clinical intervention but there's not a lot of personal intervention or on natural alternatives as well. […] It's not just a clinical recovery, it's a holistic recovery, it's like all types of medical interventions: A lot of the interventions we have around drug and alcohol use are quite clinical and they've mostly been through the system. They're 16 and they've grown up in the system with their mother being a drug user and they so know the system that it's totally ineffective for them because they've lost faith in it, because they've watched a parent grow up with an addiction and not seen anyone really help them and they're seeing how they've thwarted the system or used the system but it actually hasn't done anything for the family. I think the family of the people who use drugs are the people that are missing in the picture. We can see the users, we can support them, most of the time they've lost their family. A lot of the time the family still needs support, reunification, it's possible, it's a huge gap. A lot of these people are still using... absolutely they've lost everything and they don't know how to get back. The family have never been educated on why it's happened, they've never been healed and so there can't be a reunification. They may get well and they may get off the heroin but still their family don't believe in them. They don't trust them, they don't understand and they don't know why they did it so they won't have them back. They are so grief-stricken, there's a lot of grief counselling that needs to happen too because there is such a loss. There's a loss of life and that's something that is missing*.

Uma asks a pertinent question: what does *drug users' health* in harm minimisation discourse 'stand' for? Clean drug paraphernalia, supervised injecting rooms, hand washing campaigns, HIV/Hepatitis C detection, liver clinics, methadone maintenance, pharmacotherapy of

different kinds, retractable syringe trials, (peer) drug education and some primary health care responses, all very *selective* attempts at defining '*public health*' and '*health*' in general for people who take drugs, particularly those who use drugs problematically. Dieticians and dentists have not been part of the response; no-one asks a drug user whether s/he had a good night's sleep, a place to call home, nutritious food or whether s/he was able to obtain and afford education/training, a selectiveness we should remember when calls to address drug problems as (public) health problems are being uttered.

Uma reveals the challenge of designing a service system that is effective in providing *help*, not just according to the parameters of '*service accountability*'; seeking holistic responses would require to 'join up' discourses, selectively dropping, merging, diversifying and smudging them. As did many other interviewees – she shows that the service system neither necessarily *helps* individual clients nor their families; not only are family-inclusive responses missing, by and large – with exceptions like the Mirabel Foundation[203] or the Nobody's Client Project[204] – the family is not even *considered*, whether drug users' parents are concerned or their children or siblings, orphaned children, family members caring for drug users' children or family reconciliation.[205] In addition, service systems should be flexible and judicious as to the inclusion of families; for some clients it is not wanted or even detrimental, whilst for others it may be a strategy for recovery, reintegration and for assuming family responsibilities.[206] In any case, the *political-economic* concern with the drug user for the sake of *non-drug users* does *not* include the family[207] as *non-drug user*, but an *abstract* and *generalised 'community'*[208].

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[203] The Mirabel Foundation was set up to help children who were either abandoned or orphaned in association with parents who used illicit drugs.

[204] Odyssey Institute of Studies ran a project which helped to assess and meet the needs of children whose parents were involved in drug treatment. The project staff helped with parenting skills, schooling and daily routines as well as caring responsibilities, etc.

[205] Family-inclusive practices in the service system are still in their infancy and subject to much advocacy work at federal and state level (see VAADA's submission to the (federal) Inquiry into the Impact of Illicit Drug Use on Families 2007).

[206] The political-economic level brings forth the tension between a notion of responsibility, which is lived in the *relational*, accepting and respecting people's responsibilities towards themselves and others and which may be limiting and enriching, and a notion of responsibility which is enforced by the so-called over-responsibilisation of the individual in the market and social framing in contemporary society.

[207] This oversight is particularly difficult to explain given the Howard Government's national mail-out of an information brochure in 2001, claiming that drug problems needed to be addressed preferably and primarily by families. A new ANCD report on the impact of drug problems on families has acknowledged the systemic lack of family-inclusiveness in treatment and other responses to drug issues (Dawe et al. 2007). The report finds that the National Drug Strategy does not address the needs of children from drug-using parents (Dawe et al. 2007, p. xi) and emphasises that drug use problems should not be treated in isolation from unemployment and poor housing conditions (Dawe et al. 2007, p. viii).

[208] Many workers said they would like to see the drug using client reintegrated into the community, but I would argue that they are already not only *in* the community but *part* of it. Their marginalisation, discrimination and 'social

Efforts to minimise harm cannot exhaust themselves in trying to constitute drug problems as *prohibition* and (public) *health* problems; Querida explains how drug problems are medicalised and abstinence becomes *discursively absent*:

> [Querida] *The drug and alcohol workers that I work with aren't ever looking for abstinence. They're only sometimes looking initially for reduction and they've got all sorts of strategies to help you reduce. It's very much: let's help you on a path of reduction and then perhaps you can manage your life better and then if there's underlying anxiety and depression then perhaps if you get off the drugs you're going to need something to replace that with, if you've all your life relied upon that to quell the anxiety. A lot of these young people can't get on a bus or walk down the street without feeling paranoid or anxious. So it's very important to focus on 'Would you like me to set up some appointments with your doctor to talk about anxiety with him, just see if they can assess you as suffering from anxiety or depression?' Let's look at the differences, a doctor can often help work out which sort of medication might be helpful while you're reducing your marijuana to perhaps replace that and start building that up in your system so you'll find actually you don't need that much marijuana to survive each day. It's looking at medical needs, the doctor might want to help you get some blood screens so at least you can know if at this point in your life you're virus free and you're not carrying any blood borne diseases then you know that only your behaviour in the future is going to contribute to that and at the moment you're healthy*.

Working with the young homeless, Querida reveals the *narrow* definition of 'harm' in adopting practices of drug reducing, drug testing, blood and virus screening as well as illicit drug 'replacement' medication dispensation and how intimately harm minimising is linked to practices inherent in the medical system, a powerful part of the established political-economic establishment. Fred, the bail advocacy program worker, showed how a methadone program constitutes a unique meeting of welfare, medical, criminal and political-economic rationality:

> [Fred] *Whoever thought of using methadone as an alternative should be forced onto a methadone program. It is far worse than heroin. It has more side effects and all it's doing is putting money in other people's pockets. The chemists are charging $5-6 a hit of methadone. And the bup[renorphine][209] has now reached the same level. So any self-respecting junkie would need a hit a day. You work that out over two weeks, there's $84. Now a decent junkie is put on a methadone program to help them deal with their problems and it will also reduce the need for crime. Now if you're on the dole and they get cut-off, they've got no income and they're constantly being cut-off. They're constantly being penalised by Centrelink for being a junkie. Well how can somebody that's using go for ten jobs a week or a fortnight. They can't… And Centrelink knows what's going on. These people tell them they're on their methadone, they can't hide it. Most of them are honest too and they realise... 'give me a break I'm on methadone, give me a break'. 'No sorry, the rules are'... I don't know how many times I've been to Centrelink trying to*

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exclusion' operates in very subtle and very blatant ways but they are *not outside* of the community. Again, '*re-integration*' always has a flavour of needing to conform to '*societal expectations*'.

[209] '*Bup*' refers to buprenorphine maintenance treatment.

*negotiate that one. No sorry, tough! [..] Now what junkie are we going to turn around in two years? Very, very, very few. Everything they try, everywhere they go... somebody's against them. And as far as the people in Centrelink, it's very rare you find any sympathy for them... as far as they're concerned, they're the scum of the earth, they're junkies. Some of them seem to think they'll get a performance enhanced benefit if they can bloody well get them off the dole. Now if they want to stay on their methadone or bup they've got to find that $84 a fortnight. But what about eating and a roof over their head? Their chances are they're only getting $200-300 a fortnight anyway. So chemists and governments should be shot! If they're going to put them on programs they should give it to them for nothing. It's just as hard to keep somebody on there as it is to try and keep them off the other shit. They can't afford it. 'Oh, I can't afford that... I've got $50 and I've got to live for the next 2 weeks, I've got to get cigarettes, I need at least a couple of coffees and a fucking hamburger'... and they're right. A lot of them would tend to let the roof over their head go before they will give up the cigarettes or coffee and the bup. But then, all-of-a-sudden they're transient, no address, cut off. It's cyclic*.

This is a snapshot of the political-economy of poor people's drug use in metropolitan life: pharmacists make money; Centrelink staff (are encouraged to) suspend people's welfare payments ('*breach*' them) and discriminate against drug users; programs are not compatible with their daily lives and there's no pressure to subsidise or make substitution free; housing and health services are not geared to provide a basic safety net; and emergency relief agencies are as selective as their own precariousness forces them to be (Engels 2006). '*Choices*' in the financial counselling context 'offer' the freedom to be homeless, 'disconnected' or hungry:

[Lara, financial counsellor] *This is a non-judgmental sort of area that we're in and how people spend their money that we don't say, 'you know, you must cut out drinking', 'you must not gamble', 'you must not do this' – that's their choice, we might point out to them that 'well look, this is what you get in every fortnight, this is what goes out, you might need to make some choices in your lifestyle about what's going to be most important to you. If you're behind in your rent or your mortgage or you might have your home at risk or something and you need to look at paying the basics of keeping a roof over your head and your children's, if you've got them, and keeping the gas on and the water on and the power and things and buying food and …' then we might just point out that they've got choices to make about how they want to spend their money and if they're having difficulties paying their gas bill or paying their rent, then that's some choices they have to make, but that's all*.

To respect a client's '*choices*', however, is also to *accept* harm being *produced* through *not* helping and accepting the conditionality, restrictions and compromises of a service system that does not even pretend to act as social insurance or safety any longer. Workers learn to address only what/who is 'addressable': the political-economy is *hardly* addressable, the service system *sometimes* is and the individual is *very* addressable, so they concentrate on the client as an

individual and shrug their shoulders about the overall picture. '*Harm*' is *not* being without a home to come home to; *not* being unable to afford nutritious and wholesome food or dental care:

> [Uma, family and personal support worker] *I learnt that methadone completely wrecks their teeth and a large proportion of my clients have extreme pain with their teeth, dental health is a major problem in this country, in this city, that there's thousands, hundreds of thousands on the waiting list for dental and that's a really big barrier to a lot of the users because of their teeth. They go off the heroin onto the methadone, their teeth get completely destroyed and they are eaten away with the methadone and therefore they don't feel they can go for a job because they look ugly, they believe that they may have had beautiful teeth and they can't afford to get new teeth and they don't want to have false teeth. First, they can't just go and get all their teeth out and false teeth put in, it's a huge cost. While they're using that's not a possibility, while they're on the methadone program they're usually not able to work. They're usually not able to pay for a dentist and the dental health really exists on such a minimal basis it's a joke, an absolute joke. I learnt how important their teeth are to them, they talk a lot about them and the older clients have problems with their teeth and they suffer chronic pain, toothache, abscesses, holes, nerve damage, poison through their veins through lack of education around their hygiene*.

Harm minimisation discourse thus willingly *compromises*, based on a narrow construction of '*health*' for drug users; but its greatest compromise remains the issue of *abstinence*; most workers unequivocally regarded it as the ultimate goal and achievement for their clients. An example from a domestic violence worker:

> [Vera] *Don't get me wrong, I think harm minimisation works with some people. I think it works for some people but, again, people who it doesn't work for haven't many options any more. ... Even like the rehabs have to do harm minimisation now. [..] but the majority of the women that I saw that came into rehab had like problems with alcohol, had problems with illegal drugs and had problems with prescription drugs, so it was about trying to get them off all their drugs at the one time. Now I know that these women in the rehab I used to work at and they're on Valium. I'm not saying that that's wrong at all, but I'm saying that sometimes you don't give people the opportunity to be totally clean. I think the government did a really bad thing when they shut down a lot of the rehabs. There're very few rehabs and detoxes are so hard to get into. Like I don't know how you go on a waiting list to go on a detox. If someone's chosen to get clean, then they need to almost walk into a detox. To actually say, 'well look we're full but come back in two weeks, we have two detoxes', or 'here, yes you're a drug addict but we'll do a home detox and we'll leave you with Valium'. That's one of the reasons I changed jobs, I loved it and I often think I'd like to go back and work just solely with people with addictions but there's not that kind of work around. It's all harm minimisation and I think harm minimisation's great if you've got someone with a problem with alcohol but if you've got someone who's an alcoholic, harm minimisation is not going to work for them, they need to not drink at all kind of thing*.
>
> [R:] … are you saying that harm minimisation doesn't allow abstinence-based approaches or…?
>
> [Vera] *It does, but I think it's not pushed as much…*

Vera spells out a concern attached to harm reduction since its inception: abstinence is not regarded as an aim within its policies or practices; it might be a desired outcome but it is not an *expected aim* of harm reduction interventions. She also distinguishes between people having a '*drug/alcohol problem*' and '*alcoholics/addicts*' in terms of the interventions on offer; her objections resonate with McKeganey's work, which found that drug users contacting drug services wish to become *drug free* and he questions the *reducibility* of harm with continued drug use (McKeganey et al 2004 and 2006,p.568).

Vera's doubts were amplified when asking Indigenous workers[210] what they thought of harm minimisation:

> [Eva, Indigenous family support worker] *Failure, that's what it means. The only people it works for are people who aren't addicted. [..] If people are heavy users of alcohol or social drugs, it works for people who are socially overusing a substance. [..] But it doesn't work for addicts and that might be 5% of the people we meet who go, 'Oh shit yeah, I have gone a bit overboard' and they would have done that anyway. We needn't have set up all these stupid retard services for them because they're going to get it anyway. Their mates are eventually going to say, or their girlfriends or their mums whoever, 'You've gone too far, Freddy. Pull your head in' and they have the ability to do that but addicts don't. Alcoholics don't have that ability … that's what I find frustrating. Repeating the same thing to someone who's addicted and you can see they just don't want to get it*.
>
> [R:] Well, it's interesting because I've spoken to a lot of workers now and most of them believe in harm minimisation but they understand it to almost be meaning safe usage.
>
> [Eva] *That's exactly what it means but [..] Because we're saying we're minimising the harm that people do to themselves but I say, let's look 10 years back with person X and 10 years forward and let's see if we have minimised the harm and I'll tell you, we haven't. We have prolonged the harm over a longer period of time. We've minimised the crises that are affecting society, that's all we've done. We haven't helped the person change the circle that they're going round and round on and they just live longer. I think the drug and alcohol system sets people up for failure. If people could go out and have one shot of heroin a day or one drink of whisky a day… well they would, wouldn't they? […] There're systems that say, "Well, go on methadone". Now we've got 13 year old kids going and getting methadone and not seeing what methadone does to kids. It knocks the crap out of them and they get more addicted to the methadone than the shit they were on before and they're stuck in this horrible cycle and their lives revolve around having to get to the right chemist at the right time… I just think the whole system's shit. That's my opinion. […] our community's getting more and more people who have got less and less hope. So we're not harm minimising. The intention was to harm minimise but now we've got an alky and an addict who are going to live 3 times as long as they ever would and they're still going to need the same amount of money to get their booze and their drugs so they're going to be breaking into a lot more houses over 30 years than they were over 5…*

[210] I speak here of three workers who identified themselves as Indigenous to me. There may have been more indigenous people in the study who did not disclose their ethnicity.

*we're just creating this monster. This horrible monster and I don't think it's intentional, it's just sometimes you get a bit burned by it*.

That harm minimisation policies in effect *prolong harm* is confirmed by Fred, who uses a different language to talk about people trapped in the *prison-chronic-drug-use* cycle:

> [Fred, bail advocacy program worker] *A lot of them are on the merry-go-round but for different reasons. It's just that their fate is as far as they're concerned, that's the way it is. That's the way it's going to be. That's very much a symptomatic thing of people… until something happens that makes the decision that they finally start to make that decision to sort of… it's time to get out – if they do, I mean there's a lot who don't. We're seeing people in their 50s that have been doing this for 25-30 years, they never will change. Mind you, there's not a lot of them because generally they've either gotten out or they've overdosed, but we are seeing a higher rate now of people in that cycle that are now in their 40s and even 50s. The quality of life's obviously improving somewhere*.

People with a decades-spanning drug habit are living longer but their *living conditions* may not change and the fact that their health may not be (as) detrimentally affected does not mean that other harms have been minimised. The '*drug addiction holding bay*' metaphor Fred is intimating is not often encountered in the harm minimisation literature. The workers' observation that people are involved *longer* with drug use under harm minimisation policies again raises the question about the *complexity of abstinence*. Abstinence is *both* conforming *and* resisting by stepping out of the drug-use discourse; it is a way of *resisting* discourses that govern drug use by *escaping* them and a way of *conforming*, as one is able to be '*productive*' by avoiding certain drugs or drug-use effects. At the same time, abstinence is also a way of *not* conforming, as *most people do use drugs* and increasingly use them to enhance their '*functioning*' and ability to 'perform', from doping to 'smart drugs'. We go to work in spite of having a bad cold, as we cannot afford to not go or our employers want us to be there regardless, so we take drugs hoping to continue to perform.

Interestingly, the Indigenous human service workers I interviewed displayed a more *communal* way of understanding drug users; whilst most Anglo-Saxon and 'white' workers had an '*us*' and '*them*' attitude towards drug users, the former understood them as people of *their* community, objecting to harm minimising as *moderation* or *reduction* of drug use - particularly '*safe*' drug use - in the strongest terms. This difference can be understood as an effect of the *cultural political-economy*: white workers (generally) enculturated in (possessive) individualism don't see the ties between clients and themselves as having the quality of *communal* relating;

indeed, they do not take what happens to their clients *personally*, making this a *virtue* and a *proof of professional conduct*, whilst Indigenous workers do.[211]

The cultural political-economy, therefore, has an effect on preconceptions, as do class, gender and age positions; we are products of our environment as it is a product of our actions, but we often forget how ignorant we actually are when it comes to understanding people in different life situations and who have made different '*choices*'. Oliver describes this as a 'clash':

> [Oliver, community legal service worker] *You have a client who's in a drug related matter, most of the time if you can get it you want them to be represented in court by somebody who is professional and who you can pay to represent them and a lot of the time we can't do that because clients don't have the funds, we don't have the funds, the government doesn't have the funds, nobody has the money for it, so I think that limits our ability to get the best result for clients possible. [..] Students have to realise their clients usually come from incredibly different backgrounds from the students themselves. The average law student profile is private school background, eastern suburbs ... and most of our clients don't come from anything like that, so you have to understand their thinking process and their lifestyles are very different from the students themselves, and not to judge them in relation to that*.
> [R:] Do you think there is a class dimension in there?
> [Oliver] *Oh yes, I mean this is a classless society isn't it? [laughs] Look 75% of our students, especially law students, come from a private school background and live in an inner-eastern suburb, as did I, and come from privileged backgrounds as a general rule. 95% of our clients come from completely non-privileged backgrounds, probably 99% of our clients, so there's a culture clash for the students, there's no doubt about it*.

Oliver summarises the '*real*' and the '*imagined*' distance between people who 'help' socio-economically deprived drug users; a *real* distance, based on socio-economically polarised suburbia and an *imagined* distance because we often quite literally do not know or are unable to relate to how others live.

I have attempted to show how workers (and clients) learn which harms they ought to recognise as such and those which have become 'addressable'. Through the selective dynamics of identifying and addressing *some* harm whilst not constructing many other effects of poor people's (problematic) drug use as 'harm', harm minimising policy and practice can become somewhat of a game of roulette as to making a difference for non-drug users and drug users alike.

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[211] It would be worthwhile to research this dynamic further and ascertain if this is a trend that can be generalised or a peculiarity of the interviews I did.

## 2.4. The government of 'choice' in harm minimisation discourse

As stated in Chapter Four, a key idea about drug use is the idea of '*choice*,' which is a rather difficult term to capture in its multitude of meanings. What does '*emphasising choices*' in the worker-client encounter mean within the harm minimisation context? Adam, member of a multidisciplinary youth team, explains how 'choices' can mean clients learning how to find their veins:

> [Adam] *I've seen people with kind of blood pouring out of their arm, trying to find their vein, and those types of things don't disturb me. I just sort of tell them to go somewhere else, they're trying to find it in the wrong spot, give them a few other choices about where to find their veins*.

But some *practices* that have attached themselves to '*harm minimisation*' discourses are not just '*vein care*'; they can also mean being given the choice to '*use needles first*':

> [Angela, youth residential worker] *I've had an incident where I've told a kid, like they said that they'd shared a needle and I said 'oh well you should have used it first, if you only had one at least then it was clean for you' [laughs]. I mean it's just stuff like that, and that kid was like, 'oh yeah, you're right'. And then I knew that next time they went out there was a good chance they were going to use the needle first which is something that could save their lives. But it also gives you windows of opportunity to get them to think a bit more about why they're taking whatever they're taking and the communication also helps you to work with them on ways of reducing or minimising their use so*.

'*Purist*' harm minimisation discourse may well be non-existent in practice and its diffusion in social service spheres has been contradictory, incomplete, sometimes even entirely absent. Many harm reductionists would be appalled to read the above and find Angela to 'misinterpret' their intentions; one government departmental official I spoke to thought Angela was condoning sharing needles. Whilst it is difficult to ascertain what Angela *thought*, she '*advised*' her client to use his 'competitive' advantage when using with peers, demonstrating that minimising 'harm' means *accepting* that it is 'produced' in the first place and that it leads to individualising people and divorcing them from their social contexts and that 'their' choices in harm minimisation are muddy and even opposite to what its intention is. O'Malley and Valverde state that drug users are given information so as to make '*informed decisions*' (2004, p. 36), yet this information is delivered by workers who may have *little idea* about drug use, are minimally trained and work in 'non-drug related' services, unable to 'verify' the information they have been given.

For many reasons, my interviewees often learned more from clients about drug use than from other sources. As already mentioned, 'we' inhabit vastly different life-worlds[212] and the *fragmentation* of our lives means that relating to other people's experiences may become ever more difficult. Paired with their *habitus* of being '*people people*,' workers relate to clients' stories more than to training and text book knowledge.

Needle and syringe programs (NSPs) are often described as one of the hallmarks of harm minimisation programs, yet, workers who are not working in NSPs may, even if they wanted to, may not be able to give clients needles for '*safe use*'. Marc regards his workplace as not operating within a 'total' harm minimisation logic:

> [Marc] *The policy or the guidelines that we generally follow are dictated by the Department of Human Services. There is a bit of a conflict in terms of what the definition harm minimisation is. I'll give you an example. We have residential units where these young people are housed. Now the Department have dictated in their guidelines that there is to be no drug use or drug paraphernalia in any of these places. OK. Not a problem with the drug use but the drug paraphernalia, that doesn't actually sit well with the harm minimisation approach, not entirely. That's actually more directive and a bit more zero-tolerance approach than what a harm minimisation approach is. So that means that I can't give clients clean needles. I can direct them, tell them where to go to get them, but I can't physically get them for them, but in a total harm minimisation philosophy I'd be able to do that*.

Here, the framing of *youth residential clienthood* excludes the choice to be supplied with clean needles, even though workers, knowing clients are injecting drugs, would like to dispense them. In addition, providing a drug-free environment to other young residents who do (not yet) use drugs becomes rather difficult. The presence of drugs, equipment or paraphernalia creates its own problems, as Charles, a youth residential worker, pointed out:

> [Charles] *Like the syringe disposal box we have up there. It's mandatory that we have that in there and I can't imagine any home or a place that you're trying to make as a home, feel like a home, with a syringe disposal box in the corner of the lounge room. I think knee-jerk reactions to cases similar to that really restrict our freedom to move and work positively with the clients*.

The message that the syringe disposal bins sends to the client may be that '*we're preparing you for your drug use, we allow your drug use and we have the equipment in place for*

[212] Life-world, originating from German phenomenologist Edmund Husserl, developed by Alfred Schütz, refers to the (natural, practical, pre-scientific) skills, knowledges, experiences and expectations which allow us to give meaning to the world we inhabit (Schütz & Luckmann 1973). It is a '*phenomenology of the natural attitude*' and refers both to methodological considerations and the study of a subject matter (Vaitkus 2005, p. 98). The concept has subsequently been taken up in a more theoretically abstract form by Habermas, Giddens and Luhmann (Vaitkus 2005, p. 98).

*you to dispose of it*'. To Charles, working positively with clients seemed incongruent with the practices and physical outfit of residential units, also being concerned about the increasing lack of discretionary practices and the constant regulation of a 'risk' environment:

> [Charles] *Say if one kid who became critically ill over one really sort of isolated incident, there will be policies and boundaries thrown in just to protect that from ever happening again which in turn will say institutionalise the way we work.*

Olga, an intake family support worker, recognises that '*choice*' is itself a social construct:

> [Olga] *Well my first instinct was to say it's a choice and I do think it can be a choice but it's a choice sometimes that… it's kind of like an ill-informed choice where obviously no one is forcing them to stick a syringe in their arm or whatever, but given what their circumstances have been, they feel like there is no other way. But I think for some people it literally is, they decide they'll go out and they'll take an 'e' because that's just what you do when you go out or have a choof in a group because that's what everyone's doing… but I think some stuff that is much more entrenched and so probably I can backtrack and say it becomes not a choice. It becomes just what their lifestyle is and a very difficult thing to get out of, that's why we need to work from harm minimisation, so acknowledging that it is hard but what's the ultimate aim and the ultimate aim would probably be choose not to use, I suppose, but maybe they never will, so we have to find a way to work with them around that*.

Olga '*backtracks*' when reflecting on the *conditionality* of *choice making*, but harm minimisation discourse seems to have succeeded so well that she remains convinced it being the *only* discourse recognising complexity and difficulties in drug use patterns and that it is the only '*hanging in there*'-approach available to workers to work '*realistically*' with users. Recognising *choices* in their subjective and contextual framing is always already *discursively constructed* and the following more *humanist* version of 'choosing' by a counsellor reveals her concern with the magnitude of some choices her clients have to make:

> [Kirsty] *They may still be using but are they more present in themselves, are they more aware of the effect of the drug and maybe the choices they're making? They may go on making those choices to use, so no, my measure of success is not if they get off the drug, that's your ultimate. But the next stage is terribly frightening to them, which is why they find it so hard to do, which is can they survive without drugs, that's the first thing. That's okay we can get them to that, but can I live without drugs? Can life be interesting without drugs? Can life be exciting? Can I cope with normality – that's really scary for most of them [...] We talk in terms of 'drug of choice', so it may not be that they've got a choice about using something, but they do choose what drug they use*.

This description represents the dual meaning of '*drug (of) choice*' at *political-economic* and *individual* levels: the former brings clients into a position where they are more likely to use drugs *problematically* (its consequences more immediate, because they are poor), whilst the latter

has clients choosing from a range of drugs (already available and commercially exploited). In Kirsty's account, the question for clients is '*how can I/we live without drugs*?' and even if the 'situated context' of someone's decision making is *understood* at all levels of its constitution, the 'choosing' individual in such situations is still the only one for whom they have *immediacy*[213].

This counsellor connected choice with 'empowerment' and reminds us of its discursive construction at the *individual-relational* level:

> [Theda] *I think you need to maintain your expectations but you've also got to be realistic, I guess and just understand that this is what will happen when you're working with these sorts of people. In the years that I've been working, I suppose I've developed lots of personal techniques and things, but one of the things is that it's really important that it is actually* ***their life and their choice****. It's very easy, particularly with someone who is very vulnerable, to want to almost do it for them or to think they may not be able to make choices. What we've got to remember, I think, we've got to keep focused, that no matter what condition somebody's in, they are* ***open to another choice*** *and I need to leave the power in their hands. I'll support them in any way possible but once you lose sight that someone's able to make a choice, it becomes a bit dangerous I think in a sense. So for me it's always, no matter how small the choice is, it's always presenting something, always putting things forward so that they are able to* ***empower that aspect of choice*** *and even if it's a choice I don't necessarily agree with. Of course people's safety is an issue and that's probably the area where there's self-harm or suicidal thoughts… all those kinds of issues… I mean that becomes more complex then, but other than that I think there's an acceptance that it's a long haul, you're going to be there for quite a while probably. There'll be some up days and up times and there'll be some down times* [my emphasis]

This quote presents workerhood as asserting '*positive liberty*' in clients and mobilising their *own subjectivity as means and ends*. For Cruikshank, the notion of 'positive liberty' meant that the '*[t]he state could not legislate morality, but it could legislate in order to prevent harm*.' (1999, p. 47)[214]. One cannot force people to be 'happy' but one can help them to make '*better choices*'. As long as people choose to do something within a range of offered choices, such as self-care, education or health, positive liberty can be enacted: '*So long as individuals acted in the*

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[213] The fact that drug problems do affect all layers of society to some extent and disproportionally does not mean that we will eradicate drug problems if we were to eradicate social inequality. Zajdow explains how she changed her mind: '*For me, the answer to alcohol and drug problems was to sweep away poverty and inequality; the social and personal body were indistinguishable – what was good for one was equally good for the other. After listening to the unmediated stories of pain, anguish and redemption, I came to believe that I was wrong. Not that poverty and inequality should not be swept away, but that alcoholism would be swept away with them*.' (2004c, p. 42) This means that recognising a class dimension or social inequality in people's choices is important but cannot exhaust or explain sufficiently the bodily and subjective experiences which make us take certain (drug taking) paths.

[214] The notion of harm is connected to the Principle of Liberty in liberal doctrine, as Gray explains: '*This Principle – that individual liberty may not be restricted except to prevent harm to others – cannot fulfil the liberal role Mill wants for it, because of the intractably controversial character of the concept of harm which it incorporates and because, even if the concept of harm it contains could be adequately specified, the Principle would remain an insufficient guide to action*.' (1986, p. 53)

*interest of their own well-being, they would be acting in the interest of society*,' (p. 46) which is how choice and empowerment are *politically* connected: we empower ourselves and are empowered by encouraging choices and then negotiate (or acquire) ownership of the chosen.

The idea of '*choice*' is a product of liberal political philosophy;[215] in many '*advanced*' capitalist societies, neo-liberalism[216] became dominant political rationality: '*The Hawke/Keating Governments (1982-1996) basically bent to the neo-liberal agenda*.' (Davidson 2007, p. 3) Davidson argues that economic theories are particularly valuable in their *psychological* utility and are '*less expensive than coercive powers*' (2007, p. 2). Ironically, the theoretical vision of subjectivity neo-liberalism (and neo-classical economic theory) is based on is an individualism that cannot cater for, deal with or account for diversity:

> Mirowski has argued that a common response within neoclassical economics had been to reduce diversity by homogenising the individual actor, an ironic development for a discipline so fiercely committed to individualism (2002, p.450). By limiting the diversity of preferences, in some cases reducing all individuals to the same preference set, diversity is minimised, and thus the models become more tractable and more stable. (Spies-Butcher 2006, p. 123)

For computing and modelling purposes, individuals were reduced to rationalist and game theoretical assumptions (Spies-Butcher 2006, p. 123 ff), modelled on human conduct based on individual (rule-based) self-interest which, in its naïve formulation, also assumes that individuals are not inclined to cooperate. Game theory is unable to predict '*outcomes of games … due to [its] adopting* ***Homo economicus*** *from neoclassical economics*.' (Gintis 2000, p. xxiv) and viewing subjectivity as rational and self-interested lacks historical and empirical foundations:

> Monetarism, re-badged as Rational Expectations and then as Public Choice Theory, didn't have much in the way of empirical or historical foundations but it was built on a one-dimensional view of the individual as economic man (sic) who the medical profession would recognise as a psychopath. (Davidson 2007, p. 2-3)

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[215] '*Ideologically, liberalism claims that economic, political, and social relations are best organized through formally free choices of formally free and rational actors who seek to advance their own material or ideal interests in an institutional framework that, by accident or design, maximizes the scope for formally free choice*.' (Jessop, 2002b, p. 453)

[216] Beidatsch claims that Australian neo-liberalism is known as '*economic rationalism*' (2007, p. 55) but whilst there are many overlaps of these two concepts, it would be problematic to equate them because neo-liberalism is a distinct theoretical 'movement', originating in the German-speaking regions of Europe (Austria, Germany and Switzerland) in the 1920s and in the USA in the 1930s (Walpen 2000), in reaction to the establishment of the Soviet Union and the Great Depression of 1929 (Walpen 2000). Neo-liberalism does not originate in 1947, as David Harvey thinks (2005, p. 40) but he is right in asserting that it built consent in the 1970s (2005, p. 39ff). In any case, it is better understood in terms of 'neo-liberalisms' (Walpen 2000, p. 1066) because multiple strands exist (including ordo-liberals and the '*Chicago Boys*' – students of Milton Friedman) which are at times at odds with each other, in particular with regards to their position on the welfare state. Furthermore, '*Chicago Boys*' just hints at the androcentric mentalities and discourses in neo-liberalisms' subtexts and texts (Kreisky 2001, p. 5).

Whilst neo-liberalism is primarily conceived of as an economic paradigm,[217] its root assumptions about human conduct are '*conceived by liberalism, from Adam Smith to F.A. Hayek, as relying on the actions and choices of free individuals pursuing their own interests*.' (Dean 2002a, p. 40) The drug using subject has a duty to choose and to live with the consequences of his/her choices; neo-liberal discourse may or may not problematise the choices on offer or not, nor the mediation of 'choice' by *societal* processes. Instead,

> Individuals are to become, as it were, entrepreneurs of themselves, shaping their own lives through the *choices* they make among the forms of life available to them […] The political subject is now less a social citizen with powers and obligations deriving from membership of a collective body, than an individual whose citizenship is to be manifested through the *free exercise of personal choice* among a variety of marketed options [ …] Forms of conduct are governed through the personal labour to assemble a way of life *within the sphere of consumption* and to incorporate a set of values from among the alternative moral codes disseminated in the world of signs and images […] The self is *not merely enabled to choose, but obliged to construe a life in terms of its choices*, its powers, and its values. Individuals are expected to construe the course of their *life as an outcome of such choices*, and to account for their lives in terms of the reasons for those choices. (Rose 1999b, p. 230-231, my emphasis)

Whilst *liberal* rationality builds more on the *freedom* to choose, *neo-liberalism* seems to build on the *duty* to choose: (if possible) people must be activated and mobilised to make 'choices' through *indirect* government; they represent entrepreneurial selves obliged to choose within (quasi-)market options.

### 2.5. Harm minimising within the market: prohibition, neo-liberalism and neo-conservatism

The (quasi-)market processes suggested within harm minimisation policy and the impact of other political discourses on their operation was addressed by Fred, one of the few locating 'choices' internationally in the context of political decision-making:

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[217] Colin Hay cautions against stable or fixed definitions of neo-liberalism but does, nonetheless, offer a set of unifying assumptions of what he calls today's '*institutional embedding of neoliberalism*': '*Economic neoliberalism, I suggest, can be defined in terms of the following traits: 1. A confidence in the market as an efficient mechanism for the allocation of scarce resources. 2. A belief in the desirability of a global regime of free trade and free capital mobility. 3. A belief in the desirability, all things being equal, of a limited and non-interventionist role for the state and of the state as a facilitator and custodian rather than a substitute for market mechanisms. 4. A rejection of Keynesian demand-management techniques in favour of monetarism, neo-monetarism and supply-side economics. 5. A commitment to the removal of those welfare benefits which might be seen to act as disincentives to market participation (in short, a subordination of the principles of social justice to those of perceived economic imperatives). 6. A defence of labour-market flexibility and the promotion and nurturing of cost competitiveness. 7. A confidence in the use of private finance in public projects and, more generally, in the allocative efficiency of market and quasi-market mechanisms in the provision of public goods*.' (Hay 2004, p. 507/8)

> [Fred] *We're just seeing all those people that were forced out of the mental health services now coming into the criminal system all because they cannot cope. […] Prohibition doesn't work. The penal system doesn't work. Punitive measures don't work. To turn people into criminals because they use heroin is the most ridiculous thing I've ever encountered in my life. We're so far on the wrong track it's ridiculous. The history shows prohibition's never worked anywhere, whereas patience and education have proven in many cases to pay off. You look at the experiments that they've done in Denmark, Germany... the results they're having, the dwindling figures... whereas Denmark has got a proven track record of how it's worked for them since 1968 or 69, I think they started. With them it came down to education and choices and it's made a difference. Whereas the way we do things is ridiculous. I don't have very good views of politicians or law makers in this country. It's tunnel vision. It's not a good thing. We don't seem to be blessed with many people with long-sightedness or visionaries. I don't agree with enforcement and bullshit terms like zero-tolerance and things like that... they don't work. It just causes more heartache and more pain, and more deaths*.

Fred identifies the world-wide prohibition regime but comments on the vast differences in which prohibition itself is being interpreted and how other discourses have altered policy. His rejection of *punitive* responses in dealing with drug problems was the strongest among the interviewees. Theda outlines how drug users are constituted by the *prohibition* regime, reminding us of the individual level dynamics discussed in Chapter Four:

> [Theda] … *I ran out of money because I had to score yesterday, haven't eaten because I had to get the score and I just couldn't eat and score. So not eating means poor health and then there's this whole sort of thing about expectation to give up and can't get into detox and you've got to ring in every day for a week and availability of beds and I wouldn't give up now and the day I want to give up there's no beds but then by tomorrow when there is one I've already had a hit so I don't feel like giving up now… so it's all sort of volatile, turbulent lifestyle from one day to the next. There's a lot of anxiety in it usually about scoring or getting stuff or where's the money coming from and then quite often in desperation there might be a planned burg[lary] or they may have an opportunistic stealing some money from somebody they were visiting, or something happens or they get very aggro and upset, paranoid maybe on the tram and they have an altercation with someone on the tram. Any one of these things could lead to police action and then they have court cases and then they're terrified because they've got to go to court. Then there's the pressure to straighten up, so there's intensive counselling and they get all their intensive supports happening again pre-court and then the worry of the court case is over and things slide away again for a while. So you're talking about 3 steps forward 2 steps back kind of work with people who are using, that's the nature of I guess – the hecticness of what's happening*.

Both workers point to the service system being unable to meet demand: Theda mentions waiting lists to access detox- and rehabilitation services[218] and Fred describes how the criminal justice system became a last 'resort' for people with unmet mental health needs, both illustrating effects of prohibition. Theda describes the 'cyclical' drug use produced by prohibition but also identifies the *neo-liberal* inspired request from clients to show 'desert' and 'commitment' to *self-help* prior to getting a place in detoxification programs: '*ring in every day for a week*'.

Escaping the narrow definition of *harm* in harm reduction and medical discourses (viruses, unsafe use), 'harm' could arguably also be constituted by discharging someone prematurely, letting people wait to receive services or, worst, having no services on offer or offering substandard accommodation operating as drug supply centres. Henry, a fostercare worker, had observed the lack of support (services) as harmful:

> [Henry] *I think there need to be more agencies offering counselling and rehab programs, a lot of residential facilities for them to actually stay in because in many places I have seen that they go into detox and because of lack of beds and room they are sort of discharged prematurely and then after a couple of months or 3 months they hit drugs again and they end up losing their children or sort of their life is significantly affected. There needs to be a sort of greater level of follow up, like ongoing intensive support for a long period of time because from my experience these people can have sort of this pattern of success and failure. They just go on really well, they do their screening and everything's clear for up to 4 to 6 months or so and something happens, boom, they start using drugs again. So there needs to be more intensive follow up and more intensive support which is currently lacking, I think, in the system, both from government as well as agency level*.

Henry considers ongoing support services as vital to recovery,[219] yet their absence is not defined as *harmful* at the political-economic level and governments are not '*fined*' for not supplying sufficient funding. Theda explains how agencies struggle to maintain flexibility:

> [Theda] *I think where the difficulty comes in, not so much for me because we're not government funded at this site, we've actually chosen to maintain donations and trust funding which gives us flexibility. A lot of people come across agencies where because of the funding they can only have a certain number of sessions and that I think would be very difficult because you're trying to pack in something in a very short time, you're trying to*

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[218] Latest newspaper reports highlighted the unmet demands for DOA services with up to 100 people on waiting lists and with at least 3 months waiting time to access residential rehabilitation services in the state of Victoria (Stark 2007). Mike Coleman from the Salvation Army describes the situation as creating a 'revolving door': '*If someone comes into the system and physically withdraws but then can't follow up they'll drop out of the system, and by the time they've got a place in a residential rehabilitation facility or a counselling service they're back into their drug or alcohol use so they have to do the detox again. It creates a revolving door for people*' (Coleman cited in Stark 2007).

[219] Non-residential drug services are always 'cheaper' than residential services: For example the 2004 costing of AOD services in Victoria reveals that an 'episode of care' (EOC) for an 'outpatient withdrawal' is A$351.45 whilst the bed per day funded 'residential rehabilitation' costs A$9,859.98 (Drugs Policy and Services Branch 2007).

*force some change in that timeframe which is not the person's, it's the funding time. So funding is a huge issue which probably comes under what doesn't help workers*.

When taking the human being as a *cost factor*, it appears worthwhile to spread the resources among many people rather than invest in a few, a rationality not conducive to making interventions '*effective*' either. As already discussed, emphasis is on the sector's *accountability*, which is interpreted as *transparency* of service provision and '*auditability*', rather than '*effectiveness*' or as making a difference or achieving (maintaining) recovery. Oliver, working in a community legal service, illustrates '*the audit society*' effect on practice:

> [Oliver*] I have exactly the same complaint that every other person that works in the community sector has which is we're always asked to do more with less and we have to spend half our time reporting what we do and we also have to report all the wrong things which is all quantitative reporting rather than qualitative. They actually don't care whether we're making anybody happy or resolving people's problems, they just want to know what the throughput is, how many numbers are going through which I find very irritating and we're subject to audits and we're subject to reporting requirements and all that sort of stuff and I often feel like writing in reports... I spend most of my time just reporting... because that's really what we do rather than working and answering silly questionnaires and stuff in terms of what do you do… they know what we do [..] It just drives me mad the constrictions they put on the work you do... they just make it difficult for us to do our job on an every-day basis because they have this sort of terrible desire to be reported to all the time and every dollar to be accounted for in such an intense way*.

Such form of accountability is '*calibrated*' to the workings of the *political-economy*, where pressures to deliver welfare and drug treatment services that '*serve the individual*' are not high, but are evaluated as to their 'overall' cost-effectiveness and their effect on other institutions, like '*clogging up*' courts.[220] Drug courts are partly a result of the pressure for economic re-evaluation (also resulting from a humanist impulse to keep drug users out of the prison system); whilst the cost of Australian drug courts, which involve '*[s]tate-based pre-arrest and pre-sentence programs diverting illicit drug users to education or treatment*,' (Loxley 2005, p. 279) are comparable to costs of incarceration, they save A$19,000 for each offence by reducing the offending rate (p. 286). Welfare economics and economic rationalist discourse

[220] Oliver was feeling more confident about the place of legal aid and community legal services in the service system, because it was more efficient to fund such services than to have 'clogged up courts': '*I think community legal services are more settled nowadays in terms of we know we're a part of the legal landscape and we know that we're an important part of the legal landscape and that the government has actually acknowledged that a lot of the work that we do nobody else wants to do and without it the court system would be sort of hopelessly clogged up but I think they've now acknowledged that and I think they can squeeze us and they can slice us but they're never going to get rid of us and I think that's probably where we're standing now*.'

entered the way workers regarded clienthood as well; for Damon, a fostercare worker, every 'drug user' is a potential taxpayer:

> [Damon] *I mean, to me the government realises that the more money they spend on drug prevention issues, the more money that is saved by people, well, leading more sort of productive lives and I guess if somebody gets off drugs they generally get their act together and might get jobs, start working and pay tax that sort of thing. So the government actually gets that back otherwise the government's just paying out all the time to support people's drug issues so if they look at it from that point of view, any sort of drug prevention initiative will save money in the longer run... and also not just for the person using the drugs but also from the family that are affected as far as their lifestyle and future potentials are affected by a parent who does use drugs... a flow on effect as well*.

Damon refers to payers of *income* tax, ignoring the fact '*that over 25% of public revenue is raised by consumption taxes that substantially offset the progressive effect of the income tax system*;' (ACOSS 2003, p. 2) his clients are already paying taxes and do not start to pay them once recovered from drug use or gaining employment.[221] The twin ideas that (the loss of) productivity is the government's major reason for being interested in investing in services and that of cost-effectiveness are deeply anchored in lobbying strategies for harm reduction programs.

Virtually absent from harm minimisation policy debates are references to the *readiness of drug supply*, perhaps because this is discursively dominated by drug law enforcement, often at odds with public health advocates over exactly who can take the credit for particular 'successes,' such as the reduction of drug deaths. The question of how drug availability on the political-economic level affects the drug user at the individual level is referred to by Uma, family and personal support worker:

> [Uma] … *I had one client today who smokes, he said, a shit-load of marijuana and he loves it, he has no desire although he is aware of the health issues and he's only 45 and he's pretty much decided that's a good way to go. He had a very high professional job prior to that. So it just shows me that they're educating me in the way that the drug is extremely powerful, it rips them of everything very quickly. Sometimes I think that when they're talking it's as if they want people to make it more inaccessible or they want the police to come down on it more so it's not so easy to get. It's pretty easy. They talk about it being very difficult to stay away from it because it's on every corner and then they can't relocate to another place where it's not on every corner without massive amounts of problems. They don't have the capacity to do the footwork for that, and so they stay and*

[221] Another comment to make about Damon's rationale is that the overall ABS proportions of 1998 household income indicate that '*the top 20% of households paid an average overall rate of tax of 33%, compared with 25% for the middle 20% and 26% for the bottom 20%. The progressive effect of income taxes is almost offset by the regressive effect of consumption taxes*.' (ACOSS 2003, p. 16) The overall tax burden is partly carried by his very clientele: '*The highest tax rates are not paid by high income-earners. They are paid by unemployed people and low-income families.*' (ACOSS 2003, p. 21)

*before you know it they have a bad day and someone's on the corner. They're back into it because they've lost everything... their family, their children, their friends, their jobs… so there's this sense of hopelessness around it*.

Uma explains the difficulty of escaping or ignoring the physical presence of drug supply in today's suburbia. Drug users and human service workers alike are *subjectified* as '*choosing consumers*' at the political-economy level, where legal and illegal drug markets continually renew our consumption and commodification practices and establishes firm views of ourselves as '*neuro-chemical selves*' (Rose 2007), where the promise of mental, physical, reproductive and genetic health – even well-being – can be achieved through the use of drugs. This is how political-economic conditions shape us and we shape them, '*the drugs themselves embody and incite particular forms of life in which the "real me" is both "natural" and to be produced*.' (Rose 2007, p. 222) Whilst Rose refers to drugs used in the treatment of mental illness, the argument extends to all forms of drug use; self-enterprising neo-liberal subjects monitor their health constantly and harm minimisation discourse itself offers technologies of '*self care*' with regards to some of the health effects of drug use.[222]

David Moore and Suzanne Fraser (2006) - describing how harm reduction has embraced neo-liberalism - suggest that neo-liberal notions of subjectivity can be '*empowering*' for drug users (p. 3038), offering examples of clients having learnt that their 'predicament' was *self-made* thus recognising that change is possible and that users possess the resources to change '*in*' themselves. Self-pathologising seems unproblematic from this perspective, as if it is also a *product* of *social being*, leaving only *external* pathologising as problematic, a humanist-psychological discourse which is widespread. This thinking is, however, neither new nor neo-liberal as is the idea that it is useless to help drug users when still '*in the problem*,' Paula describing it as '*propping them up*':

> [Paula] *There's no point in us propping them up and giving them money because they'll just… or even propping up their other bills in that situation because they're still going to be in the problem. So with that particular matter to tell a person I couldn't help him, you refer them on to drug and alcohol counselling but whether they go is another thing. I mean that again is their lifestyle choice. ... There wasn't much I could really do for him because I'd be only propping up his habit. It's the same if we had a gambling client,*

[222] Health is not the ability to spend time with friends and family, health is not the careful engineering and aligning of labour market policies with reproductive policies, health is not being protected from intrusive marketers ringing you all-day long, health is not the transparency of food ingredients and transportation routes, health seeking behaviour is not the finding of relations between capitalist health systems and capitalist institutions, health is not the breathing of clean air – *health is the absence of some illnesses and the aligning of the interests of the individual with the interests of the political- economy at best*.

*there's not much point in us giving lots of emergency relief or giving lots of handouts because they're still going to be in the problem unless they start to deal with the real issue that's causing the problem. And so, in that case, sometimes we basically have to say we cannot help you*.

Working in community development and emergency relief, Paula excludes from her account all *framing* of *choices*; when handing-out emergency relief no-one talks about privatised energy markets, the abundance of gambling venues in suburbia, black-market profits that ensure ready drug supplies, over-prescription of pharmaceutical drugs, doctor's kick-backs from drug companies, which all ground people's 'choices' at the political-economic level. Nonetheless, acknowledging *political-economic dilemmas* (funding-cuts to emergency relief, increases in welfare payments suspensions, the spread and 24-hour opening times of alcohol outlets or understanding the skilful '*social engineering*' by alcohol industry in its advertising) does not remove *individual-relational level dilemmas* (violent relationships, drink driving, betrayal of trust) and does not make social relations with (and for) problematic drug users easier.

Paula's refusal to help until assured to not '*prop up*' someone's '*habit*' is one instance of *new forms of government*; Cruikshank demonstrated how democratic government depends on citizens being interested in their own empowerment: '*The will to empower, or the desire to help the poor, had to be balanced against the imperative that the poor must help themselves*.' (1999, p. 74) Applying this argument to the '*war on drugs*,' drug users are not only instrumental in managing prohibition and its ill-effects, they (and their affected families) are *the **only ones** who need to manage prohibition* because they are the only ones criminalised by it. By ensuring drug users' participation in harm minimisation programs and measures, they act in their own self-interest.

Cruikshank identifies the compatibility of harm minimisation discourse with neo-liberalism at its core: *people need to be made to act in their own interest to prevent harm* and statutory and legislative means can be applied to enforce the harm being minimised (1999). At the political-economic level, harm minimisation has become part of the *'peace keeping'*[223]

[223] If we want to shed some light on the peace-keeping effects of harm minimisation discourses and practices, it is useful to render 'war' or 'struggle' just as worthy of an explanation as 'peace' and security'. Mariana Valverde suggests exactly this perspective when she discusses some of the latest translations of Foucault's work on governmentality (2007). She explains just how difficult this kind of dynamic thinking really is: …'*if one agrees that the default setting of both human and non-human life is war, or at least struggle, how can we sharpen our philosophical pencils so that the terms we use are not mere models of how struggle happens, but are themselves in struggle, are themselves dynamic? After all, Marxists too believe in permanent struggle, like Nietzscheans, but they generally believe in 'laws of motion' that are themselves fairly static. The challenge faced by post-Marxist, poststructuralist thinkers inspired by Nietzsche (a diverse group that includes Derrida as well as Foucault) is thus*

mission of hegemonic discourses; its policies are *keeping the peace* with regards to problems resulting from drug use under contradictory conditions, permitting and encouraging the consumption of 'some' drugs (the 'legal' ones) and prohibiting 'others' (the 'illegal' ones). Erickson et al. are not clear either to which extent harm reductionists and legalisers 'overlap' in their intentions (1997, p. 4ff), but she suggests that the '*search for a harm reduction perspective was a reaction to deficiencies of existing [prohibitionist] approaches*' (1997, p. 4). Levine, instead, argues that harm reduction is '*a movement **within** drug prohibition that shifts drug policies from the criminalized and punitive end to the more decriminalized and openly regulated end of the drug policy continuum*' and that it is '*not inherently an enemy of drug prohibition*' (2002, p. 173 my emphasis). I argued earlier that prohibition *created* the drug user subject position and that opposition to prohibition was partially responsible for '*creating*' drug user organisations. Opposition to prohibition, however, is *not* a central feature of harm minimisation/reduction discourse, meaning that the first peace-keeping act of harm minimisation was *not* to challenge prohibition, but only some of the ways of going about prohibiting.

Lynch and Wodak saw the defeat of the Disability Discrimination Amendment Bill 2003[224] as an '*indicator that attempts to define illicit drug use as a criminal justice issue have reached their peak and have now begun to decline*' (2004, p. 173), an overly optimistic declaration, followed by calls to *increase* penalties for cannabis use and, in Melbourne's suburb of Footscray, by the '*trial*' ban of drug users from particular areas. Such bans are 'neo-liberalizing space[s]' (Peck & Tickell 2002) in that they use *prohibitive* measures to provide '*undisrupted*' consumption spaces in local streets.

Harm minimisation logic has proven to be a useful peace-keeper in urban environments with measures such as supervised injecting sites; Fischer et al. argue that these were invented to '*to deal with the increasing challenge of 'urban drug scenes' towards public order interests*

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*not the nineteenth-century project, shared by Hegel, Marx and Durkheim, of 'how to capture change'. It is rather the more reflexive challenge of encouraging dynamism in our own thought making the very terms with which we work dynamic.*' (2007, p. 168) In many regards thinking dynamically (for a drug as social policy perspective and otherwise) is a methodological problem: We have to describe something and in order to describe something we need to hold it still to examine it and in the very act of examining it still we change its character and dynamism as we have forced this stand-still onto the subject of investigation, depriving it of its dynamic and fluid character thereby.

[224] For example, in the recent campaign against the Disability Discrimination Amendment Bill 2003, Lynch and Wodak talk about the submissions of two conservative commercial law firms which '*focused on the purely legal and technical rather than social and economic aspects of the Bill*' (2004, p. 171) as making a considerable impact on the Committee as advocates not being recruited from the '*usual suspects*' (2004, p. 171). Technical and legalistic considerations create impressions of non-biased, non-ideological arguments that can wield considerable influence in legislative processes.

*'entrepreneurial city'*.' (2004, p. 357)[225] Drug users' conduct is not only governed as they assume clienthood, but also as '*public citizens*'. Laws against 'public drunkenness', 'anti-social behaviour', 'public nuisance', public health laws, acts 'for' drug-dependent people, arrests, anti-littering laws – they all govern suburban *spaces* and their *occupants* in an age where cities compete to become the most liveable, business-friendly, least taxing in the world.[226] These rules, regulations and laws are designed to *protect* the community, its aesthetics and commercialised sensitivities.

The most prominent political-economic/hegemonic discourses that harm minimisation discourse has to respond to and coexist with are neo-liberalism[227] and neo-conservatism, as already discussed. Interestingly prohibition, neo-liberalism and neo-conservatism *all* seek solutions to 'drug problems' through the *market as the ultimate regulator*. *Prohibition* created an illegal and a legal drug market in the name of '*protecting the community*' from drug problems. *Neo-liberalism* offers solutions through quasi-markets (i.e. the service system through which harm minimisation primarily operates), but leaves the market mostly intact (with possible 'statist' adjustments through rescheduling of drugs, restriction of tobacco use in public spaces), particularly as far as drug *supplies* are concerned. *Neo-conservatism* trusts the market to solve drug problems, but '*the problem for neo-conservatives is that market rationality cannot produce the moral ground on which it stands or falls, by which it produces general affluence or inequality and poverty*' (Cruikshank 2004, p. 3). A typical *neo-liberal* response to drug problems is that of Federal Minister for Health and Ageing, Tony Abbott:

> We can't abolish poverty because poverty, in part, is a function of individual behaviour. We can't stop people drinking. We can't stop people gambling. We can't stop people having substance problems. We can't stop people from making mistakes that cause them to be less well-off than they might otherwise be. (9.7.01 Four Corners, cited in ABC AM, 10 July 2001)

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[225] Those facilities are located within the prohibition regime and might have 'deals' with local police, they provide temporary safety from arrests etc so as to give drug users the 'choice' to inject their unregulated, uncontrolled and unsafe substances in a supervised environment. The safe injection of illicit drugs is a contradiction in terms. Seeking the peace-keeping effect, the *government of injecting practices* inside supervised injection rooms however requires no dealing, no assaulting of staff, cleanliness and hygiene of the injector (Fischer et al 2004, p. 360).

[226] It is not surprising that the city (or local government) is the level of government where pressures to 'deal' with drug problems are most keenly felt and where 'innovative' responses are being devised (Wodak 2006; Room 2006b). Other levels of government have bigger roadblocks to confront: '*For these substances, it is not only that the city is the first line of government response. It is also that higher levels of government are often compromised or paralysed. In particular, they are bound by the constraints of the international narcotics control system and especially by pressures from the system's mainspring, the U.S. federal government*.' (Room 2006b, p. 136)

[227] Neo-liberalism is a form of government that '*works on individuals and organizations through the disciplines imposed by their interactions with others in market and quasi-market regimes*' (Hindess 2000, p. 16).

The '*convergence of consumer society and neo-liberalism transforms the compulsion of addiction into a freedom of choice*.' (O'Malley & Valverde 2004, p. 36) – as the workers' narratives also confirmed. Those drawing on neo-liberal ideas assume that it is apparent and feasible for the individual (how) to detect, circumvent or avoid 'troubles' and 'risks' and Abbott does not investigate structural influences on decision-making or the lack of choices that are due to lower educational attainment, school exclusion, socio-economic disadvantage and pressures on affordability of housing and education.

At the political-economic level, *why* people would (want to) use drugs is relevant only in as far as their motivation can be influenced by advertising, scarcity or illegality of substances; the *conditions under which people 'choose'* remain irrelevant. Harm minimisation is compatible with and incorporates neo-liberalism when regarding drug users as '*consumer[s] in a world of consumerism, quite capable of making rational choices and of discerning between advantageous and disadvantageous commodities and behaviour*.' (O'Malley & Valverde 2004, p. 36)

Federal Minister for Families, Community Services and Indigenous Affairs, Mal Brough, recently suggested that parents, who are welfare recipients with drug, alcohol or gambling problems could receive (parts of) their welfare payments in vouchers, so that their children would not be missing out on clothing and food. This is a typical instance of neo-conservative discourse, where individuals cannot be trusted to act '*responsibly*' and to self-govern '*effectively*' and where choice is no longer a viable or detrimental option:

> It is cash in the form of welfare payments that provides choices for parents in these situations to choose to gamble before buying food, or purchase drugs rather than clothe their children. (Brough cited in Dunlevy 2006)

Although both are members of the Liberal Party and Federal Ministers, Brough's position is a very different from Abbott's, the former a neo-conservative one as it prefers a '*strong, moral, and violent state*' (Cruikshank 2004, p. 7); this illustrates that neo-liberal and neo-conservative 'solutions' to the drug problems can be at odds as to their political rationality. Cruikshank argues exactly this point when she summarises that '*neo-liberal policy aims to reduce the size and scope of state power by relying on market rationality, neo-conservative policy aims to increase the moral authority of the state*' (2004, p.1). The tensions neo-liberal market policies produce for the service sector are portrayed by this worker in a community legal service:

> [Oliver] *There's a big problem with gambling in that the people who are doing the gambling are the people who can least afford it. At the same time, the government takes a lot of money out of gambling and I'm paid by the government, right? I mean there's a bit of conflict there, isn't there? I mean every time I have a client with a gambling problem*

> *am I thinking, well* ***keep on gambling mate because otherwise I won't get my salary****, you know what I mean? There's a conflict there, there's no doubt about it. I would like to think we're a classless society but we're not in that people who have more money will access justice easier. […] And that way I would like to believe that the law should be classless whilst acknowledging that it isn't. How's that? Very complicated!* [my emphasis]

The welfare service sector '*lives off*' the problems of others, in particular, those produced by unresolved contradictions of society-at-large. The political-economic level manages and tries to prevent those harms which are relevant to keeping the '*internal peace*' of the social 'whole.' Keeping internal peace is constantly re-thought in terms of direct and indirect measures of governing the drug user and the associated workerhoods, charged with fulfilling the mission of governance. With different policy options,[228] we would ask which *subject position*(*s*) harm minimisation discourse produces and which *techniques of appeasement* are deployed in order to produce a peace which not just 'appeases' social tensions by forcing some people into compromise or disadvantage, but one that seeks to establish relations conducive to tolerance and equality within differences and diversity of choices, lifestyles and persuasions. I will now briefly discuss whether and how workers felt they had changed in relation to drug using clients and which social change they aspired to.

**3. Cracks in the surface of drug social policy and recognising potentials for change**

In a society where 'populations' are pitched against other 'populations' (e.g. prison staff against prisoners, regarding the availability of needle and syringe programs pitching staff safety against prisoner safety; deserving versus undeserving 'populations'; preferring tax concessions over benefits for unemployed people; or the juxtaposition of younger and older drug users), the assumed and posited '*scarcity of resources*' forces workers to create *hierarchies of desert*. One emergency relief worker expressed this juxtaposition, recognising that she is not the police, yet doing police emergency relief distribution:

> [Germaine] *So I think we try to embody - and I think we do a pretty good job of a non-judgmental, respectful approach to people. Say just because they're a drug user doesn't mean they have any different access to the services than anyone else. The only time that will change is if we thought they were actually going to go out and use. And sometimes a volunteer or an interviewer has come back in and said to me as duty worker, 'I'm not*

[228] There is a series of policy options which present themselves at the political-economic level which are discursively unavailable or explicitly excluded, including: legalisation of illicit drugs, complete decriminalisation of drugs, proper funding of ('expensive') long-term rehabilitation, revising various taxation schemes in order to prevent harms that are associated with the commodification of drugs, de-commodification of drugs, etc.

*really sure, I think he might be going to go out and use'... and we've looked at each other and said, 'Well, what can you do? If we're going to stop him what does that mean now? Who are we? Are we the police? No.' So we go through that, it's not comfortable because the next minute you might have a single mum coming in there with a baby and you've run out, you've used our last $20 on somebody who may blow it on whether it's alcohol or drugs*.

Here, the single mother with baby '*wins*' on the scale of desert over the drug user; Germaine's story features multiple factors and implicit thinking: first, funds for emergency relief provision are very limited, so '*choices*' need to be made; second, the emergency relief dispensing needs to be based on some distributional rationale, whereby food preceeds drugs; thirdly, human service workers do not view themselves as '*primary*' agents of control, so they are less willing to judge clients' desert, even as they need to as part of their job. The term '*blowing it*' indicates that drug use has no legitimacy in emergency relief '*humanism*' and providing funds to users is always potentially '*wasteful*' because of their 'addiction,'[229] whilst for others it - at least temporarily - 'fixes' what emergency relief is meant to be '*for*'.

Adam identified another '*crack*' in the logic of the service system, problematising its dealing with cigarettes:

> [Adam] *We're not supposed to give our clients a cigarette… if the Department was aware of that type of activity they would be upset. It would probably even incur disciplinary procedures. But with people who have got significant drug issues, and also anger issues, I mean the offer of a cigarette is like a peace pipe, do you know what I mean? They smoke, you smoke… the reasons people did smoke is that "here let's stop, let's have a smoke, it's actually let's have a discussion", it's used to defuse that tension. We're dealing with clients with significantly increased anxieties, anger, drug use, you know like quite escalating behavioural issues, but a smoke can actually be a beneficial engagement tool. Like if there's no tool there for people to actually use to field mediation, the answer is either… is the opposite, people are angry and their anger goes up. I know it's an unusual example but it's one I've thought a lot about and it's one I'm prepared to lose my job over if it came to that*.

Working in a multidisciplinary youth team, Adam talked about the tension between recognising cigarette smoking, underage drug use and causes of cancer, on the one hand, and realising that having a cigarette cannot be reduced to a health effect, because it is a good mediating and tension diffusing tool, on the other. We also encounter a classic tension within any drug or health policy and state relations: the discursive clash between *civil rights* and *public health*. Adam thinks he ought to be able to '*engage*' through smoking with a client to defuse

[229] The peculiar quality of addiction is that explanandum (addiction) and explanans ('uncontrollability of drug use') are indistinguishable, the latter in turn 'becoming' the addiction.

conflict or anger, but workplace rules are designed to protect clients' health, thus preventing this type of engagement. It is also a clash of temporalities: what is beneficial in the short-term is not necessarily so in the long-term. In *public health* discourses, the state (juridical authority) is presumed to be the ultimate regulator, guaranteeing rights and protecting the population's health; civil rights discourses see the state as an intruder, the suspicious source of control and discipline. Both views are obviously flawed and oversimplifying.[230]

As mentioned earlier, many workers had changed their own attitudes towards drug users, learning about the reasons behind their use; some became less fearful and more understanding:

> [Querida, homelessness worker] *I've become more knowledgeable and I understand it [drug use] and I understand it as a need… fulfilling a need and I'm not fearful of it any more, it's nothing to be feared. Although I knew as a professional and I don't judge people, I let people go, but I might still be fearful or what does it mean to be with someone who is a heroin addict or… and ultimately they're just the same as you or I and they just have this issue in their life that they've formed as an antidepressant as a coping mechanism or something to fulfil a need in them. I have always tried to see people just as human beings and it doesn't really matter what ways they go about coping with life… there but for the grace of God we all go and none of us can say we won't ever use drugs inappropriately because we never know what we might be confronted w*ith.

Workers often had at least some minimal AOD training opportunities, often describing themselves as moving from an 'idealistic' to a 'realistic' understanding of drug use(rs) and of what the current service system and governments are capable of delivering. They also used '*realism*' to describe their disappointments and lack of confidence in social change, based on their communicating to the 'wider' community what they had learnt about clients' troubles and stigmatisation. Many equated harm reduction/minimisation with safe drug usage principles and as an approach recognising the complexities of drug use, drug use patterns and the 'unreason' of expecting someone to become abstinent, even though for many abstinence remained the ultimate goal of drug interventions. Tensions between specialist and generalist community services and their approaches were expressed as were the mismatch between how workers thought the service system ought to function and their daily struggle to achieve individually meaningful outcomes for their clients.

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[230] The duty to be a healthy citizen 'clashes' with the right to choose which drugs to use: the question is not whether there is a conflict but what in our social relations makes this conflict possible and what this conflict produces. The juxtaposition of public health and civil rights implies an inherent contradiction between 'the individual' and 'the population' preferences, it assumes *the state* to be a protector or an intruder (rather than both) and it deflects attention from practices that constitute and undermine the juxtaposition. Additionally, it is problematic to personify the state and its political and legislative powers, because the state and its policies is not only one form of governing conduct but also not a unified actor but in itself contradictory and heterogeneous. It would also be problematic to define politics only in regards to matters of the state.

Many saw their professional approaches to drug use(rs) and the priorities they set and their expectations of clients as changing; whilst the majority of Anglo-Saxon workers said to have become more open-minded, flexible and accommodating to drug use (and drug users' needs), Indigenous workers held that they became more strict and less tolerant of clients' drug use over time; respecting a person meant insisting that abstinence was possible and achievable. All workers wished waiting lists to become shorter and services expanded, better staffed and properly resourced; apart from (external) supervision access, all workers considered changes necessary at the *institutional* (increasing flexibility for clients and workers' discretionary practices) and *political-economic* level.

This counsellor was most explicit in the structural changes that he would like to see:

> [George] *I don't think government policy is sufficient. In terms of general approach it has a tendency to focus on things like harm minimisation and all the usual arguments apply, such as a lack of preventative measures, information just isn't enough, and as a social worker I'm more interested in the broader structural perspectives, so no I don't think government policy functions particularly well. […] From a general welfare sense it would be to do things like the distribution of wealth and the prevalence of poverty, housing, welfare services, even things like labour market reforms, economic reforms, deregulation, I mean all of those things work against those lower socio-economic, the people that are stuck in that lower socio-economic bracket and it's blatantly obvious when you work in places like [a poor suburb in Melbourne] you can see all of that and you go to other places and it's just not there*.

Workers identified many 'cracks' in harm minimisation policy including tensions with child protection and prohibition and - most of all - that it had not diminished discrimination and stigmatisation for drug users, still left alone trying to 'manage' their poverty and disadvantage. Examining fluidity and change in workers revealed more '*agentic*' qualities of workers at the political-economic level, congruent with Hoy's assertion that, over time, people draw on different discourses:

> …[P]erhaps we should say that subjects find themselves using different discourses in the present than in the past; they might then prefer the present discourse not for the reason that it is truer in general to their continuing self, but for the reason that it more usefully captures social change and increasing complexity. (Hoy 2005, p. 211)

Another objection, most forcefully expressed by Indigenous workers, was the lack of recognition of clients' *ongoing* needs, as many services acted as *temporary patches* at best and as *abusive* and *discriminatory* impositions at worst. Castoriadis' observation is helpful here:

> […] the distinction between synchronic and the diachronic view has been transformed into an absolute opposition and the synchronic point of view has been held to be the

> legitimate one, diachronic considerations being regarded with condescendence, relegated to the descriptive level, and excluded from 'scientific' status. (1997, p. 216)

The neglect of 'diachronic time' is evident in assessments of the 'effectiveness' of methadone maintenance treatment: quality of life and well-being of patients *over time* are largely excluded as measure (Fischer et al. 2005, p. 7) and 'synchronicity' can be exploited by denying medical treatment to people considered addicts.[231]

In conclusion, the critical analysis of the interview material shows that 'harm' and 'minimising' are themselves contested categories and that different harms and different harm producing and minimising practices can be identified some of which have come into discourse, others are excluded or entirely absent. The human service workers struggle to make sense of their own role and to define how drug users are being 'helped' and could or should be helped. Their understanding of harm minimisation discourse aligns with, supports and/or resists other discourses such as (neo)liberalism, neoconservatism, prohibition and economic rationalism. The workers are portrayed as having substituted increasing complexity for initial simplicity in the course of working with 'drug users'.

[231] 'Fuzzy ideas about abstinence, we have argued, unjustifiably restrict access to treatment for somatic conditions in people with substance disorders.' (Rehm et al. 2003, p. 291)

# Conclusion: Meeting the needs of 'such a fluid needy bunch of people'

This thesis started out discussing the instability of what should or could be meant by 'meeting the needs of drug users' and has subsequently shown the actual and socially instituted difficulties of meeting the '*needs of such a fluid needy bunch of [young] people*' [Querida]. I embarked on a journey to find out what drug use, human service work and their relationship with drug-using clients meant to workers, paying particular attention to the fact that they worked in so-called non-drug related services.

Chapter One established how ways of thinking about drug use and human service work emerged and changed over time. Foucault argued that the subject in history has been objectified – as speaking (philology, linguistics), labouring (wealth and economics) and/or living subject (biology, natural history) (2002a, p. 326). Following his logic, the chapter therefore described how the *drug using subject* (pharmaceutical, prohibitionist, medical and harm reduction discourses) and the *helping subject* (social work, psychology, philanthropy, welfare state discourses) became constituted and hence objectified, problematising the taken-for-granted subject positions of both.

Chapters Two and Three moved beyond the narrow confines of contemporary drug research; I recounted some dilemmas about drug research (lack of interdisciplinary and integrative perspectives) and explained my constructionist discourse-analytic approach to interviewing 51 human service workers about their experiences working with drug users. Chapter Three, in turn, constructed a multi-level framework – with individual, relational, institutional and political economic levels - to capture the complexities of workers' interpretations of their daily experiences with drug using clients. The chapter also continued the historical account describing harm minimisation (policy) and the notion of harm *production* was introduced, defining the oscillating struggle between harm production and minimisation discourses and practices.

Chapters Four to Six covered data analysis and interpretation. These three chapters built the core of my thesis by presenting original, qualitative research interview material with regard to the following research question: Which practices and discourses constitute the drug user and the humans service worker?

Chapter Four identified practices and discourses relevant to the *individual* and *relational* level dynamics constituting drug user and human service worker. The drug user appeared shaped by discourses of *rationality*, *choice*, *normalcy* and the *exclusion of pleasure*, whereas the human service worker was constituted in terms of *expertise* and *professional conduct*, as *enabler* and *facilitator* of clients' lives. Their relationship revealed the complexity and negotiations to achieve multi-dimensional meaning-making in service encounters. This chapter illustrated that one of the central dynamics in the relational level is the negotiation of the instituted level: The human service worker – perceived in Australian contemporary drug literature as predominantly acting in a functional and instrumental capacity – has to manage the tension between 'joining the client's will' and the deficit model of the drug user. This means that whilst human service workers co-constitute and co-construct the drug user as a subjectivity dominated by deficits, the very pathologisation of this subjectivity stood in the way of acting as 'change facilitators', a role which needs to undermine the deficit construction of the drug user in order to unleash the agentic abilities of the drug user to enact change by deproblematising, if not normalising his or her actions in some way, shape or form. The management of the contradiction of the simultaneous pathologising and de-pathologising that occurs when the drug user becomes a client is a central concern of workers' engagements with their clients. In this process workers are required to deploy their selves as principal sources and tools for facilitating change in their clients. They need to transform the construction of the drug user as self-centred into a construction of clients as experts of their lives. Both, workers and clients use their selves, authentically storied in client-worker encounters, as resources for reflection and self-problematisation. Hence, their individuality and their selves are already *relational* achievements whereby the situated negotiation of socially instituted workers and socially instituted clients assembles and reconfigures social meaning networks.

The research question in Chapter Five is answered with regard to the drug welfare service system and the workers' reflections on it. In Chapter Five's investigation of the institutional level a picture of a highly conditional, discriminated 'drug user' clienthood unfolded, produced by a service system governed by rationalities and discourses constituting the him/her as a *resource-intense*, if not *resource-wasteful* person. In effect, the welfare client is an *abstraction* as all service characteristics are assumed *before* clients enter the agency doors. Clients are governed in terms of sub-populations: today's *claimants are constituted as different 'entitlement populations'* (and subject positions) in ever-more carefully devised and 'targeted' need constructions.

Whilst social discourses produce the drug user as *unaccountable* and medical discourses as relapsing, welfare economics, administrative and criminal justice discourses produce him/her as an *accountable* entity, a dichotomy of clienthood which reveals the complexity of assumptions well before clienthood is assumed. The very definition of drug users as *relapsing subjects* means that the service system can largely escape accountability, as one can hardly fail someone who is defined as failing (relapsing). The institutional level brings the tension between the 'us' and the 'them' constructions to the fore, rationality is juxtaposed with intoxication: drug using clients are in a different state of mind whereas workers portray themselves as rational beings striving to free clients' agentic capacity to express cognitive insight into how they are victims of their own and/or other people's making. Here, the relational-individual constructions reverberate at the institutional level. Clashes in workers' and clients' constructions are pronounced when the self of the client is viewed as displaying synchronic self-interest whereas workers' are preoccupied with 'furthering' clients' diachronic self-interests which tend to be more aligned with social and societal interests. Chapter Five also argued that harm minimisation has been reified and that many institutions, players, time-and-space interactions have escaped scrutiny in current drug (policy) research. Workers' respect for clients' choices is often coterminous with accepting that social harms will be and are being caused.

The workers' constitution was discussed in terms of their adopting *institutional selves* struggling to identify service system dynamics congruent with their own assumptions of how it *ought* to work. *Knowing the drug user*, being a *professional* and *emotionally-balanced* worker as well as *negotiating 'catch-22' situations* with their clients were key elements of their institutional selves. Resisting pressures and mismatches between clients and their expectations of the service system was part and parcel of a worker's *habitus* to make a difference as a 'people person,' wishing to engage with clients and rejecting text-book approaches and red-tape.

The clients' constitution at the *institutional* level was characterised by *diagnostically* achieving clienthood and setting clients' stories into a relation with addiction and assessment discourses. Worker and client subject positions were involved in a '*class war*'. Clienthood in the service system configuration is often determined along a *matrix of eligibility and conduct criteria*: some services prohibit bringing drugs onto premises, others demand clients to abstain from drug use whilst clients; parameters of catchment areas, targeted or 'special needs' client groups, service types and sectors, eligibility criteria (age, ability, ethnicity, gender, family status, income group), entry criteria, waiting periods, eviction, compliance, adherence to 'policies', exit

and discharge procedures. This program diversity *pluralises* clienthood and presents the service system as willing and able to cope with, in fact, '*cater for*' individual's diversity.

This was exposed as being flawed, when analysing the political-economic level in Chapter Six, which both decentred and centred drug user and human service worker; catering for '*individual needs*' was made less likely by a vast array of discourses, including prohibition, neo-liberalism, neo-conservatism, the societal care for the *generalised non-user* of drugs and the lack of client-centricity. Chapter Six explored the research question in relation to the political economic dynamics, including the war on drugs and harm minimisation discourses and practices. The political economic level distributes drug enjoyment chances. However, the discursive construction of 'the needy' – clienthood – cannot but clash with and exclude pleasure discourses. Clients' disadvantaged position allows no discursive spaces for fun or pleasure because dominant discourses struggle to establish coping clienthoods, enabled by 'helping systems'. The coexistence of pleasurable drug use experience with experiences of disadvantage, vulnerability and social marginalisation is irrelevant or denied at the political economic level. In fact, it is at this level that reasons why people use are made irrelevant because it is the consumption of drugs that matters, in terms of exchange value and the commodification of social practices, not the reasons for use (other than in as far as reasons can be culturally produced, enhanced or undermined and meanings are amenable to harnessed into profit rates). Workers' habitus by and large does not problematise binge-borrowing, binge-drinking or binge-taxing but there are definite signs of rejecting the war on drugs as a useful technology of generalising about the drug user. The cultural political economy co-constitutes drugs as a quick fix and as a time-stretcher but most workers' narratives do not seek to reconfigure this constitution.

*Reification* processes in and of harm minimisation meant that it could not possibly act as a 'middle range' operator (with a middle range claim being theoretically implausible); political-economic pressures on shaping harm minimisation policy made it take on a *peace-keeping* role, trying to align individual with societal interests and only addressing harms previously discursively constructed as such in policy and funding formulations. The socio-political struggles to define 'harms' were witnessed by workers when learning to identify the disparity between what *they* considered harmful and what was defined and funded as such in harm minimisation policy and services, including the discursive construction of *abstinence* as a non-realistic, non-expected and even 'irrelevant' (Hamilton and Rumbold 2004, p. 136) outcome of service provision.

Harm minimisation discourses were shown to be morally saturated, value-laden and ideological; they do not operate in a political vacuum and pursue explicit and implicit political aims in their every move. The very definition of harm minimisation as emphasising *choices*, '*by taking account of the users' own interests and the responsibilities they retain in their societal context*' (Hamilton and Rumbold 2004, p. 136) is a deeply compromised and contested endeavour. Client-centricity, expert status and choice identification are already embedded in institutional dynamics and reflect just some of the tensions between drug using clients' preferences, the actual assistance they receive to achieve them and the relational negotiations and political-economic mediation of their interests. That the service system still does not even respond well to clients' needs, let alone consider their families as potentially involved in addressing drug problems, is indicative for the *peace-keeping* mission of harm minimisation and our current inability to successfully problematise harm *production* regimes.

The client and the worker are caught in the middle of historic compromises, available discursive constructions of their rights and responsibilities and the peace-keeping missions and conformism at the political-economic level. Workers felt to have changed their approach to drug use and users and aspired to a more flexible and better resourced service system, hoping for more structural and communal solution seeking. Chapter Six was essentially concerned with the contradictory intersections between policies and practices and tracked how workers changed over time, substituting increasing complexity for initial simplicity.

Whilst I have only scratched the surface, I hope that this thesis was able to share the workers' and my own learning; whilst identifying some of the cracks in the service system and suggesting a rethinking of harm minimisation discourses, my main aim was to explore whether Nietzsche's combining the qualities of the 'true believers' with those of the 'keen observers' would be possible. Becoming more open to observation and recognising the temporality of our conclusions, we could start the task of resisting harm *production* on all four identified levels of constitution and see how a societal re-framing of drug use could produce less harm. In an institutionally strong harm production regime, harm minimising is weak by implication; stepping outside of the dominant discourses and recognising them as institutions with practices, we would render 'society' more fluid and changeable.

I have illustrated how human service workers struggle within socio-cultural binaries, contradictory policy regimes and service system discourses. Their questioning of exactly what harm minimisation has come to mean in the *situated encounters* with their clients, points to the '***chemical intent***' with which both are imagined within harm minimisation policy. The drug harm

producing society has deployed '*peace keepers*' and *objectified people* as drug using subjects and human service workers. The *positive chemical intents* of substance use exist at each of the four levels, but they only become fully achievable when intoxication is freed from its harm producing framings at *all* four levels.

After a critical engagement with the current literature on drug treatment, services and policies and establishing its multi-level theoretical framework based on a poststructuralist approach, this thesis concentrated on discussing the findings from an interview study into how human service workers work with drug using clients by examining the workers' art of dealing with the (historically and institutionally) frozen meanings of drug discourses. Having gained a more complex understanding of the service systems' *helping cultures* and how it enrols human service workers in harm producing and harm minimising practices which revolve around therapeutic, sociological, spiritual, administrative, economic, political and legal discourses among others, this thesis illustrated the workers' (co-)constitutive and relational role in seeking to establish, undermine and reconfigure dominant drug discourses. The analysis of the interview data has shown that each level reverberates with the other levels of this four level framework and thereby proven its theoretical utility as a device for a multi-relational approach to studying the helping culture. Scrutinising the helping subject as one of the possible selves with which the drug taking subject is 'partnered' assists the development of new research questions which acknowledge that the helping and the drug taking subject are not only not mutually exclusive subject positions but that a relational and multi-level approach can illuminate more facets of drug using and helping practices.

## Appendices

INTERVIEW SCHEDULE

*For human service workers in the project: Community Services and Drug-Using Clients*

1. How long have you been working as a human service worker?

Could you briefly describe for me what your work involves?

2. How do you experience working with drug-using clients?

3. How do you feel personally when dealing with drug using clients?

4. Is there anything that sets drug using clients apart from your other clients? If yes, what is that difference?

5. What do you focus on when working with drug using clients?

6. Which professional practices are most effective in assisting your work relationship with the drug-using client? And why do those practices work?

7. What is your influence on drug-using clients? How do you use your influence?

*Prompt:* Has your approach to drug using clients changed?

8. What do you think supports you in doing your job?

*Prompt:* Do you think the government (policy) supports your work with the client?

*Prompt:* Do you think that your organisation supports your work with the client?

9. What do you think prevents you from doing your job?

*Prompt:* Do you sometimes have 'to play the system' to achieve the best outcomes for your clients?

*Prompt:* Do you think you have sufficient training that assists you to deal with drug-using clients?

10. What do you think needs to change?

11. What does it mean to you to be a human service worker?

12. What do you think is the nature of the client-worker relationship?

13. How do you personally define 'drug use'?

14. What class would you describe yourself as belonging to?

ETHICS APPROVAL FROM THE HUMAN RESEARCH ETHICS COMMITTEE

From: "res ethics" <r.ethics@patrick.acu.edu.au>

To: "Ruth Webber" <R.Webber@patrick.acu.edu.au>,

"Judith Bessant" <J.Bessant@patrick.acu.edu.au>, leacampbell76@hotmail.com

Subject : Ethics application V2001.02-68

Date: Thu, 12 Sep 2002 15:43:31 +1000

Dear Ruth, Judith and Lea,

The ethics amendments have been accepted and signed by the Deputy Chair.

Good luck with your research.

Sincerely,

Liz Ryan

INFORMATION LETTERS TO THE PARTICIPANTS

[ACU LETTERHEAD]

INFORMATION LETTER TO PARTICIPANTS

TITLE OF PROJECT: COMMUNITY SERVICES AND DRUG USING CLIENTS

NAMES OF PRINCIPAL INVESTIGATOR/SUPERVISOR: ASSOC. PROF. RUTH WEBBER

NAME OF STUDENT RESEARCHER: LEA CAMPBELL (ENROLLED PhD STUDENT)

The purpose of this study is to gain an in-depth account of the way community service organisations and their staff deal with drug-using clients when the services' core function is not drug-related. After analysing the context human service workers work in, namely organisations' practices and policies, the focus of the study will be to assess the level of support offered to workers by their organisations, the sector and the government and how staff experience working with drug-using clients. Methods will include sending out questionnaires, interviews and fieldwork.
There are no anticipated risks in participating in this study.

Participation in this study will require you to spend half an hour to fill out a questionnaire and in case of an interview between half an hour and a maximum of one hour.

The benefits of your participation will be a contribution to an in-depth account of the way the staff, and thereby the service sector, is dealing with the 'new' demands posed by drug-using clients. This account of staff's working experience will indicate ways the sector can improve both, the workplace environment and the service to its clients. The results of the study will be published and provided to other researchers in a form that does not identify the participants in any way.

You are free to refuse or to withdraw consent and to discontinue participation in the study at any given time without giving a reason.

Any comments or stories that you tell in the interview will be treated in confidence. In any report on this study, all names or identifying information will be altered to ensure that no person, department or organisation can be identified in any way.

*Any questions regarding this project should be directed to the Principal Investigator* or *the Student Researcher:*

Associate Professor Ruth Webber
School of Arts and Sciences
Australian Catholic University
St Patrick's Campus
Locked Bag 4115
Fitzroy MDC VIC 3065
Tel: + 61-3-99533221

Lea Campbell
School of Arts and Sciences, SPARC
Australian Catholic University
St Patrick's Campus
Locked Bag 4115
Fitzroy MDC VIC 3065
Tel: + 61-3-94590759

[ACU LETTERHEAD]

If the participants would like a copy of the results from this study please contact Lea Campbell at the above address.

*This study has been approved by the Human Research Ethics Committee at Australian Catholic University.*

In the event that you have any complaint or concern about the way you have been treated during the study, or if you have any query that the Investigator or Supervisor and Student Researcher has (have) not been able to satisfy, you may write to the Chair of the Human Research Ethics Committee care of the nearest branch of the Research Services Unit.

Chair, HREC
C/o Research Services
Australian Catholic University
Locked Bag 4115
FITZROY VIC 3065
Tel: 03 9953 3157
Fax: 03 9953 3315

Any complaint or concern will be treated in confidence and fully investigated. The participant will be informed of the outcome.

If you agree to participate in this project, you should *sign both copies of the Consent Form, retain one copy for your records and return the other copy to the Student Researcher.*

Yours sincerely,

…….. .....

SIGNATURE OF PRINCIPAL INVESTIGATOR (SUPERVISOR)

SIGNATURE OF STUDENT RESEARCHER

CONSENT FORM

[ACU LETTERHEAD]

CONSENT FORM

**THIS COPY TO KEEP**

TITLE OF PROJECT: COMMUNITY SERVICES AND DRUG USING CLIENTS

NAMES OF PRINCIPAL INVESTIGATOR/SUPERVISOR: ASSOC. PROF. RUTH WEBBER

NAME OF STUDENT RESEARCHER: LEA CAMPBELL

I ..... *(the participant)* have read and understood the information provided in the Letter to Participants. Any questions I have asked have been answered to my satisfaction. I agree to participate in this activity, realising that I can withdraw at any time. I agree that research data collected for the study may be published in a form that does not identify me in any way. I also agree that the research data may be provided to other researchers in a form that does not identify me in any way.

NAME OF PARTICIPANT: .....
(block letters)

SIGNATURE ..... DATE .....

SIGNATURE OF PRINCIPAL INVESTIGATOR/SUPERVISOR: .....

DATE:……..

SIGNATURE OF STUDENT RESEARCHER:.....

DATE:.....…….

[ACU LETTERHEAD]

CONSENT FORM
**THIS COPY TO HAND TO RESEARCHER**

TITLE OF PROJECT: COMMUNITY SERVICES AND DRUG USING CLIENTS

NAMES OF PRINCIPAL INVESTIGATOR/SUPERVISOR: ASSOC. PROF. RUTH WEBBER

NAME OF STUDENT RESEARCHER: LEA CAMPBELL

I ..... *(the participant)* have read and understood the information provided in the Letter to Participants. Any questions I have asked have been answered to my satisfaction. I agree to participate in this activity, realising that I can withdraw at any time. I agree that research data collected for the study may be published in a form that does not identify me in any way. I also agree that the research data may be provided to other researchers in a form that does not identify me in any way.

NAME OF PARTICIPANT: .....
(block letters)
SIGNATURE ..... DATE .....

SIGNATURE OF PRINCIPAL INVESTIGATOR/SUPERVISOR: .....

DATE:……..

SIGNATURE OF STUDENT RESEARCHER:.....

DATE:.....…….

## Abbreviations

| | |
|---|---|
| AA | Alcoholics Anonymous |
| AASW | Australian Association of Social Work |
| ACOSS | Australian Council of Social Service |
| ADCA | Alcohol and other Drugs Council of Australia |
| ADF | Australian Drug Foundation |
| AIHW | Australian Institute of Health and Welfare |
| AIVL | Australian Injecting & Illicit Drug User League |
| AMPSAD | Australian Medical and Professional Society on Alcohol and Other Drugs |
| AMSAD | Australian Medical Society on Alcohol and other Drug Problem |
| ANCD | Australian National Council on Drugs |
| ANCO | Australian National Classification of Offences |
| ANNA | Addiction Neuroscience Network Australia |
| AOD | Alcohol and other Drugs |
| AODTS-NMDS | Alcohol and Other Drug Treatment Services National Minimum Data Set |
| APSAD | Australasian Professional Society on Alcohol and other Drugs |
| APSU | Association of Participating Service Users |
| CALD | culturally and linguistically diverse |
| CSV | Community Services Victoria |
| DCPC | Drugs and Crime Prevention Committee |
| DHS | [Victoria's] Department of Human Services |
| DPEC | Drug Policy Expert Committee |
| DPMP | Drug Policy Modelling Project |
| DTC | Drug Treatment Court |
| EOC | episode of care |
| Hep C | Hepatitis C |
| HIV | Human immunodeficiency virus |
| IDU | injecting drug user [confusingly also 'Identified Drug User (IDU)'] |
| IGCD | Intergovernmental Committee on Drugs |
| IHRA | International Harm Reduction Association |
| INCB | International Narcotics Control Board |

| | |
|---|---|
| INPUD | International Network of People Who Use Drugs |
| MCDS | Ministerial Council on Drug Strategy |
| MSIC | [Sydney's] Medically Supervised Injecting Centre |
| NCADA | National Campaign Against Drug Abuse |
| NCETA | National Centre for Education and Training on Addiction |
| NDS | National Drug Strategy |
| NFP | not-for-profit organisation |
| NGCSO | non-governmental community service organisations |
| NGO | non-governmental organisation |
| NHMRC | National Health and Medical Research Council |
| NSPs | Needle and syringe programs |
| PDPs | 'people with drug problems' |
| SIF | supervised injecting facility [sometimes authors use 'safe' instead of 'supervised'] |
| TGA | Therapeutic Goods Administration |
| VAADA | Victorian Alcohol & Drug Association |
| VCOSS | Victorian Council of Social Service |
| VIDDISRG | Victorian Illicit Drug Diversion Initiative State Reference Group |
| VIVAIDS | Victorian Drug User Organisation |
| WHO | World Health Organization |

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