

HIV AND ENGLISH DRUGS POLICY

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ABSTRACT

This thesis uses a theoretical framework and methodological approach drawn from the work of Foucault to analyse the response within English drugs policy to HIV. A range of research techniques were used, including document analysis, interviews, postal surveys and observation. The thesis traces the genealogy of drugs policy, in discourse and specific practices, showing how the response of syringe exchange and harm minimisation was possible.

Discontinuities in drugs policy can be understood in terms of changes in the discourses and practices of medicine, public health and psychiatry. These three disciplines are central to the exercise of power in the disciplinary society.

The thesis argues that the exercise of that power is *individualising and totalising*; over the last two hundred years, the disciplines of the human sciences have constructed the modern individual through surveillance and normalisation. The exercise of power has become ever lighter and more diffused, and has produced the *self surveying subject*. This subject is the object of a plethora of discourses spoken by experts exhorting the individual to take responsibility for care of the self.

The disciplinary society makes drug use subject to its individualising and totalising power no less than any other behaviour. The thesis traces the exercise of that power in the history of twentieth century drugs policy. In the late twentieth century, the drug user is constituted as no less responsible for the production of the healthy self than anyone else.

The emergence of syringe exchange and harm minimisation can be understood within this particular form of individualisation, which takes the *self managing drug user* as its object. The thesis then examines the way three syringe exchanges developed to offer diverse forms of self care, those of *care of the body* and *knowledge of the self*.

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This thesis is dedicated to John and Katherine Lart.

INTRODUCTION

In November 1986, the Secretary of State for Health, Norman Fowler, announced the introduction of a new service for people who injected illegal drugs. The government that only a year before had run a mass media campaign based around the slogan 'Heroin screws you up' proposed to finance and support the development of pilot 'injecting equipment exchange schemes', places where drug injectors could obtain sterile equipment. How could a government endorse the distribution of the very means by which such an activity could be carried out?

The immediate context was that of the discovery of the Human Immunodeficiency Virus (HIV). The need to control the transmission of this virus by and among injecting drug users was a major public health issue, as this was a potentially highly effective bridge for the virus into the general population. Yet other countries faced with the same threat did not choose to use syringe exchange as a response.

Fifteen pilot syringe exchanges (unsurprisingly, the term 'injecting equipment exchange schemes' never entered popular usage) were set up and monitored in the year April 1987 to 1988. By the end of that year, a major report from the Advisory Council on the Misuse of Drugs, the body of experts that advises ministers on drugs policy, had recommended the expansion and extension of syringe exchange and other means of preventing the spread of HIV among injecting drug users. Government endorsement followed, after a wait for the results of the evaluation research, with guidelines for practice and extra financial allocations to health authorities, to set up further exchanges.

Within two and a half years of the first syringe exchanges, there were an estimated 120 such schemes in England. Syringe exchange had become a normal part of the practice of drugs services, and was also being offered by other, non specialist services in contact with injecting drug users. Alongside syringe exchange as a practice, there developed a discourse of 'harm minimisation' or 'harm reduction', and the provision of forms of primary health care and advice and information giving aimed at reducing the adverse results of injecting drug use. This thesis aims to analyse this response to HIV. The study examines *English* policy. In the drugs field there has, for a long time, been a tendency to discuss *British* policy, as if both discourse and practice were uniform across the UK. One of the first lessons of the response to HIV was that what was possible in one part of the UK was not necessarily possible in others; no pilot exchanges were located in either Wales or Northern Ireland, and the story of the

Scottish response was very different to that of the English one. Some material from Scotland is used as comparison in this study, but it is essentially focussed on the English response.

Theoretical framework

The theoretical framework within which this thesis is located is drawn from the work of Foucault on power, knowledge, discipline and the body. This framework is outlined in Chapter One. My research question is 'what made it possible for syringe exchange, and with it harm minimisation, to be the response within English drugs policy to HIV?'.

My argument locates drugs policy within the discourse and practice of the domains of medicine, public health and psychiatry. These three disciplines are central to the exercise of bio-power and the workings of the disciplinary society. From Foucault's work, I argue that the exercise of that power is individualising and totalising; over the last two hundred years the modern individual has been constructed by the disciplines of the human sciences through the specific practices of surveillance and normalisation. That individual has been subject to the exercise of power that has become increasingly lighter and more diffuse, operating less through direct coercion than through techniques that make the individual self surveying and self managing. This individual is the object of a plethora of discourses spoken by experts, that together are the effect of that individualising and totalising power.

Key themes

Chapter Two of the thesis traces the history of drugs policy in the twentieth century, showing how the changes and discontinuities in policy can be explained in terms of the wider changes in the exercise of disciplinary power through the disciplines of health: medicine, public health and psychiatry. Chapter Three analyses the emergence of syringe exchange and harm minimisation and shows how they can be understood within this particular form of individualisation. The immediate pre-history of drugs policy shows that there was an emerging discourse and corresponding development of new sites for practice that made syringe exchange possible. Chapters Four and Five then examine the development of syringe exchange, and identify the diverse forms of practice that emerged.

Key themes that arise are the shifting location of the object of drug use, between the drug user's body and mind, between the social body and the individual, over time. There are also changes in the production of that object, changes in those speakers

authorised to produce the truth about drug use, in the sites from which that truth is produced, and in the specific practices that are both explained by and constitutive of the truth.

Methodology

My methodological approach is that of genealogy, and I provide an discussion of what I mean by this in Chapter One. It is an approach closely linked to and largely dependent on the assumptions of the theoretical framework. The approach does not imply a particular set of research techniques, and my practice has included document analysis, interviews, postal surveys and observation. The theory and method used are not predictive of the future, nor reconstructive of the past, but seek to explain the history of the present.

The significance of the study

This thesis covers what is now almost an historical period, in the history of English drugs policy. The role of the thesis is to analyse that period and to show how the events it included could happen. The period since has seen further developments and new emergences: calls from both the left and the right to liberalise drug laws, against the background of a continued 'war on drugs'. However, syringe exchange and harm minimisation are so incorporated into the discourse and practice of the drugs world that I can now enter the very smart chemist shop near my university department in Bristol and pick up a Department of Health leaflet that tells me, in matter of fact terms, how to obtain injecting equipment, how to clean it and how to dispose of it safely. How and why this is possible is a fascinating and worthwhile story.

The analysis offered here locates that story in a theoretical framework that links the micro processes of practice in local sites, with broader historical themes and theoretical concepts.

CHAPTER ONE: THEORY AND METHOD

Introduction

This thesis uses Foucauldian genealogy to analyse the response within English drugs policy to the issue of HIV transmission among injecting drug users.

In order to do this, this chapter will discuss several substantive themes from Foucault's work. Very briefly, these will be:

1. The conception of the state as coterminous with a knowable and manageable population, as opposed to the state as the potential of the sovereign, or the state as an abstract juridical concept. The notion of the '*governmentalisation of the State*' from the eighteenth century onwards (Foucault 1979a:20).
2. The process of making that population knowable and managed by external knowledge and surveillance and the imposition of discipline (Foucault 1979b). Minson describes this as the transformation of the '*populace*' into '*population*' (1985:24). The creation and integration of the individual by an '*individualising and totalising form of power*' (Foucault 1982:213). Power as productive and constitutive as well as repressive.
3. The gradual lightening and internalising of the means of knowledge and management, as self discipline, and finally the self surveying subject (Foucault 1979b:203) and the production and management of the self (Foucault 1988a:48-49).
4. Discourse and the '*regime of truth*'. The '*specific intellectual*' with the authority and status to pronounce the truth within any given discourse (Foucault 1984:68).

I then go on to discuss medical discourse, and within this the domains of clinical medicine, public health and psychiatry. I will elaborate on the theme of the production and management of the self within health.

Finally, I briefly outline how I see this theory as useful in the analysis of drugs policy.

I stated that my methodological approach was that of genealogy, and having discussed the substantive theoretical concerns, I shall describe what I mean by this, and discuss my practice in producing this thesis.

The modern state

The whole of Foucault's substantive work on power, knowledge, discipline and the body makes sense within the framework of his conceptualisation of the modern state. This he discusses in several places, most clearly in two lectures: 'Governmentality', published in *Ideology and Consciousness* (1979a), and 'Omnes et singulatim' (1981a, also published in a revised version as 'The political technology of individuals' in 1988b). In these lectures he opposes the modern *governed* state to the two traditional conceptualisations of the state: that of the *juridical* state, and that of the *sovereign* state. The first of these derives from Christian tradition and the claim that

government is essentially just. It respected a whole system of laws: human laws; the law of nature; divine law. (1981a:243)

The second derives from Machiavelli's analysis in *The Prince*, in which

Machiavelli's problem is to decide how a province or territory acquired through inheritance or by conquest can be held against its internal or external rivals. Machiavelli's entire analysis is aimed at defining what keeps up or reinforces the link between prince and state ... (1981a:245)

The difference between these two definitions of the state and the arts of governing they imply, and the modern state and 'reason of state' as Foucault describes the art of modern government, is that the latter takes the state as an entity in itself, not dependent on an abstract set of laws, or on the person of the sovereign, but as 'something which exists per se' (1988b:151):

In a few words, reason of state refers neither to the wisdom of God nor to the reason or the strategies of the prince. It refers to the state, to its nature, and to its own rationality. (1988b:150)

The aim of such modern government is to reinforce and strengthen the state itself:

Finally, we can see that reason of state, understood as rational government able to increase the state's strength in accordance with itself presupposes

the constitution of a certain type of knowledge. Government is only possible if the strength of the state is known; it can thus be sustained ... Government therefore entails more than just implementing general principals of reason, wisdom and prudence. Knowledge is necessary; concrete precise and measured knowledge as to the state's strength. The art of governing, characteristic of reason of state, is intimately bound up with the development of what was then called either political *statistics* or *arithmetic*; that is the knowledge of different states' respective forces. Such knowledge was indispensable for correct government. (1981a:245-46)

The object of this knowledge was *population*; it is to the 'emergence of the problem of population' in the eighteenth century that Foucault attributes the possibility of conceiving of an entity within society between that of the family and that of the sovereign: the population (1979a:16-17, 1984:25). The art of government then becomes the management of the population:

population comes to appear above all else as the ultimate end of government, that is the welfare of the population since this end consists not in the act of governing as such but in the improvement of the condition of the population, the increase of its wealth, longevity, health etc. (1979a:17)

It is to the notion of population and the knowledge and management of population that I now turn.

Knowing and managing populations

Foucault uses the term 'discipline' to describe the particular technique which makes populations knowable while at the same time exercising power over them. The disciplinary technique has three elements: 'hierarchical observation, normalising judgement and their combination in a procedure that is specific to it, the examination' (1979b:170).

Hierarchical observation involves bringing together, observing, measuring and recording many objects. Foucault is discussing the process in relation to people, but the methodology is also one of the natural sciences. The public buildings of the eighteenth and nineteenth centuries afforded increasing opportunities for such observation or

surveillance: the hospitals, schools, orphanages, asylums, workhouses, factories and housing estates. In less tangible form the development of uniform systems of record keeping, registration of births, deaths and marriages, and the national census, captured the population on paper.

The institutions were not just mechanisms for the exclusion by enclosure of an undifferentiated mass, as they had been in previous ages, they were the apparatus for the exercise of discipline through *normalising judgement*. Within the institutions the use of space became divided and specialised, reflecting increasing differentiation of the populations they enclosed; within hospitals, different wards contained people divided by age, sex, symptoms and prognosis; within the factories the division of labour sorted people by skill and specialisation. People were ranked and graded, distributed between classifications, measured against ranges constructed from the observation of the whole, norms defined and deviations from the norm identified. As Minson (1985) describes it:

Discipline submits a whole mass of behaviour, speech, physical deportment and cleanliness, sexual activity, utilisation of time and space (matters hitherto of relative indifference to the law) to exhaustive, detailed inspection and disciplinary punishment ... no behavioural phenomenon was too minute or trivial for a norm not to be erected about it, and the slightest departures from the norm made punishable ... (Minson 1985:24-26)

But the response to non-conformity was not purely punitive, but also corrective: exercises to reinforce training, repetitive drill, the learning or copying of lines, for example. Similarly, punishment was matched with gratification; behaviour was placed on a scale:

instead of the simple division of the prohibition, as practised in penal justice, we have a distribution between a positive pole and a negative pole; all behaviour falls in the field between good and bad marks, good and bad points (Foucault 1979b:180)

and so good behaviour could be rewarded within

A penal accountancy, constantly brought up to date [which] makes it possible to obtain the punitive balance sheet of each individual. (1979b:180)

Surveillance and normalisation combine in the ritual of the *examination*. The examination is how normalising judgement is applied, and the detailed and meticulous recording it involves leaves behind the written traces of the examined individuals. The technique of examination, whether of pupils, patients, criminals or workers, is the means by which the individual is caught in the light of surveillance, and placed in the ranks and scales of normalisation.

The Panopticon

The paradigmatic form of the disciplinary mechanism Foucault discusses is Bentham's design for a prison, the *Panopticon*:

at the periphery, an annular building; at the centre a tower; this tower is pierced with wide windows that open onto the inner side of the ring; the peripheric building is divided into cells, each of which extends the whole width of the building; they have two windows, one on the inside, corresponding to the windows of the tower; the other, on the outside, allows the light to cross the cell from one end to the other. All that is needed then is to place a supervisor in a central tower and to shut up in each cell a madman, a patient, a condemned man, a worker or a schoolboy. (1979b:200)

Each cell, containing the object of observation, is atomised, separated from its neighbours. The backlighting makes its occupant totally visible to the watcher in the tower, while the watcher is invisible to the watched. The watcher can observe not only the individual, but the whole field of individual bodies arranged in space.

While the Panopticon describes the literal arrangement of bodies within buildings, and can be used in many settings and with different populations – 'it serves to reform prisoners but also to treat patients, to instruct schoolchildren, to confine the insane, to supervise workers, to put beggars and idlers to work' (Foucault 1979b:205) – it also has a more diffused role:

The panoptic schema, without disappearing as such or losing any of its properties, was destined to spread throughout the social body; its vocation was to become a generalised function. (1979b:207)

The argument is that surveillance and normalisation operate not only within the walls of an institution, but also throughout society, in a myriad of ways. The techniques and practices for making the population known are the same ones that make the population manageable, through a network of power relations which Foucault calls both disciplinary power and 'bio-power'. Bio-power designates:

what brought life and its mechanisms into the realm of explicit calculations and made knowledge-power an agent of transformation of human life. (1984:143)

Panopticism is not just about the architectural configuration of institutions; it is a way of grasping the operation of power in modern societies.

Foucault's account of power is a key element in his work. He does not offer a theory of power, a universal, objective description, but rather an analysis of power:

power is not an institution, and not a structure; neither is it a certain strength that we are endowed with; it is the name that one attributes to a complex strategical situation in a particular society. (1981b:93)

Power is *exercised* not *possessed*. It is not a commodity that one side of a relationship holds and not the other; it only exists in its exercise and in its effects. Power is intrinsic to the networks of all relationships that constitute society – 'economic processes, knowledge relationships, sexual relations' (1981b:94) – not just political institutions. Power relations are 'both intentional and nonsubjective' (1981b:94). At the local level power is exercised rationally and intentionally, and all those local exercises of power may well share an overall direction and coherence, but this does not imply that there is any subjective control at the centre:

let us not look for the headquarters that presides over its rationality; neither the caste which governs nor the groups which control the state apparatus, nor those who make the most important economic decisions direct the entire network of power that functions in a society (and makes *it* function). (Foucault 1981b:95)

As Dreyfus and Rabinow argue, this insight is central to Foucault's account of power, and yet how can we talk about strategies and intention without some idea of how these are implemented?

The answer must lie in the practices themselves. For it is the practices, focused in technologies and innumerable separate localizations, which literally embody what the analyst is seeking to understand ... There is a push towards a strategic objective, but no one is pushing. (Dreyfus and Rabinow 1982:187)

This is not a functionalist argument, which would imply that there was a necessary equilibrium. Instead, there is always resistance, or at least the potential for resistance; resistance, like power itself, is not a commodity, but is also only present in its exercise, in specific locations.

These points of resistance are present everywhere in the power network. Hence there is no single locus of great Refusal, no soul of revolt, source of all rebellions, or pure law of the revolutionary. Instead there is a plurality of resistances, each of them a special case ... by definition, they can only exist in the strategic field of power relations. (Foucault 1981b:95)

Individualising and totalising power

A key feature of disciplinary power or bio-power is the 'reversal of the political axis of individualisation' (1979b:192). In the Panopticon, the observer is obscured, while the object of surveillance is clearly lit and visible. This reverses the direction of visibility typical of other concepts of the state:

Whereas in monarchical regimes it was the sovereign who had the greatest visibility, under the institutions of bio-power it is those who are to be disciplined, observed and understood who are made the most visible. (Dreyfus and Rabinow 1982:191)

Under juridical and sovereign power, it is the law or the monarch that is visible, represented and symbolised, at the apex of a pyramid of visibility. Under a disciplinary regime, it is those upon whom power is exercised who are visible and individualised, in a 'descending' individualisation (Foucault 1979b:193). The exercise of bio-power raises 'ordinary individuality' above a 'threshold of description'. Whereas in the past

to be looked at, observed, described in detail, followed from day to day by an uninterrupted writing was a privilege (1979b:191)

this was now the lot of ordinary people under the disciplinary techniques of measuring, recording and ranking of facts about birth, marriage, death, residence and occupation. Individuals were given recorded biographies in the files of public records, they existed, were part of the population, and left official traces when they died. They were also subject to the detailed organisation of body movements, the prescribing of 'correct' ways to carry out daily tasks. The paradigm of this is military drill, with each action broken down to the minutest element, and the ordering and timing of their performance laid down. However, the form can also be seen in, for example, the way workers were employed in factories, the way children were taught handwriting or such body maintenance skills as teethbrushing (Nettleton 1992).

Bio-power therefore creates individuals;

Discipline 'makes' individuals; it is the specific technique of a power that regards individuals both as objects and as instruments of its exercise.
(1979b:170)

However, the aim of the exercise of that power is the management of the total population, to increase efficiency, productivity and welfare, creating the paradox of what Foucault calls 'an individualising and totalising form of power' (1982:213):

From the state's point of view, the individual exists only insofar as what he does is able to introduce even a minimal change in the strength of the state, either in a positive or in a negative direction. It is only insofar as an individual is able to introduce this change that the state has to do with him. (1988b:152)

This is not to argue that the state is inherently oppressive of the individual and I shall go on to delineate Foucault's argument that power is productive as well as repressive. But in constructing the individual, power operates to increase the effectiveness of the whole: 'the disciplines function increasingly as techniques for making useful individuals' (1979b:22). While the disciplines make the individual more visible, they do so in order to better integrate the individual into society.

Productive power

Finally, power is not just repressive. While domination and repression can be an effect of power, they are not its essence. Power is productive and constitutive, and this can be

positive as well as negative. The scrutiny of the individual in the Panopticon gives that individual a visibility and an identity:

a power relationship can only be articulated on the basis of two elements which are each indispensable if it is really to be a power relationship: that 'the other' (the one over whom power is exercised) be thoroughly recognised and maintained to the end as a person who acts; and that, faced with a relationship of power, a whole field of responses, reactions, results, and possible inventions may open up. (Foucault 1982:220)

As Lacombe (1996) argues, there has been a tendency in many pieces of work that use a Foucauldian framework to focus on the oppressive and social control effects of the exercise of disciplinary power. Certainly reading *Discipline and Punish* can leave a sense that the disciplinary practices are inherently and only oppressive, describing mainly as it does the process of *objectification*. In later writings, Foucault developed his ideas on the process of *subjectification*; the way in which the individual can produce the self. It is this reading of the concept of productive power that informs this thesis. I will argue later in this chapter that the techniques and practices of health promotion are means by which the individual is incited to produce the self.

Self knowledge and self management

While the actual Panopticon was a design for a specific architectural arrangement, the schema of power for which it is a metaphor is more diffused than this: the *disciplinary society*. The 'discipline-mechanism' is:

a functional mechanism that must improve the exercise of power by making it more light, more rapid, more effective, a design of subtle coercion for a society to come. (1979b:209).

The point about that society is that it is not just *disciplined* but also *disciplinary*. The mechanisms of discipline are not just external to individuals and their everyday lives, imposed in moments of crisis, but are intrinsic. The individual constituted by the disciplines, made visible by surveillance, becomes self regulating. Foucault's argument is that panopticism makes it no longer necessary to use force to constrain people, the knowledge of constant surveillance is enough. To return to the concrete Panopticon, the individual in the single cell knows s/he is visible to the watcher in the tower, but cannot

see the watcher. Neither can s/he confer with other individuals in the same relationship of power to the watcher:

He who is subjected to a field of visibility, and who knows it, assumes responsibility for the constraints of power; he makes them play spontaneously upon himself; he inscribes in himself the power relation in which he simultaneously plays both roles; he becomes the principle of his own subjection. (1979b:202-203)

Two things are happening here: one is the lightening of the mechanism of power,

The external power may throw off its physical weight; it tends to the non-corporeal; and, the more it approaches this limit, the more constant, profound and permanent are its effects: it is a perpetual victory that avoids any physical confrontation and which is always decided in advance. (1979b:203)

The other is the corresponding internalisation of surveillance and management, and the production of the *self surveying subject*. If the concrete forms of panopticism worked on the body and, through the control and arrangement of the body, thence on the mind, the non-concrete, diffused form of panopticism that is the disciplinary society works on the mind, and thence on knowledge of and self production of the body. The self surveying subject will know (even if s/he resists) the norms of behaviour, dress and body maintenance. It is by means of those norms that s/he is integrated into society.

Care of the self

It is through specific techniques that the awareness of external surveillance is transformed into self surveillance and self production. The practice or technique that Foucault identifies as central is that of disclosure of the self (1981b). He traces this back from the contemporary techniques of psychoanalysis, through the Christian practice of confession, to the ancient Greeks. His argument is that the injunction '*take care of yourself*' was once as important as that of '*know yourself*' (Foucault 1988a:19, Hutton 1988:133-34), and self knowledge, through disclosure, was a method of self care. The centuries of Christian morality obscured the link between the two, because 'self-renunciation [was] the condition for salvation. To know oneself was paradoxically the way to self-renunciation' (Foucault 1988a:22), and not the way to care for oneself. Similarly, he argues, even with increasing secularisation after the enlightenment,

criticism of established morality has been undertaken in the name of the importance of recognising and knowing the self. Therefore it is difficult to see concern with oneself as compatible with morality. 'Know thyself' has obscured 'take care of yourself' because our morality, a morality of asceticism, insists that the self is that which one can reject. (1988a:22)

Knowing oneself therefore became associated with renunciation of the self, and the practice of confession with that of penance and mortification (1988a:48), whether Christian or secular. However, over the last two hundred years, and particularly since Freud, the practice of self knowledge through disclosure has become a means, not of renunciation of the self, but of the production of the self:

From the eighteenth century to the present, the techniques of verbalization have been reinserted in a different context by the so-called human sciences in order to use them without renunciation of the self but to constitute, positively, a new self. To use these techniques without renouncing oneself constitutes a decisive break. (1988a:49)

The practice of confession is reinvented as the modern practice of psychoanalysis, with the analyst as confessor. Rose (1989) describes the diffusion into new areas of our lives of the practice of disclosure and reflexion:

The truthful rendering into speech of who one is, to one's parents, one's doctor, one's lover and oneself, is installed at the heart of contemporary practices of individualisation. (1989:240)

The practice has been reproduced in a range of situations and involving a variety of other professional groups: those related to the psychoanalyst such as psychologists, psychiatrists, counsellors, social workers, probation officers, and others, such as teachers, nurses, even, at times, the police. All these, to a greater or lesser extent, employ the technique of inciting self disclosure and knowledge in the objects of their practice, in order that those objects become self producing and managing subjects. The 'empowered' client is now the aim of these professions, someone able to understand and take charge of their own life.

More diffusely in society, the responsible and empowered citizen is the object of the information-giving inherent in popular journalism, advertising, the publishing of self help manuals. We are exhorted to produce and manage our own bodies, through diet,

exercise, clothing, make-up, alternative therapies. At the very extreme, we can literally produce our bodies anew, through surgery, to conform to norms and social expectations. Turner describes 'an interesting alliance between the state, the medical profession and the healthy citizen' in which 'the monogamous jogger is the responsible citizen' (1984:221).

The practice of monogamy, of course, is not so much something we do *to* our bodies, as *with* our bodies, and *to* our interpersonal relations. The whole sphere of our social being, as well as embodied being, is also subject, through the practice of disclosure, to scrutiny and positive constitution. Counselling, support groups, therapies such as Gestalt, primal therapy, transactional analysis, techniques of stress management, even career guidance; all are based on an assumption that there is an essential 'truth' to be discovered about our psyches, our histories, our relationships, our feelings and emotions in the face of life events, and that with guidance and information we can choose to reconstitute our selves and our lives.

These practices are further individualisations; the level of 'truth' is set at the individual, the individual's mind and body becomes the site for change, responsibility for change rests with the autonomous individual. However, disciplinary power is both individualising and totalising. The reconstituted, autonomous individual is better integrated into society.

Discourse and the speaker

So far I have largely discussed non-discursive practices, though implicit in what I have said has been the relationship between these and discourse. What I mean by a discourse is the set of 'statements' that together make up accepted truth or knowledge about a given domain. These statements, which do not have to be literally spoken but can be written or drawn (maps or diagrams, for example) or painted, can take many forms:

Qualitative descriptions, biographical accounts, the location, and cross-checking of signs, reasonings by analogy, deduction, statistical calculations, experimental verifications, and many other forms of statement are to be found in the discourse of nineteenth century doctors.
(Foucault 1974:50)

The point about these statements is that they were the ones that were made, out of all the ones that might have been made at that time. Their significance is not, therefore, something hidden, of which they are representatives or symbols, but belongs to them at a

superficial level. Together the statements that form a discourse have a coherence and integrity; there are regularities and links between them. This coherence will, therefore, mean that other statements cannot be part of the discourse; they are by definition ruled out of the 'truth'. In discussing discourse, what Foucault is not doing is making any judgements as to validity or essential truth, indeed the notion of essential, universal truth is irrelevant:

Each society has its regime of truth, its 'general politics' of truth: that is the types of discourse which it accepts and makes function as true; the mechanisms and instances which enable one to distinguish true and false statements, the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth, the status of those who are charged with saying what counts as true. (Foucault 1984:73)

In modern societies, this regime of truth has five characteristics:

'Truth' is centered on the form of scientific discourse and the institutions which produce it; it is subject to constant economic and political incitement (the demand for truth, as much for economic production as for political power); it is the object under diverse forms, of immense diffusion and consumption (circulating through apparatuses of education and information whose extent is relatively broad in the social body, notwithstanding certain strict limitations); it is produced and transmitted under the control, dominant if not exclusive, of a few great political and economic apparatuses (university, army, writing, media); lastly it is the issue of a whole political debate and social confrontation ('ideological' struggles). (Foucault 1984:73)

Those people authorised, within this regime of truth, to speak are those Foucault defines as the *specific intellectual*. He counterpoises this to the role of the *universal intellectual*, 'a universal consciousness, a free subject' (1984:68), which was to speak universal, eternal truths:

The oldstyle 'universal' intellectual claimed to give voice to the otherwise inarticulate masses, being the conscience of the nation or perhaps all humanity; his or her truths were presented as universal and binding. (Stenson 1991:11)

The specific intellectual, by contrast, has a delimited domain of knowledge, but within that domain produces truths that are accepted and validated. That domain articulates with the more general regime of truth:

'Truth' is to be understood as a system of ordered procedures for the production, regulation distribution, circulation and operation of statements. (Foucault 1984:74)

'Truth' is linked in a circular relation with systems of power which produce and sustain it, and to effects of power which it induces and which extend it. (Foucault 1984:74)

The institutional sites for the production of those truths – the hospital, the laboratory, the 'documentary field' – are also the source of legitimation of the discourse and of authority for the speaker (Foucault 1974:51). Modifications in the sites for discourse, and the practices associated with those sites, result in shifts within the discourse (Foucault 1974:52).

So we have several things: we have discourse taken as 'truth' because it conforms to the general regime of truth; a speaker justified and authorised as an expert with the authority to produce that truth and an institutional site from which to produce it; a delimited domain within which that truth operates; and a set of practices which both produce the truth and are its effects.

Medical discourse

I now turn specifically to medical discourse, or more accurately, discourse around health. Throughout Foucault's analysis of discourse he uses medical knowledge as an example of discourse, and doctors as paradigmatic authorised speakers. Similarly, the hospital is seen as a key site for both the production of knowledge and for the exercise of disciplinary power.

Medicine, because it encompasses knowledge of bodies both singularly (clinical medicine) and collectively (epidemiology, public health) is clearly central to the exercise of bio-power. What I will now do is to take the two domains of clinical medicine and public health, discuss each separately, and then look at the relationship between the two.

I will then go on to discuss a third domain within medicine: that of psychiatry. I argued earlier that disciplinary power in its most invisible, diffused form works on the mind, and through this on knowledge of and self production of the body. Here I will look in more detail at the development of the discourse that constructs the mind within medicine.

Clinical medicine

Foucault describes how nineteenth century medicine directed its gaze at the body, employing the techniques of disciplinary power, and how the hospital and the laboratory became the key sites of medical discourse. The physical examination of the body, the careful noting of signs and symptoms, the recording of diagnosis and prognosis, the keeping of records of observations and of the course and outcome of disease and, finally, the dissection after death of the body, became the practice of medicine within hospitals, and the mode of production of medical knowledge (Foucault 1974, 1976).

This form of medicine, practised on large numbers of people within hospitals, constituted disease in a particular way. Anatomo-physiological knowledge of the body allowed the construction of norms, standards of functioning and organic structure, against which deviations, in the form of disease, could be measured. The source of disease was understood to be directly related to abnormalities of function or structure within the body:

experience reads at a glance the visible lesions of the organism and the coherence of pathological forms; the illness is articulated exactly on the body, and its logical distribution is carried out at once in terms of anatomical masses. (Foucault 1976:4)

Hospital medicine also integrated the laboratory: 'the site of a discourse that has the same experimental norms as physics, chemistry, or biology' (1974:52).

This perception of disease as existing within, and coterminous with, the physical body, while familiar to us, has a short history; 'There have been, and will be, other distributions of illness' (Foucault 1976:3). However, the point for the present argument is the way in which, through specific practices, nineteenth century clinical medicine constructed truths about the body and disease.

Public health

The concept of public health is implicit in the concern with population characteristic of the modern state. The need to know and manage the population produced the knowledges of demographics and epidemiology. While clinical medicine looked at collections of individual bodies and the patterns of disease within them, public health looked at the distribution of bodies within space and the articulation of that distribution with those of disease, poverty and squalor. The epitome of this perspective is, of course, the work of Snow to map the distribution of cholera, locate the source and then remove the handle of the Broad Street pump. Before laboratory science had produced the concept of the specific causative agent, effective control of infectious diseases was made possible by the more generalised attack on dirt and overcrowding through sanitary reform and housing policy. In this period, public health was 'the prism through which urban reform of many and varied kinds was enacted' (Lewis 1991:200).

However, this concern with environmental factors in the causation of disease, and consequent focus on the relationship between bodies and their surroundings, gave way towards the end of the nineteenth century to a concern with social contact and personal hygiene, and a focus on the relationships between bodies (Stimson and Lart 1991). This has to be linked to the growth of medical knowledge. In Britain, even when the definition and scope of public health was at its widest, doctors were an integral part of the movement for reform, and public health has always been seen as a medical speciality (Lewis 1991:195). The truths produced within clinical medicine became the truths that determined the practice of public health. With the scientific knowledge of bacteriology came new practices within public health:

A new emphasis upon notification, isolation, and disinfection had a high profile amongst Medical Officers of Health in the 1880s. A list of the most common infections spread by social contact was made notifiable under an adoptive act in 1889 and the law became compulsory in 1899. (Fee and Porter 1991:37)

By the early twentieth century, public health doctors tended to regard the nineteenth century's preoccupation with sanitary engineering as somewhat degrading. During this period public health switched its attention away from environmental concerns and towards 'personal prevention', offering

advice on the prevention of disease and the promotion of health to individuals through clinics. (Lewis 1991:196)

From a sociologist's, rather than an historian's perspective, Armstrong (1983) has discussed the same process as that described by Lewis (1986, 1991) and Fee and Porter (1991), a closure of the gap between the perspectives of clinical medicine and those of public health (Stimson and Lart 1991:1271), and it is to this and the implications for the production of knowledge that I now turn.

The wider gaze: the Dispensary

Taking Foucault's work as his starting point, Armstrong traces how medicine developed new ways of looking at illness and disease, in the twentieth century, out of new ways of practice. He describes how

the medical gaze, which had, for over a century analyzed the microscopic detail of the individual body, began to move to the undifferentiated space between bodies and there proceeded to forge a new political anatomy. (Armstrong 1983:6)

The challenges to health of the early twentieth century were contagious diseases like tuberculosis (TB) and venereal disease (VD). These were diseases of contact, of relationships between people, not between people and the environment as cholera and typhoid had been. Armstrong takes the *Dispensary* as emblematic of a way of seeing illness (1983:8). Dispensaries had existed in Britain since the late eighteenth century, but at the turn of the twentieth century they took on a new importance as special institutions for the diagnosis and treatment of TB. This model provided treatment not on an in-patient basis like the nineteenth century hospital or the sanatoria, but as ambulatory care. The patient stayed in the community, but the condition was managed by the Dispensary. Also undertaken were screening, contact tracing and the observation and monitoring of the course of the disease within the community.

Armstrong contrasts the Dispensary, a diffused, open form of surveillance, operating in the spaces between bodies, with the Panopticon and the operation of panoptic power, which he characterises as enclosed, involving 'rituals of separation and exclusion' (:9), focussing on the individual body. He seems uncertain whether he regards the Dispensary as an alternative to the concrete form of the Panopticon, but a further refinement of panoptic power, or as marking a break with panopticism and the start of something new

(1983:111). As I argued earlier, Foucault uses panopticism to include the generalised, diffused form of surveillance, which pays attention as much to the ranging and relating of bodies as it does to the individual body. I would therefore see the Dispensary as a form of panopticism, rather than an alternative, and as the point at which the gaze of clinical medicine, looking for signs of disease, articulates with the gaze of public health, mapping populations and demographic change.

What was made possible by the Dispensary was the extension of the medical gaze, out of the hospitals and away from the individual body into the community. Instead of being located within and coterminous with the individual body, disease was located 'in the spaces between people, in the interstices of relationships, in the social body itself' (Armstrong 1983:8). In its concentration on the enclosed sick population of the hospitals, the gaze of nineteenth century medicine had ignored or made assumptions about the unenclosed general population (1983:51).

In the Dispensary, the gaze was extended out from the actually ill to the potentially ill: the 'normal' population. Contact tracing and notification of disease made visible the patterns of relationships between people. Similarly the institutional arrangements for dealing with VD (Evans 1992) brought even more personal and private relations and contacts under scrutiny and surveillance. So 'a new way of seeing illness' (1983:6) emerged: no longer enclosed within the body, but existing between bodies; no longer enclosed within the hospital, but visible in the community:

A single patient with venereal disease was simply a manifestation of a disease which in all probability had already moved on and was manifesting itself elsewhere ... Disease was constituted in the social body and it was the social movement of the disease as it traversed that body, which had to be observed, monitored and interpreted, thereby establishing by its analysis the very existence of that same social space. (Armstrong 1983:18)

The difference between this and the old public health, then, was the supposed accuracy of the signs of disease being looked for and monitored in that space. This accuracy was provided by the medical knowledge that had been constructed within the hospitals and laboratories.

Armstrong's argument is that while TB services were the starting point for this new way of seeing illness, the Dispensary as a concept was not limited to TB. The medical gaze then 'began to focus with greater intensity on the potentially ill; the healthy and the normal'. Other sites for the operation of the clinical gaze were created: milk depots, maternal and child welfare services and the school health services to survey the infant and child population; general practice and health centres for the general adult population (Armstrong 1983:32-41). These were forms of practice central to the redefinition of public health and the role of public health doctors, the Medical Officers of Health, as preventive medicine (Lewis 1991:203).

The post-war discipline of social medicine

According to Stacey, the key to the transformation in knowledge was the adoption by medicine of survey methods, already used by government for administrative purposes and by social researchers such as Booth and Rowntree; '[t]hese techniques medicine now took to itself' (Stacey 1988:100). Screening, to identify the potentially ill, became both technically possible and medically desirable. Armstrong traces the growth of the use of the survey during and after the second world war to examine whole populations and the discovery that physical signs, hypertension or glycosuria for example, which had been regarded as abnormal and which were part of the definition of illness were in fact present in large numbers of the 'normal' population (1983:95-97). Surveillance thus arises from and in turn creates a perception of health in which the normal/abnormal divide begins to dissolve. The hospital had constructed the binary separation between the normal and the abnormal. The Dispensary extended the clinical gaze to the whole of society and uncovered the difficulty of that binary separation:

If so-called disease states were continuous with general population measurements, then how could disease be a separate, discrete entity? (1983:96)

Similarly, even within one individual, there was no clear separation between a state of health and one of ill-health; clinical signs could come and go, with no apparent relationship to symptoms (1983:44).

This new discourse of health – social medicine – took as its object states of health and illness that were no longer fixed, and that were manifested in the social body rather than the individual body. The practices were those of preventive medicine, notification and

case-finding, through to screening and health education. I am aware that my discussion so far may suggest that this was the dominant discourse within medicine during this period. This is clearly not so; the continued growth of clinical medicine and of the hospital as the site for practice are the key features of the post-war context, institutionalised in the hospital dominated National Health Service. The tripartite structure of the NHS between 1948 - 1974 privileged the hospital services over the sites for the production of social medicine; the local authority run community services and general practice.

As Lewis argues, in the post-war period, 'public health allowed itself to become defined by the activities it undertook' and lacked a clear philosophy to underpin those actions (1986:3). Part of Lewis' analysis is that public health failed to maintain a broader range of concerns because of the political challenge implicit in such a broad focus. However, she also describes the discursive effects of the articulation of clinical medicine with public health; 'the concerns of social medicine were defined primarily by academics' (1996:37) and the need this brought for the discipline to conform to the regimes of truth of clinical medicine. The momentum gained during the war was lost in the 1940s as the concept of social medicine moved away from the broader 'truths' of public health towards those of clinical medicine. Social medicine was dominated by clinical medicine, both as practice and as an academic discipline. For the argument of my thesis, however, what matters is that, although so dominated, the discipline of social medicine did bring an extended gaze to the discourses of health.

Psychiatric medicine

I now want to discuss the development of the medicine of the mind. Part of the argument is essentially the same; that in the enclosed space of the nineteenth century asylum, knowledge of madness was constructed through the disciplinary techniques. The bodies of the mad were arranged, examined, subjected to normalising judgement. The development of instruments of psychological assessment in the early twentieth century made possible the surveying of non-hospitalised, general populations, and therefore an extension of the psychiatric gaze out into the wider community and a dissolution of the binary divide between the normal and the abnormal (Armstrong 1983:64-67). However, two other changes in psychiatric discourse are also important. One is the move from a somatic basis for mental pathology to the discovery of the importance of the social and psychic realms. The other is the growth of professional groups other than doctors who claimed the right to speak on the mind.

The first of these two changes may seem odd – I am arguing that psychiatrists were not, primarily, concerned with the psyche. Both Prior (1993) and Rose (1986, 1988) describe the somatic focus of late nineteenth and early twentieth century psychiatry:

Thus in the earlier case notes [of asylum patients] one reads not so much about the substantive detail of the manias and melancholias which disturbed the various inmates, and still less of the social circumstances which led to the onset of such disturbances, but of the bodily state of the patients ... Details of the patient's body weight, height, the shape of the nose, the head, the hands and the feet. (Prior 1993:31)

This focus on the body was natural in a psychiatry seeking to establish itself within the wider medical profession. To be able to explain madness in somatic terms, linking pathologies of the mind to actual abnormalities of structure and functioning, and to prescribe somatic therapies, changed psychiatrists from merely the keepers of the insane to doctors. Hence the emphasis on body shape, posture, facial expression, looking for signs, written on the body, of madness.

Rose (1986) argues that the re-siting of psychiatry away from the body, and into the mind and social being, began with 'the discovery of a new range of objects of administrative concern and psychiatric attention – the neuroses' (1986:47). These were mental disorders not sufficiently grave to constitute madness, but enough to affect social efficiency and personal happiness – they were a way of conceptualising what was happening in the case of those individuals who failed to conform to normalising judgements:

The problem of the neuroses emerged outside both asylum and consulting room, in all those sites where individuals could be seen to fail in relation to institutional norms and expectations – the army, the factory, the school and the courts. (1986:48)

In particular, the experience of treating 'shell shocked' soldiers during and after the first world war contributed to the development of a knowledge of 'the existence of unconscious mental processes, elements repressed from consciousness as an attempt to resolve some intractable mental conflict' (1986:49). This, of course, is the basis of Freudian psychoanalytic theory, but in the case of shell shock, the Freudian insistence

that repressed elements were specifically to do with sexuality seemed irrelevant. In the therapeutic space set up by the treatment of shell shock,

a new way of conceiving of the relation between madness and society was being born. Within this new conception, it would not be a question of organic predispositions, exciting causes, and virtually incurable lapses into insanity. Madness was now thought of in the terms of social hygiene. Mental health could be maintained by proper adjustment of the conditions of life and work; poor mental hygiene and stress could promote neurosis in large numbers of people. (Rose 1989:21)

Mental illness was therefore potentially present in most people – the shell shocked soldiers did not have abnormal histories – and was both treatable and preventable. There was not a binary divide between the mad and the sane, but rather a continuum. However, it was not psychiatry that first constructed this new definition of mental illness, but general medicine (which included neurology). Armstrong traces the appearance of the neuroses in the text books of neurology through the 1920s:

The appearance of the psychoneuroses in medical texts formalised an increasing concern of general medicine with the mind. The mind in all its detail had become important – not the diseased mind of the mad or insane but the ordinary mind of everyone. (1983:22)

Armstrong's argument is that at this time psychiatry was still concerned with the 'great binary division of madness from sanity', while:

In contrast, the neuroses celebrated the ideal of a disciplined society in which all were analysed and distributed. (1983:22)

The sites for practices concerned with neurosis were not within the asylums, but in general practice and, increasingly from the 1920s, out-patient departments and private or charitable clinics (Rose 1986:51, Prior 1993:44). The paradigm of the Dispensary can be applied to these sites from which the extended disciplinary apparatus was concerned with minds not bodies, and began to employ the survey to construct knowledge about how mental illness was distributed among the population. The second world war proved a further stimulus to concern with the mind and the inscribing of a 'neurotic topography of the population' (Rose 1989:25). In the build up to the war, and the planning for the predicted airborne bombing of civilian populations, the assumption was made that there

would be an epidemic of neurosis among civilians under stress. In the event, there was no such reaction, but the state of the population's mind was of concern, not only in terms of anxiety and stress, but also morale – how to maintain and strengthen the civilian's commitment to the war. Surveys, opinion polls, hospital admissions figures, all gave useful information, and further created the psyche as an accessible realm:

The mental state of the population was beginning to be translated into a calculable form: inscribed, documented, and turned into statistics, graphs, charts, and tables that could be pored over in political deliberations and administrative initiatives. (Rose 1989:25)

It was not only the psyche of the civilian population that was made visible, but that of serving personnel as well. All three branches of the armed forces established psychiatric services, and psychological testing became increasingly common through the war in recruitment, selection and allocation of personnel (Rose 1989:41-42).

Psychiatry emerged from the war with a unified construct; the difference between the psychoses and the neuroses were seen as quantitative rather than absolute, and both were sited, at least to some degree, in the psyche, the proper object of psychiatric discourse. General medicine, or rather the speciality of neurology, on the other hand, began to withdraw from concern with the mind, rather than the brain. Just as in the 1920s chapters on the neuroses had begun to appear in the neurological texts, so in the 1950s and 1960s they began to disappear (Armstrong 1983:68), leaving psychiatry in possession of the realm of the psyche. Psychiatry has, of course, never lost its use of somatic explanations and therapies. But within medical discourse, it is the speciality that claims knowledge of and expertise over, and hence the right to speak the truth about, the mind.

It is perhaps useful to contrast the discursive accounts of this change, provided by Armstrong and Rose, with the materialist explanation offered by Shortt (1986). Shortt argues that psychiatry's focus on the extreme of mental abnormality, linked to the late nineteenth century concern with heredity and 'degeneration', articulated with existing class relationships (1986:108). The nineteenth century mad who were, in their vast number, enclosed in the asylums, were largely the degenerate poor and by the inter-war period:

the pool of degenerates - that is the very poor - was steadily receding into invisibility. Partially through the growth of welfare institutions such as the asylum itself, the desperate poor were, if not reduced in number, sequestered from view. In effect, by its very success in corralling the degenerate, psychiatry was in danger of losing the social rationale behind its theories. It was clearly time to seek a new clientele, to move beyond the narrow confines of the asylum and its degenerate inhabitants. (1996:108-109)

Shortt suggests that, leaving the question of heredity to the growing eugenics movement:

psychiatry now chose to go its own way. It would establish that even within the ostensibly sound cerebrums of the growing middle class, untainted by hereditary blight, lurked the unconscious potential for mental aberration. the discovery of the unconscious, in short was to provide psychiatry with both a new clientele and a vastly enhanced social authority. (1986:109)

This theoretical account suggests a conscious direction to the relationship between the acceptance of notions of the unconscious by psychiatry, and the rewards of that for the discipline in terms of a new class as the market for its services. It is based on a very different framework of power and social action from that which this thesis is using, and its inclusion points up the particular perspective from which I am writing. However, it describes a process, the moving out of psychiatry from the enclosed world of the body within the asylum, into that of the mind within the clinic, which did have the effect of changing the nature of the population subject to psychiatry's gaze.

The breaching of the discursive divide between the mad and the sane was followed, in the post war years, by the breaching of the concrete divide, the wall of the asylum, and the creation of a new spatial and architectural arrangement (Prior 1993:43). Hospital care remained central to psychiatric practice; the annual number of psychiatric admissions in England rose from under 50,000 in 1945, to over 200,000 by the end of the 1980s (Prior 1993:40). What was no longer thinkable was the building of large, isolated services, in which people, once admitted, would spend most of their lives. From the 1960s the pattern has been the siting of psychiatric in-patient units within general hospitals, bringing the site of psychiatric practice into the wider site of clinical medicine's practice. But there has also been the fragmentation and diffusion of 'community care':

Side by side with hospital care there has also arisen a new array of practices and facilities, and consequently the functions of care and treatment of the mentally ill are now dispersed and fragmented across numerous sites and numerous professional groupings, rather than concentrated on a single site. (Prior 1993:43)

It is not just care and treatment of the mentally ill that is dispersed, but also the authority to speak on the mind. Outwith the medical domain, psychiatry is faced with a variety of groups that also claim this authority. Clinical psychology shares the site of, and is largely subordinate to, psychiatry in its practice, but other groups such as industrial psychologists and educational psychologists practice and speak from other sites. Psychoanalysts speak a discourse which, unlike psychiatry, excludes the somatic, and, while there is an overlap in membership between psychoanalysis and psychiatry, the sites of practice are different, psychoanalysis being largely confined to private practice.

Other occupational groups who staff the welfare state are concerned, if not solely, then at least for some of their time, with the minds of their clients: counsellors, social workers, nurses, health visitors, probation officers, teachers, art therapists, occupational therapists. Beside these are the groups who offer their services in the voluntary and private sphere: relationship counsellors, bereavement counsellors, therapists of many kinds. Beyond these are those whose work, while not being about therapy, still claims expertise over the mind: advertisers, opinion pollsters and the political 'spin doctors'.

The healthy self

My argument about medical discourse in the twentieth century is firstly that we have seen the construction of the social body and the psyche as realms within which health and illness exist, alongside the individual body which had been constructed by nineteenth century medical knowledge. This is not to argue that illness had never been seen to exist in these realms before, but to argue that they re-emerged in this period, through specific practices linked to the scientific regime of truth: assessment tools, surveys, statistical analysis.

Secondly, I have argued that there has been a blurring of the divide between the normal and the abnormal, both within the social body, with the focus on the potential for abnormality held to be inherent in the presence of certain signs, and within individual bodies and minds over time. Within a focus on prevention comes the idea of a 'natural

history' of a disease. This stresses the importance of the recognition of early signs of disease, of precursor disorders and, further back in the development of a disease, of family history and finally the individual's lifestyle, all of which may put them 'at risk' of developing a disease. What is the status of the 'at risk' population, identified by screening? It becomes difficult to say who is well and who unwell, and for any given individual what their status is if they manifest a sign designated a precursor of illness and yet have no symptoms and appear healthy. The Human Immunodeficiency Virus (HIV) is a paradigm of this; are people who have the clinical sign of the antibody, and yet do not have any symptoms, well or unwell? Within some discourses, the economic one of actuarial calculations for example, they are unwell. Yet within others, that of needs and priorities for housing for example, they are well - being HIV positive but asymptomatic does not automatically qualify as being 'vulnerable' on medical grounds under the Housing Act 1985 (Means et al 1994:72-75).

It is with this idea of 'risk' that I return to the self surveying, self managing subject. Medical and government discourse on health now locate the major causes of preventable morbidity and mortality in behaviour: smoking, drinking, poor diet, lack of exercise, unprotected sex (DoH 1993:11), and this is reflected in the media, in popular and serious journalism, and advertising. This is less true of mental illness; the most severe mental illnesses, schizophrenia and affective psychoses, are not conceptualised as amenable to prevention by behavioural change. Mental health, however, is closely linked to behaviour and the management of stress, anger, grief and loneliness.

As discussed earlier in this chapter, the self knowing and self managing subject is the object of a plethora of discourses spoken by experts that together are the effect of an individualising and totalising power. I would argue that this was particularly true of the 1980s, during which we were all made responsible for the surveillance and regulation of our own bodies. Forms of the technology of surveillance were made available during this period; blood pressure machines and cholesterol testing kits, for example, appeared in high street pharmacies. The development of the gaze of genetics is now perhaps altering this, with more sophisticated means of identifying the 'at risk', but there remains the broad, diffused approach to prevention that is health promotion. This exhorts us all to be responsible for our own health, both mental and physical, and offers us the guidance of experts who will teach us the techniques of self care. As Lupton (1995) argues, these techniques are underpinned by the importance of better knowledge of our bodies and of the impact on them of behaviours we may choose. One of the key tasks of

health promotion is communication of that better knowledge. Health promotion also contains the notion of 'empowerment', of both individuals and communities, although this is set within the limits of the 'truths' of biomedicine;

[r]adical activists have rarely gone so far as to challenge the orthodoxies of health promotion that insist, for example that high blood pressure, obesity or the propensity towards eating junk foods are 'health problems'...there is still often an emphasis on encouraging individuals to behave in certain ways deemed appropriate by public health professionals.' (Lupton 1995:59)

We are individualised in our responsibility, yet totalised in that by these techniques we will improve the public health.

In my earlier discussion I argued that this individualising and totalising power was exercised in order to contribute to *production*, to the increase of wealth. Turner (1992) has questioned whether we are in fact now concerned with *limitation* rather than production:

In the advanced industrial societies, we can detect a transformation because the body in the late twentieth century is no longer the productive body. Whereas most social scientists are concerned to understand leisure as a mechanism of body production in consumer society, it seems to me that the body is increasingly being experienced, discussed and represented as a limit and as a brake on growth. (Turner 1992:11)

The 'ageing population' and perceived fiscal burdens of pensions and care for that population, combined with the welfare costs of the younger surplus population created by the superseding of the human body by the machine as the carrier of labour power, are elements of the way in which the body can be seen as a brake on growth in advanced industrial societies. While the regulation of bodies remains a central element of political and social life, this is no longer to increase production but to control reproduction, to limit the impact of the individual body on social relations and on the environment (Turner 1992:12).

Drug use and the drug user

This thesis is about the discourse surrounding illicit drug use and the practices that both produce that discourse and are its effects. I seek to show that the theoretical framework discussed above can explain how it was possible for the English social policy response to the transmission of HIV among injecting drug users to be to distribute injecting equipment and talk about harm minimisation. For most of the twentieth century, drug use, under one name or another, has been an entity in British medical discourse, and the drug services have been sites for the production of discourse about drug use and the location of practices. What this thesis shows is the genealogy of the present discourse and its associated sites and practices.

Genealogy

I stated at the beginning of this chapter that I had employed Foucauldian genealogy in this thesis. I do not wish to imply a fixed set of research techniques and methods that have Foucault's stamp; like Nettleton, I would argue that I have produced

a Foucauldian study and not an illustration of 'the' Foucauldian method, as his work is almost as diverse as it is extensive. Consequently a range of methodologies could, and indeed have, been derived from it. (Nettleton 1992:106)

My research techniques have been the traditional ones of sociology: reading primary and secondary sources, asking people to talk about things, counting things, and watching people. It is in my use of the data derived from these techniques and my assumptions about what was interesting in the data that I would argue this is a Foucauldian study.

Implicit in the term genealogy are several assumptions. The first is that the aim is not to discover the 'truth' about the past, but to understand the present. Thus we are not starting from some moment of origin in the past and studying a linear development. Genealogy is the tracing backwards of the lineage of the present. This lineage is not conceptualised as continuous development forward through history from a defined point of origin. We have only to think backwards through our own descent for a few generations to grasp the idea of discontinuity and the lack of a clear line. The methodological approach, then, is 'ascending' rather than 'descending' (Nettleton 1992:125).

Secondly, linked to this notion of discontinuity:

For the genealogist there are no fixed essences, no underlying laws, no metaphysical finalities. (Dreyfus and Rabinow 1982:107)

If there are no essential truths, or absolutes, then all forms are transitory and provisional; 'we should avoid thinking of emergence as a final term of historical development' (Nettleton 1992:123). Words, ideas and practices do not have intrinsic meanings or explanations, but are used tactically at any given time in a constant interplay of power and resistance. The way in which the body was constructed by the disciplines and knowledge of nineteenth century medicine is an example of this instability; it may be what we currently accept to be true about the body, but this can change, as it has in the past.

Thirdly, if we assume there are no fixities, and no necessary points of origin, then we practice what Nettleton calls *eventualism*; 'there is no necessity for things to happen', so instead of causes, we look for the 'myriad of complex features that permitted an event' (1992:124-25).

Finally, there are implications for the study in Foucault's notions of power. If power is not a commodity and centralised, but exists in its exercise, then we must look at the sites of its exercise, not to some central locus of state power (Nettleton 1992:125). Similarly, if the exercise of power is not, other than in a very immediate tactical sense, intentional, we are not looking at who has power and what s/he is using it for, but at the process of the exercise of power and its effects.

While the body of the thesis presents my argument in a chronological order, its production, as suggested by the approach discussed above, was not so linear. I now give an account of my practice in producing this thesis.

My research practice

In September 1987 I joined the Monitoring Research Group (MRG), a team of social researchers at Goldsmith's College, London, led by Gerry Stimson, and commissioned by the (then) Department of Health and Social Security (DHSS) to monitor and evaluate the fifteen pilot syringe exchange schemes set up in England and Scotland. The initiative had started in April 1987, and the research was to report in eighteen months. I discuss the policy story more fully in Chapter Three; here I explain my choice of approach and methodology. My post was research assistant within the Department of Sociology at Goldsmiths, but attached to the MRG. Part of my role was to produce a PhD, but it was

not predetermined what particular issues or approaches this would involve. The thesis did very much evolve over time; at the start it was not clear that the MRG or syringe exchanges themselves would survive beyond the trial period. Prior to this research post I had done a degree in social policy, linked to training as a general nurse, and had then worked in the NHS for a while.

By joining the MRG, I entered the field of drugs research, policy and services. It is a small and closely interconnected field. Illicit drug use is by definition a covert area of human activity, and so carries with it an intrinsic fascination to the sociologist. For me as a social policy graduate, the syringe exchange monitoring project added to this the excitement of working closely with policymaking and implementation. Shortly after I joined, the research team hosted a day seminar attended by staff from all the pilot schemes and civil servants from both the policy and research arms of the DHSS. Throughout the life of the project there was a close relationship with both the periphery, the projects running the schemes, and the centre, the civil servants who were using the experience of the pilot schemes to write policy documents and guidelines.

Out of this initial excitement, and the sense of something new happening, I developed my central research question: what had made it possible for syringe exchange (and with it harm minimisation) to be the response within drugs policy to HIV? Being part of the MRG put me in a unique position to observe the policymaking and implementation process, and this thesis could have been about that, using a public policy approach. However, what I also became aware of was that I was part of that process, as part of the research team. Sentences I wrote for MRG reports would reappear in the official discourse of policy documents. I was not just an observer, but also a participant, albeit a very minor one, actively constructing 'truths' about syringe exchange from the knowledge that my practice as a researcher produced.

Discovering Foucault

Like many other sociology postgraduates in the 1980s, I found that I had, at some stage, to decide what I was going to do about Foucault. It was impossible to ignore him, particularly within the graduate seminar groups to which I belonged, and yet the more I heard about Foucauldian theory the less I felt able to approach his writings myself. I therefore made the initial mistake of trying to read writing *about* Foucault, rather than *by* Foucault. As Nettleton has commented, the charge of opacity and inaccessibility levelled at Foucault, while at times fair, is perhaps more true of many of those who write about

Foucault (Nettleton 1992:viii). After taking excellent advice to start with *Discipline and Punish* (1979b), I found myself still very uncertain about articulating my views on Foucault, but caught up totally with what I saw as the central drive of his argument. Some of my uncertainties had centred around being a social policy graduate trying to deal with what I anticipated would be dense sociological theory. In fact I found that my knowledge of social policy history meant that I could focus on the argument. *Discipline and Punish* illuminated and explained social policy in a way that no other theoretical approach had done.

I moved on to the question of knowledge, specifically medical knowledge. Like other readers of *The Birth of the Clinic* (1976) (eg Armstrong 1983:xi), I was gripped by the idea that the way we 'read' the body, and the way we locate disease within the body, was historically and socially specific. As a nurse I had often been taught the 'history' of understandings of diseases, how previous ages had lacked scientific knowledge and so had made surmises as to the 'truth', most of which turned out to be wrong but some of which, by lucky chance, turned out to be right, when the 'truth' was scientifically discovered. The idea of 'regimes of truth' and Foucault's linking of the development of the human sciences with the construction of knowledge through specific practices – the exercise of the disciplinary techniques of hierarchical observation, normalising judgement and examination – provided a new perspective. Similarly many aspects of the arrangement of hospitals and the practices of both medicine and nursing took on a new significance.

My nurse training had begun when it was still possible for us to be taught the 'drill' of performing dressings: each element of the procedure isolated and prescribed, instruments laid out in an exact and unchanging pattern on the trolley, every action carried out in a precise sequence. Passages in *Discipline and Punish* brought this training back vividly. However, I was also aware of huge transformations in what I was by now thinking of as the discourse, as well as in practice. By the time I left nursing, the ability to adapt basic principles of asepsis to the needs of individual patients was seen as the core of this task, not the repeated performing of an unvarying drill; the practice had irrevocably altered. Similarly, into the discourse of 'normal ranges' for clinical signs such as pulse, temperature and blood pressure, there had entered the idea of 'the norm for the individual'. Some of these transformations made sense in terms of Armstrong's argument of the extended gaze.

Understanding the history of drugs policy

Some of Foucault's themes were accessible to me through my own experience of disciplinary techniques. I also found that when I began library based research the theory became even more relevant. While reading Foucault and Armstrong, and others writing in that vein, I was also trying to understand the history of British drugs policy. I began to read the historical documents, the Rolleston Report, the two Brain Reports and material contemporary with them; and secondary sources, the work of historians such as Berridge. For a while I saw the sociological theory and this primary historical material as two separate literatures, but out of the two grew the analysis presented in the first part of Chapter Two. The historical documents formed a discourse amenable to analysis. In this analysis, I show how seeing the Home Office Index as a technique of surveillance explains how the construction of 'addiction' as an entity within medical discourse changed from that of an individualised somatic pathology to a psychiatric, socially infectious condition between the 1920s and 1960s. The chapter continues to follow the career of addiction to the late 1970s, by which time it had returned to the status of an individualised condition, though one still located in the psyche.

Even having made this connection and analysis, I still felt that I was a long way from my initial focus – how was syringe exchange possible? However, I was now alert to the issue of the construction of knowledge, and the constitutive power of discourse. All around me in my role as a researcher a discourse was being spoken which constituted drug use and the drug user in a very particular way. My fieldwork allowed me to record this and analyse it.

The first stage of fieldwork: the emergence of syringe exchange

My first piece fieldwork was carried out within the wider evaluation project to look at the ways in which the pilot syringe exchange schemes were set up and run. It comprised a postal questionnaire of mainly open ended questions, to gather basic information about staffing, organisation and resources of the pilot schemes, and semi-structured interviews with staff at the schemes. The interviews were carried out in March and April 1988 by myself and a colleague within the team, Lindsey Alldritt.

At least one person from each of the schemes still operating at the end of the pilot year was interviewed. In most cases the person interviewed was the person who had been most instrumental in drawing up the bid to become a pilot scheme, and who had been

closely involved in running the scheme. Over the year, contact between the schemes and the research team had been close and frequent. I had visited several of the schemes during this time, and the research team had run a day seminar in London at the outset of the research, which key staff at all the schemes had attended. The selection of the interviewees was therefore based on this knowledge and personal contact. In some schemes, there was only one member of staff who actually operated the scheme on a regular basis, or a particular member of a team might have overall responsibility for the exchange scheme. At other schemes, two staff might be responsible in different ways for the schemes; for example one worker might have made the plans and sought funding, while the day to day running was the responsibility of another worker. This was the case, interestingly, in both the purely voluntary sector projects, and two members of staff were interviewed at both of these, although there had not been a conscious decision on my part to treat the voluntary sector projects differently in this way.

At one of the Scottish exchanges, staff involved in the day to day running of the scheme had not been at all involved in the planning. This was dealt with by interviewing the key person within the Health Board, a senior registrar in community medicine, as well as one of the operational staff. Altogether, eighteen people were interviewed: four in Scotland and fourteen in England. This may seem a small number, but the point is that these were the 'official' pilot schemes and as I describe below, this is important to the way I have analysed the material.

Thirteen of the interviews were carried out face to face, at the exchange scheme or in the person's office, and five (all in England) were done by telephone. The use of the telephone was an economic measure, as the schemes were sited throughout the country. Interviewees were asked to set aside an hour and a half when they would not be disturbed. There were only two major interruptions. One of these was during a telephone interview with a worker at one of the biggest and most well known exchanges, when she had to ring off and call back later, in order to give a telephone interview to a North American radio station. The other was at one of the exchanges in Scotland, when another member of staff accidentally set off the alarm that the Health Board had insisted be installed in the converted hospital gatehouse used as the exchange. This was connected to the security system at the hospital, and should have meant that someone from the hospital security at least dropped in to make sure staff were not being attacked. In fact nothing happened, and eventually the bell just stopped!

All the interviews were tape recorded. While the actual interviewing was shared equally between myself and Lindsey Alldritt, the analysis presented in Chapter Three was carried out by myself, explicitly for this thesis. A separate analysis of the data, written jointly, was published as part of the final report of the evaluation (Stimson et al 1988b).

Analysis of the first stage of fieldwork

In the interviews, exchange staff were addressing me and my colleague as evaluators, who would be using the material in part of a report to the Department of Health. This report was intended to feed into the policymaking process, as part of the Department's decision as to whether syringe exchange was a 'good thing' and should be supported. This context is important to the analysis of the material. In effect the interviews were the exchange staff's opportunity to 'present' syringe exchange, through the research, to the policymakers and to the wider audience the report would have in the drugs field. I treat the interview material as exactly that 'presentation'; that is as not necessarily objective accounts of some external reality, but as speech revealing a particular perspective and way of seeing drug use and the drug user, and the appropriate service response.

As my explicit intention is to treat these interviews as what the exchange staff were *saying* and not as some key to what they were actually *doing* (or not doing) then in Chapter Three I am taking an 'internalist' (Silverman 1985) position vis-à-vis any reality about syringe exchange. The accounts given to me as part of the evaluation team can be treated as part of discourse about drugs policy, in the same way as in Chapter Two I take what was being said and written between 1920 and 1980 not as objective accounts of a reality, but as discourse revealing different perspectives and ways of seeing and understanding drug use and the drug user.

I have structured the analysis of these first interviews around five questions:

1. Who is the speaker?
2. What is the object of speech?
3. What is the task in relation to this object?
4. What is the relationship of the speaker to the object?
5. What is the site of the task?

The first of these questions contains elements of status: who are the speakers, why do they have authority to speak on this subject; and of site: where are they speaking from? This use of status and site draws on the Foucauldian analysis of discourse discussed in Chapter One. The object of the speech is a specific construction of the drug user. The task and relationship, to be carried out within a specific site, are elements of the practice that is both explained by and constitutive of the speech.

The construction of drug use and the drug user that I draw out from those interviews is not one of a disease and an ill individual, but one of a lifestyle choice and a responsible individual who can be enabled to maximise his/her physical health. The term 'harm minimisation' was used in the interviews for this enabling, and syringe exchange was a central practice in that. Harm minimisation entered the official discourse around drug use and Chapter Three contains an analysis of the key policy document, the first report by the Advisory Council on the Misuse of Drugs' (ACMD) working party on AIDS and Drug Misuse (ACMD 1988).

The national survey

I then followed the spread of this practice, out from the pilot schemes and into the wider network of services. My next piece of work was a postal survey carried out between February and April 1989, to identify other sites of the practice of syringe exchange and build up a national picture (Lart and Stimson 1990). A questionnaire was sent to 74 agencies throughout England, with postal reminders after two and six weeks, and a final telephone reminder. Sixty five responses were received (88% response rate) including negative responses and duplicates (ie the same agency operating at two sites). Of these, 55 referred to agencies running syringe exchange schemes in February 1989. Data from this survey are used in Chapter Three to show the rapid spread of syringe exchange, and the range of institutional sites from which it was practised.

Tracing back from the responsible drug user

The construction of drug use that I discuss in Chapter Three, and the practices that are informed by and support that construction, are radically different from those of the late 1970s that I discuss in the first half of Chapter Two. I needed to be able to explain this transformation. There was a lot of talk about a 'paradigm shift', and of the initiation of syringe exchange as somehow a break with the existing pattern of services and practice. However, what had come through clearly in the first round of interviews was that harm

minimisation was already current in the discourse and, to an extent, practice of most of the English projects running pilot exchanges. Syringe exchange itself might have been a new practice, but its introduction did not constitute a break. My methodology was to trace the figure of the 'responsible drug user' spoken of by syringe exchange staff, backwards to the 'problem drug taker' of the early 1980s (ACMD 1982), looking for the institutional sites and discursive space in which the practice of harm minimisation had emerged. The final section of Chapter Two gives my account of this, looking at drugs policy and the development of services in the early 1980s, prior to the arrival of HIV as an issue.

The focused study

My final piece of fieldwork, carried out between July and December 1989, was to look more closely at the practices of harm minimisation and syringe exchange within three projects. These three were chosen from the framework drawn up by the national survey, and were also the sites of a further quantitative evaluation of the impact of syringe exchange on drug users' behaviour carried out by the Monitoring Research Group (Dolan et al 1992). A central criterion for choosing these particular three was that they reported attracting reasonably large numbers of drug injectors. One was a specialist syringe exchange in central London, a service which had only started in 1987 as a direct response to HIV. The other two were voluntary sector drugs projects, one in London and one in another city. The first of these was a long established project, while the second had been started in 1986 under the Central Funding Initiative. Fuller descriptions of the projects can be found in Chapter Four. At the request of one of the projects the sites were never identified in any of the research reports, and I have continued this anonymity.

By choosing sites with a high number of clients, I ruled out the possibility of looking at what might be called less successful syringe exchanges. My intention was to analyse further the discourse and practice of harm minimisation, working from the framework I had established from the earlier fieldwork with the pilot schemes. My choice of these sites meant that I did not look at sites where syringe exchange had not become a main element of practice; I took a 'successful' syringe exchange to be emblematic of the practice of harm minimisation.

In saying that I worked from the framework established in the earlier fieldwork, I am not implying that the earlier work generated a set of hypotheses about syringe exchange to be

tested in these three by closer examination. What I mean is that the first interviews and my analysis of them provided a set of key themes for the focused work to start from.

The fieldwork consisted of a short period (five days) observing in each of the three projects, in-depth semi-structured interviews with all permanent staff of the projects, and shorter interviews with other professionals who came into the projects on sessional bases. During the observational period in each project, I attended all staff meetings, and was present at as many encounters in the syringe exchange as possible, sitting around in the drop-in area in between. I used a pro forma recording sheet to record details about each exchange immediately, and used the ethnographer's practice of making notes on conversations and observations on a daily basis.

The interviews with permanent staff were tape recorded, and I transcribed them in full. Those with other professionals were not taped; notes were made during the interview. This was because these were done as and when people could see me, unlike the more formal interviews with staff which were planned and for which, on the whole, appointments were made.

My intention was that the observation should supplement the interviews rather than be seen as a central element of the fieldwork. Five days in each site is a short time, but it gave me material on the organisation of the projects, in particular the use of time and space in each one. The key data generated by this piece of fieldwork were the interview transcripts and my fieldnotes.

Analysis

In using the ethnographic material and the interview data, I was not working within an interactionist framework. Following from my focus on power as constitutive, my interest was not on the meanings staff gave to their own actions and speech, but on how they constructed drug use and the drug user, and on how they maintained that construction. Similarly, I was interested in the projects themselves as sites for both practice and the production of discourse. Chapters Five and Six present this analysis.

An obvious question about this analysis is whether it can be done at all. One version of Foucauldian extremism, which holds that nothing exists except as constructed in discourse, would argue against the possibility of successfully using empirical data, as opposed to documentary material, to explore Foucault's theoretical concerns; to do so is to take 'reality' as given. I would argue that we have to start somewhere, while being

conscious of the question of reality, or else we can never really use Foucault's insights to analyse the present. The two key theoretical concerns which lead to my methodological position are, firstly the relationship of discursive and non- discursive practices and secondly the dispersal of power and the need to examine its local exercise in diverse sites.

Foucault himself wrote from the analysis of documentary (in its widest sense) material, and until recently most work in a Foucauldian vein was also based on document analysis. To do as I have done here; to claim to be analysing material obtained through interview and observation in a Foucauldian way might be considered methodologically confused. However, my view is that if we are to take seriously the notion of constitutive power and the interdependence of discourse and practice, then we have to look at practice. Foucault's claim is that power is exercised in local sites, in day to day relationships; I would argue that this means we have to look at the exercise of that power. Herbert makes a similar point:

Foucault's analyses of modern disciplinary power usefully draws attention to the outskirts of the networks of that power. His methodological injunction to study the 'how' of power in ascending analyses shifts focus from the center to the periphery, where the finer and wider play of discipline is most importantly evident. (Herbert 1996:56)

Stemming directly from this theoretical position is the methodological problem; is it possible to do this? If I make the claim that discourse and practice are mutually reflexive and productive, how do I go beyond that theoretical claim to some form of demonstration? There is no 'tool kit' of techniques for doing this. Foucault provides particular points to start from; his analysis of power/knowledge, surveillance and resistance, and certain fields of investigation; discourse and practice, and the objects they produce, but no examples of how to do this with empirical research. It is useful therefore to look at other studies informed by Foucault's theory in which ways have been found ways successfully to analyse data obtained through such 'traditional' sociological methods.

Traynor (1996) takes an approach similar to that I have used in analysing the first round of fieldwork interviews, those from the pilot exchanges. He uses transcripts from interviews carried out with key speakers within community based NHS Trusts

to explore what happens when the 'data' of interview transcripts are approached as 'text' available for literary criticism rather than primarily as offering a window into the consciousness and intention of the speaker. (Traynor 1996:316).

In his analysis he shows how the notion of measurement, underpinned by the necessity to produce verifiable 'truths' about objectives and activity within the NHS, is central to the discourse of management within the post-1991 health service and how other, competing, discourses such as that of nursing are having to come to terms with this notion. He links this to the broader narrative of rationality in forms of modern government. The point for my present discussion is that he has abstracted the interview data from concerns about underlying 'reality' and so made it amenable to this form of analysis.

Herbert (1996) uses data from observation to explore the fine detail of practice among the Los Angeles Police Department (LAPD). His central substantive theme is that of surveillance, but in exploring this he makes useful observations about the need to take a 'nuanced' approach to this, one which will recognise both the limits of and inconsistencies in the operation of disciplinary power and the role of a variety of discourses in constituting practice. In this he is reflecting some of the ambiguities in Foucault's own writings as to the extent and completeness of disciplinary power, the 'cautionary notes Foucault interspersed within his commentary on modern discipline' (1996:50). He shows how at first glance the LAPD, as a technologically well equipped police force, may seem to exemplify a simplistic reading of Foucault's notions of surveillance and social control, but 'the disciplinary net itself is not as wellknit as casual observation might suggest' (51). The very technologies which seem to deepen the LAPD's powers of surveillance; the mobile display terminal (MDT) in each car which provides extensive information on each call out, for example, in fact also undermine the police officers' own powers of observation and other skills which embedded their surveillance in the life of the communities within which they work. Herbert's study is useful both for the confident way in which he uses theorises from his observational data, and for the substantive points he makes about the operation of surveillance.

Nettleton, in her study of the genealogy of dentistry and its knowledge makes a very particular use of her observational data. She uses a very abstracted account of an encounter within a dental surgery, drawn from her observation, to illustrate the interdependence of practice and power/knowledge by crystallising the practice we regard

as modern dentistry(1992:9-17). This description is an entry point to her document based analysis of the construction of dental knowledge.

One study which applies Foucauldian theory using both interview and observational data is Bloor and McIntosh's paper on resistance within therapeutic communities and health visiting (1990). Here data gathered in two separate studies are used firstly to describe techniques of surveillance, secondly to create a typology of client strategies of resistance and finally to discuss the issue of counteraction in the face of resistance. The substantive contribution to theorising that this paper makes will be returned to in chapter Five of the thesis, where its analysis will be used in discussing the work of the syringe exchange schemes. Here I am concerned with the issue of methodology. While Bloor and McIntosh acknowledge that the analysis they present is a *post hoc* use of data, their concern about this is the question of using material from two diverse studies, rather than about the applicability of Foucauldian theory to empirical data; '[h]ad we intended from the outset to produce a typology of client resistance we would have designed different studies, employing more readily comparable methods of data collection and possibly focusing on different research settings' (1990:162). In contrast to Traynor's approach, Bloor and McIntosh use the material from their interviews as access to practices they do not observe themselves; they are client's descriptions of their own and health visitors' practices.

I am not alone then, in trying to link Foucauldian theory and empirical research. Chapter Three adopts the approach of abstracting interview material and treating it as text, similar to that of Traynor. In Chapters Five and Six the interviews are also analysed as discourse in their own right; they are a space in which the staff display their construction of their work and clients, indeed they are a space for that construction process to be carried out. However, they are also a source of information to me about practices that I may not have observed myself. I acknowledge the tension here between these two uses of the interviews, and this is one of the issues to which I will return in reflecting on the research process in my conclusions.

Summary

To sum up, I have used a range of research techniques in a sequence of research stages. The techniques I have used are document analysis, interviews, postal surveys and observation. Overall, the thesis traces the genealogy of drugs policy, in discourse and in specific practices, showing how syringe exchange was possible. The stages of fieldwork

have followed the development of syringe exchange, starting with the pilot schemes, moving out to the national picture and then focusing on three large projects.

In Chapter Seven, my concluding chapter, I bring together the fieldwork, the documentary analysis and the theoretical themes discussed in the first part of this chapter. I reflect on the research practice I have used and state the conclusions of the thesis.



CHAPTER TWO: DISCOURSE AND PRACTICE IN TWENTIETH CENTURY ENGLISH DRUGS POLICY

Introduction

In this chapter I discuss the pre-HIV history of twentieth century English drugs policy. I argue that there have been three major discontinuities in the discourse, associated with changes in practice during this time. The chapter is therefore divided into three parts, periodised in this way:

1. The period between the 1920s and late 1960s, when the medical concept of 'addiction' was reconstructed from an individualised somatic condition, to a socially infectious one.
2. The 1970s, when the definition returned to an individualised one, but still psychiatrised.
3. The early 1980s, when the concept of the 'problem drug taker' and the development of new services opened up the definition of drug use to something nearer a 'lifestyle' choice.

There are clear links between the specific discourse around drugs and the development of the wider twentieth century discourses around health, discussed in Chapter One, and that discussion sets the context for this chapter. I have defined the periods above in terms of characteristics of the object of the discourse: where is drug use located, in the body or the mind, in the social body or within the individual? However, I also discuss the production of that object: changes in the authorised speakers, in the sites from which truths are produced, and in the practices which are both explained by and constitutive of the truth.

From somatic dysfunction to psychiatric contagion: addiction 1920-1970

The contrasting of two authoritative texts, produced within half a century of each other but employing very different discourses, is a device used by Foucault, in for example the preface to *The Birth of the Clinic* (1976:ix-x). The same technique can be used to demonstrate the shift in discourse that took place between the Rolleston Report in 1926

and the second Brain Report in 1965, a shift from seeing addiction as an individualised, somatic dysfunction, to seeing it as a contagious, psychiatric condition:

...there was general agreement that in most well-established cases the condition must be regarded as a manifestation of disease and not as a mere form of vicious indulgence. In other words, the drug is taken in such cases not for the purpose of obtaining positive pleasure, but in order to relieve a morbid and overpowering craving. The actual need for the drug in extreme cases is in fact so great that, if it be not administered, great physical distress, culminating in actual collapse and even death may result...(Departmental Committee on Morphine and Heroin Addiction 1926:11)

... addiction is after all a socially infectious condition and its notification may offer a means for epidemiological assessment and control. We use the term deliberately to reflect certain principles which we regard as important, viz. that the addict is a sick person and that addiction is a disease which (if allowed to spread unchecked), will become a menace to the community. (Interdepartmental Committee on Drug Addiction 1965:para 18)

That this shift took place is well documented. What I offer here is a theoretical explanation of this discontinuity in discourse, based on the discussion in Chapter One. From that chapter I draw on the following themes. Firstly, I draw on the role of surveillance in the construction of the objects of discourse: I argue that the Home Office Index was a form of surveillance which constructed addiction, by the 1960s, as existing in the social body, and as a public health issue. Secondly, I argue that with the construction of the psyche, addiction was reconstructed in the mind, not the body, of the addict. Post-war psychiatry's claim to speak the truth on the mind, and its claim to the neuroses, meant that psychiatrists became the authorised speakers on addiction. The public health measures of specialist services sited in the community, combined with psychiatry's move into out-patient care, created the response to the perceived 'epidemic' of addiction: the Drug Dependency Clinics. The practice of prescribing for addicts is central to this. It was surveillance of prescribing which created the Index, psychiatry's definition of the prescribing practices of others as incompetent and dangerous that justified the limiting of the right to prescribe, and the siting of that limited right within the Clinics that gave a concrete expression to the changed discourse.

Individualised pathology

The career of drug use during the nineteenth century from a habit to an addiction – a pathology of the soul and will – and then to a somatic entity in medical discourse, has been traced elsewhere (Harding 1988). This analysis begins in the 1920s, by which time addiction was accepted as a disease entity by the British medical profession (Berridge 1978, 1980, 1984, Parssinen and Kerner 1980, Harding 1988). Although the condition could not be linked to a specific lesion in the body, it was classed as one of the neuroses and seen as an area of legitimate concern for the profession; the major medical texts of the time included a chapter on the subject. At this time the authorised speakers on the neuroses were neurologists, physicians and general practitioners, and it was they who treated addiction.

For those addicts the medical profession was likely to see and treat, the disease model and classification as a neurosis fitted the epidemiological evidence. Most were either doctors or other professionals with access to drugs (the 'professional' addicts) or else had become addicted in the course of treatment (the 'therapeutic' addicts). In all, addiction represented a 'very minor problem indeed, a middle-class phenomenon confined to a large extent to the medical profession itself' (Berridge 1984). Working-class use, of laudanum for example, was a matter for control via the restriction of sales, and was not seen as a medical issue (Berridge 1978). The disease was an individualised pathology; some people (principally women and physicians) were believed to have a predisposition, and the stresses of modern civilisation were regarded as a trigger for these sensitive individuals (Parssinen and Kerner 1980).

Outside Britain, most notably in North America, different views obtained. International conventions were agreed in the pre-war years to outlaw narcotic drugs, and there was pressure on Britain to conform. Bean (1974) sees the development of the international scene as important to an understanding of British policy; all the Acts concerning drug use passed in the period up to 1964 were 'directly implemented because of international agreements', or else to extend existing Acts. In the 1920s it was partly this pressure and the Home Office's wish to conform that put drug use and its control on the agenda. In the immediate post-war period, the extension of the wartime controls imposed on the military to the civilian population, the passing of the 1920 Dangerous Drugs Act and the attitude of the Home Office seemed likely to criminalise the field. Use of narcotics without medical validation was proscribed and the question became one of the delineation of acceptable medical practice. Berridge argues:

The disease concept of addiction and all that it entailed was under serious attack. A prohibitionist policy, under which the state would decide treatment and where both doctors and addicts could incur penalties, was, as in America at the same time, in the process of establishment. (Berridge 1978:369)

At stake was the right of the medical profession to autonomy in defining addiction as a disease and in the choice of treatment; was the prescription of drugs for known addicts a reasonable course of action and therapy? This issue was complicated by the question of professional addicts prescribing for themselves. The Rolleston Committee was set up in 1924 with a brief to advise the Home Office on the matter. Its role was to clarify medical opinion about the place of maintenance prescribing in the treatment of addiction. The Committee was entirely composed of medical men, mostly experts in the field of addiction, and the Report, in 1926, reflected foregoing medical opinion. It confirmed the status of addiction as a disease and the addict as sick, and asserted the right of the medical practitioner to use his discretion in the choice of treatment in this, as in other illnesses.

While the Report advised that the treatment of choice in addiction was gradual withdrawal of the drug of dependence within an institution, reflecting a concern with treatment and cure, and the separation of the normal and the abnormal, there was also the recognition that this might not be possible for all addicts and so the use of maintenance prescribing was a legitimate course of action. The report used case studies of 'stable addicts' to show how maintenance allowed some individuals to lead 'normal' lives even though engaged in an 'abnormal' activity. As Harding argues, in the Rolleston report:

The addicted state was considered basically as life under abnormal conditions, whereby the toxic action of the opiate produced changes in the conditions of normal physiological functioning. (Harding 1988:80)

Treatment by maintenance prescribing accepted these physiological changes and sought to compensate for them by the introduction of the substance of the opiate into the addict's body. A similar model underlay the treatment of diabetes, just made possible by the discovery in 1923 of insulin (Bliss 1982); the introduction of externally produced insulin returned the body of the diabetic to normal functioning.

The Committee rejected the idea of notification of addicts to the Home Office when the British Medical Association opposed it, on the grounds that it would damage the confidentiality of the doctor/patient relationship. The Report also recommended tribunals to deal with cases of over-prescribing, for self or others. This instituted a means of control, but kept its immediate operation in the hands of the medical profession, a situation that was acceptable to both the Home Office and the profession. In fact these tribunals were never used, and were officially abandoned in 1953 (Trebach 1982). The acceptance of the Report and the expression of its principles in Home Office circulars was a mark of the incorporation of the medical profession into the policymaking structures.

Rolleston represented the medical concept of addiction, as it stood in the 1920s. The report looked back to the nineteenth century: the division of illness and health and the enclosure of the sick in institutions for treatment. It protected the privacy of the doctor/patient relationship and the professional right to clinical freedom within that relationship, subject only to the scrutiny of peers. It established what became known as the 'British System' of treatment of addiction, in the tradition of what Strong (1979b) has called, in another context, 'bourgeois medicine': individualised and private.

However, it can also be seen as beginning a blurring of the line between the normal and abnormal; the concept of the maintained addict carries in it an idea that health and disease are not so easily distinguishable, and that what was termed 'ambulatory' care might be a means of what would now be termed management of a condition in the community. As I outlined in Chapter One, the 1920s saw the creation of new sites for the treatment of the neuroses, outwith the enclosed space of the institution, marked by the opening in 1923 of the first out-patient building in a psychiatric hospital, at the Maudsley Hospital (Prior 1993:44).

The 'British System'

The essentially medical nature of this model of addiction was the main difference between the 'British System' and North American policy commented on by, among others, Lindesmith (1965, 1972) and Schur (1961, 1963). Lindesmith described the British System as 'an example of a relatively successful way of dealing with narcotic drugs' and argued that this was because the legislation put 'the treatment of addicts squarely into the hands of the medical profession'. The addict in Britain was 'a weakling or an unfortunate person to be pitied and treated with compassion', not a criminal, and

the details of treatment were regarded as 'technical matters to be settled by discussion among experts, rather than by public debate'. Schur draws a similar picture, commenting on the 'almost complete professional autonomy' of the British medical practitioner in the treatment of addiction and on the view of the addict as a 'troubled person'.

More recent commentators have questioned the conclusion Lindesmith and Schur drew that the 'British System' was successful in preventing a drugs problem, or that it was really a 'system' at all (eg Spear 1975, Trebach 1982, Berridge 1984, Stimson and Lart 1994). Smart (1984) comments that the period is now seen more as one of 'non-policy'. The argument is that such a policy was only possible in the context of the small numbers and particular type of addict, rather than being an explanation for those numbers. Berridge points out that medical control was set within a framework of overall control by the Home Office, but that this was 'muted so long as addicts themselves conformed, as they did until the 1960s, to the medical model established'.(1978:370) By the 1960s and the changes in that model, the medical profession was firmly enough incorporated into the institutions of policymaking that all discussion of policy took place within a medical model of addiction, although a redefined one, and on the medical profession's terms.

Constructing an epidemic

So how, by the 1960s, had the perception of addiction changed from that of the Rolleston era, an individualised pathology, to the idea of a socially infectious condition, as manifested in the Brain Report? What I want to argue is that over the period, the addict and addiction had been made visible by a form of surveillance, the expression of the overall Home Office control left intact in the 1920s. From the 1930s the Home Office Index, a working list of all addicts receiving prescriptions, was compiled by the Home Office Drugs Branch from police reports of the routine surveillance of pharmacists' records, from the Home Office's own inspection of these records and from information supplied by doctors, especially police surgeons. Also available from this scrutiny were doctors' patterns of prescribing, as a recent account of the period by Spear shows dramatically (Spear 1994:10-12). At a time when even the black market was the overspill from prescriptions, this technique gave a picture of the course of the 'disease' of drug use through the social body. Knowledge of drug use was there in the observable facts of the prescription and dispensing of dangerous drugs. It was not so much the individual addict who was being observed (in spite of popular belief in the status of a 'registered addict') as the pattern of disease; the treatment of the addict was, as already discussed, a matter for the individual doctor.

A study by one of the Drugs Branch Inspectors demonstrates this (Spear 1969). A young man, 'Mark', was arrested in September 1951 for theft from a hospital pharmacy in May of that year. Spear identified the links between 'Mark' and most of the new cases of 'non-therapeutic' addicts 'coming to notice' over the next four years. The story is told in terms of an infective agent arriving in ideal conditions for the spread of contagion. Up to this point the traffic in cannabis had been much more important to the authorities than that in opioids. Cannabis use was believed to be a feature of the lifestyle of black immigrants, but not of white youth. The raid on 'Club Eleven', a London night-club, in April 1950, when about 200 people 'coloured and white of both sexes' were searched challenged this impression. Of the dozen or so men found to be carrying drugs (mainly cannabis, with some small amounts of cocaine), only one was black. The raid and preceding seizures of imports of cannabis led to a scarcity of the drug in London. The arrival of 'Mark' during this shortage, Spear argued, was the advent of heroin on the London scene, and the beginning of the 'case-to-case' spread of opiate addiction (Bewlay 1965a).

The report of the first Brain Committee (The Interdepartmental Committee on Drug Addiction), briefed in 1958 to review the Rolleston Committee's advice, did not reflect this changing picture. The Committee saw no reason to change the framework set by Rolleston; while institutionalised treatment was the ideal, the numbers of addicts were not sufficient to warrant the establishment of special institutions, registration would serve no useful purpose and, in contradiction to Rolleston and perhaps most importantly, the Committee saw no need for tribunals to investigate or discipline individual doctors' prescribing practices. The Committee had convened and taken evidence before the Home Office figures for 1961 were available, and before there was an awareness, beyond those immediately responsible for the collection of the figures, of the changes which had started to take place. However, Spear argues that the Committee did not competently examine evidence that was available, had they looked (1994:16).

By the time the report was published, awareness of the changing pattern of drug use was more widespread. Between 1959 and 1964, the number of addicts on the Index rose from 454 to 753. Most of this rise was accounted for by heroin addicts of non-therapeutic origin, that is they had not become addicted in the course of medical treatment. There was also a significant change in the age distribution. In 1959, nearly 90% of known addicts were older than 35. By 1964, this had fallen to just over half with the majority of the younger people using heroin. The Index charted the progress of addiction from a disease of rather sad middle-aged or elderly individuals, who had become addicted in the

course of therapy or because of professional access to the drug, to a contagious condition of the young (Bewlay 1965b; Glatt 1965; BMJ 1967; James 1971). The emergence of these young 'recreational' or 'non-therapeutic' addicts posed once again questions about the medical justification for prescribing. Was it right to prescribe these young addicts in the same way as for the older 'stable' addict?

The Brain Committee was re-convened in 1964 to review their earlier advice 'in relation to the prescribing of addictive drugs'.

Responding to the epidemic: the second Brain Report

The issue centred around a few doctors, mainly in London, who were regarded by their peers as being responsible for the supplies of prescribed drugs which constituted the black market at that time. The second Brain report stated that 'not more than six' doctors were responsible for the excessive prescribing and that 'they had acted within the law and according to their professional judgement'. Spear (1994) has provided an account of how this figure of six was arrived at, arguing that in fact the total number was more, but at any one time about six were practising, including the famous Lady Frankau whose prescribing was 'undoubtedly the mainstay of the flourishing illicit market in heroin and cocaine in London until 1966' (Spear 1994:18). The point for my argument, however, is that the problem was constructed by psychiatrist witnesses to the Brain Committee as one of general practitioners, on the whole either ignorant or gullible, who were prescribing excessively and creating networks of addicts. One psychiatrist concluded that 'if potential addicts had less contact with addicts and less ease of access to narcotics there would be less addiction' (Bewlay 1965a). In rejecting the idea of tribunals in 1961, the Committee had rejected the means of opening that prescribing practice to professional scrutiny. In its second report the Committee 'side-stepped' the issue by making the treatment of addiction a matter for specialist psychiatrists and removing the general practitioner's right to prescribe (Fazey 1979).

The Committee's main recommendations were: the notification of addicts, the establishment of 'special treatment centres' with powers of compulsory detention, and the restriction of the prescribing of heroin and cocaine for addicts to the staff of the treatment centres. An advisory committee to 'keep under review the whole problem of drug addiction' was also recommended. The report constructed addiction as firstly a psychiatric entity, on which psychiatrists were the authorised speakers, and secondly as contagious, and therefore a public health issue.

The word 'notification' was used deliberately to reflect the belief that addiction was a 'socially infectious condition'. The special treatment centres (whose establishment was now justified by numbers) were to have 'facilities for medical treatment, including laboratory investigation and provision for research'. It was suggested that 'the centre might form a part of a psychiatric hospital or of the psychiatric wing of a general hospital'. Although the report did not give details of how these centres were to be run, the Brain Committee's view contained elements of the binary divide, separating the ill addict who was to be institutionalised, compulsorily if necessary, for treatment, from the rest of the community to whom the disease could 'become a menace'. In fact, compulsion was not really taken up as an issue and when the treatment centres opened, out-patient or 'ambulatory' care was the dominant mode of delivery.

The Drug Dependency Clinics

The way that the Clinics eventually emerged was the result of debate within the medical profession. The Home Office had no wish to impose 'a massive treatment organisation' (BJA 1988) or even to see addiction become the sole concern of psychiatrists (Trebach 1982). Their worry had been the excessive prescribing, but Spear reports that a return to the Rolleston tribunals would have been a way of dealing with this (BJA 1988). It was from the medical profession's new construction of the disease of addiction that the public health measures of specialist Clinics, notification and controlled prescribing emerged.

Four linked articles in the British Medical Journal in May 1967 by three psychiatrists, Thomas Bewlay, Philip Connell and John Owens, and one general practitioner, Peter Chapple, all of whom were involved and influential in the field, dealt with options for policy following the third reading of the Dangerous Drugs Bill in the House of Commons¹. What the writers reveal are different ways of seeing disease and of responding to it.

The first, by Bewlay and closest to the Brain Report in ideas, presented a model of centralisation and fairly overt control, focussed on the body of the individual addict. There should be a small number of units, in close contact to standardise treatment and practice. The notification system and exchange of information between Clinics would prevent addicts going from one Clinic to another, and would make contact tracing easier.

¹ In a published paper based on an earlier version of this chapter, I failed to discuss the article by John Owens (Lart 1992). I am grateful to Bing Spear for pointing out this omission, and for alerting me to the importance of the question of whether consultants in this field are part of the London network, or practice elsewhere.

The need for in-patient facilities for assessment was stressed, as it was the difficulties of assessing an addict's 'true' dependency which had led to the over-prescribing of the past. Dispensing of drugs directly, rather than prescribing, might be preferable as consumption could be supervised. The prevention of the physical sequelae of intravenous drug use (hepatitis, tetanus, septicaemia, endocarditis and abscesses) was discussed, with a dismissal of the practicalities of supervised injecting in favour of the prescribing of oral methadone. There was a 'need to consider' whether voluntary or compulsory treatment was best (Bewlay 1967).

Between this and the view of the second psychiatrist, Connell, the emphasis shifts from the monitoring of the individual addict's body to a wider consideration of the 'field of drug dependency'. This presented a range of services as being necessary, talking about a 'therapeutic spectrum'. The out-patient Clinics should be distributed between a large number of hospitals to 'spread the load', with addicts making fortnightly maintenance visits. Separate in-patient units were necessary; this was to facilitate the development of a 'team approach' to treatment, to provide an opportunity to study 'methods of treatment and control' and to prevent the spread to other patients. The need for better training of doctors, nurses and social workers was stressed but the writer was dubious about the involvement of the voluntary sector who might lack the necessary objectivity. The services should not be limited to heroin users but should treat the users of other drugs like amphetamines as well. There was also a need for social security support to prevent addicts having to deal while unable to earn their living in other ways. The mechanisms of control, while still there in the standardisation of records, procedures for transfer between Clinics and uniform maintenance schemes, were lighter and more subtle; the case for compulsory treatment had 'not been made', and research into new techniques of more 'objective' monitoring (urine testing for example) and other biochemical measures of drug use were necessary (Connell 1967).

Owens began his article by saying that there were two major errors in the debate about heroin addiction: firstly that 'heroin addiction is an entity in itself', ie different to other addictions; and secondly that 'narcotic addiction is exclusively a medical matter'. In his article can be seen clearest the tension between the therapeutic and the controlling roles of the treatment centres. He outlined a model of a centre, the role of which was both to treat clinically the individual addict, and to contain the number of established addicts in an area, an issue of 'community mental health'. Seeing the individual addict as both a mind and a body, he argued that the centre should have close associations with both

general psychiatric and physical medicine facilities, and access to assessment beds. However, the role of the centre as a focus for control of addiction in the social body within a local area was also spelled out; while displaying 'maximum concern which one has clinically for the individual addict', the centre should also be fairly rigidly structured, as 'it is imperative for the successful containment of the heroin-addiction problem that there should be a maximum control of the amount of heroin available on prescription'. There was a need for a tight system of registration of addicts, for identification cards to stop addicts using more than one centre, for the allocation of addicts to specific pharmacists, and the creation in each area of a 'drug squad which would see its job in terms which one would call therapeutic, to identify cases of drug-takers and to prevent drug abuse' (Owens 1967).

The gap between the perception of the first two specialists, Bewlay and Connell, and that of Chapple, the general practitioner, reflects that between the perceptions of 'hospital medicine' and 'biographical medicine' (Armstrong 1979). The general practitioner started from the premise that institutionalised treatment was bound to fail because addiction was a disease which had to be dealt with in the world where the addict lived, and with the addict's cooperation. The appropriate site for treatment was 'in the community', by experienced practitioners who could provide a continuity of care and a 'human and friendly therapeutic atmosphere'. Monitoring by techniques like urine testing would be used, but the emphasis was on the patient as a person and the surrounding social networks. Siting addiction treatment in the therapeutic space of general practice, Chapple argued, would mean that practitioners were far more accessible to addicts than they would be in specialist Clinics (Chapple 1967).

Smart (1984), also drawing on Foucault's work to discuss this period, locates drugs policy in the process of regulation and disciplining of bodies by the application of rational scientific knowledge to human behaviour. However, she takes issue with analyses of drugs policy that define the Brain Report and the ensuing changes as representing a significant shift, saying that 'the conceptualisation of the addict as a sick person and threat to public health which emerged coterminously with the construction of addiction as a social problem in the nineteenth century remained the unshaken epistemological basis of policy in the 1960s'. Instead of as a break, she sees the Clinics as the rationalisation of existing policy, made possible by developments and applications of scientific knowledge: the development of methadone as a substitute for heroin, techniques of biochemical screening and the recording and collation of records.

My main point of divergence from Smart's argument is in her implication that there had been no change in the way addiction was perceived as a disease and a threat to public health, or indeed in the conceptualisation of public health itself. The nineteenth century sources she quotes define the addict as becoming a 'worse than useless member of society'. In this formulation the addict is a 'problem' because they are a waste of resources, an individual unhealthy member of the social body, unable to play their role in an increasingly organised society.

Here I have argued that what was different about the picture of the addict in the 1960s was the idea of infection or contagion, and the threat posed by the dissolution of the divides between the ill, the potentially ill and the healthy that this implied. Using Armstrong's work, I would argue that in this period disease concepts of addiction followed the twentieth century redefinition of the site of illness and health. The post Brain era did represent a new concern about control, as evidenced by Stimson and Oppenheimer's observations (1982), because addiction was seen as existing in the spaces between bodies. Control was not just of the individual addict, but also of the disease. The institutional arrangements of this control were a halfway stage between the enclosed, hospitalised ideal of the nineteenth century and the period prior to the Rolleston Report, and the open, community-based model offered by Chapple. The Clinics when first set up had elements of the Dispensary. The technical developments Smart points to were important; the development of drug substitutes and methods of scrutiny of addicts' drug-taking away from the Clinic made non-institutionalised treatment possible. However, the collection and centralisation of information, which had started in the 1930s, was part of the process of reconstructing the disease of addiction, a redefinition which included the siting of the disease in the social body, and thus created the space for non-institutionalised treatment: the Drug Dependency Clinics.

Here I would repeat the qualifications I make in Chapter One about the significance of public health in its social medicine form and its position relative to hospital medicine. I am not suggesting that the Clinics were structurally located within the public health services, at that time under the aegis of Local Authorities. The Clinics were outpatient departments, staffed by hospital based psychiatrists and, in most cases, linked to inpatient beds. By the 1960s, as I described, in Chapter One, the gaze of hospital based psychiatry had opened out and the institutional arrangements of this were outpatient clinics and day hospitals. However inpatient care still dominated. In 1965, there were still over 125,000 psychiatric beds in England and Wales, and psychiatric admissions had risen by 50% in

the previous five years (Prior 1993:fig2.2). The sheer dominance of hospital based medicine in the first two or three decades of the NHS is so familiar that it is perhaps easy to take it for granted, as a given against which the significance of deviation can be exaggerated.

However, what comes through in the discourse of the second Brain Report, and the papers and letters written to the medical journals of the time, is the idea of addiction as an epidemic of a socially infectious disease. Because it had been constructed in this way, the psychiatrists who conceived and ran the Clinics were adopting some of the attributes of a public health approach. This was underpinned by the sense of urgency to control the epidemic. In relation to addiction, the gaze of psychiatry operated briefly in a way similar to that of social medicine; informed by the epidemiological evidence of the Home Office Index, it sought to control a disease present in the social body. In doing this, psychiatry finally claimed addiction and the addict from the discourse of general practice, and took them, via the Clinics, into its own domain.

From social control to therapeutic challenge: the Clinics in the 1970s

Initially, the focus of the Clinics, and the attention of those who both worked in and used them, was on the practice of prescribing to control the epidemic. Over the following decade, the aims ascribed to this practice changed as the sense of an epidemic passed and the Clinics' role in controlling that epidemic became less important. The gaze of the psychiatrists running them shifted from the wider scene, the social body in which the course of the epidemic had been traced by the Index and Home Office surveillance, to their own practices, and to the people who presented to the Clinics. By 1980, the discourse had changed again, and addiction was contained within the individual addict in whom the disease manifested itself, but now located in the mind, not the body of that addict. I argue that the practice of prescribing remained central to the discourse. The scrutiny of prescribing practices produced 'truths' about how the Clinics should operate, and from the scrutiny emerged changed prescribing practices, reflecting the new construction of the disease.

Controlling the epidemic

The first task of the Clinics was to control the epidemic of heroin use by taking over responsibility for those addicts who had been receiving prescriptions from the NHS and private practitioners, and to end the excessive prescribing, while still offering enough to

keep the individual addict away from acquisitive crime and to 'undercut the black market'. The illicit market was not yet consolidated and in the hands of *organised crime*, and a major concern was to prevent demand from enabling this to happen (Connell 1969), but against this was the concern that the Clinics should not become 'merely prescribing centres' (Owens 1967). Because of the comparative inexperience of many of the Clinic staff, regular meetings between those responsible for running the London Clinics were established in the first year of operation, and have continued ever since. Because the majority of the Clinics when first established were in London, these meetings have always largely involved the consultant psychiatrists and others running the London Clinics.

Stimson and Oppenheimer (1982) give a picture of how the relationship between Clinic staff and addicts in the early days was often one of conflict and confusion in which the usual norms of medical encounters, what Strong calls the 'ceremonial order' (1979b), could not be adhered to. The staff were unusually explicit about their role in controlling a social problem and there were coercive measures (contracts, negotiations and sanctions) used which would not be considered ethical in other medical settings. These were justified by staff as being 'reasonable' because of the nature of the patients. Addicts were seen as being disenfranchised in some way. They did not want to get better, did not seek help or cooperate with treatment and behaved as if absolved from their social obligations. They did not, in short, understand the sick role and the obligations it placed on them and so confounded staff's expectations of patient behaviour. This was explained in terms of psychopathology by the staff.

To the addicts, the staff generally represented hurdles that had to be overcome; part of 'managing' was managing the Clinic staff. This is an experience similar to that reported by women seeking abortions (Allen 1981), another aspect of medicine where many of the norms of medical encounters do not operate. The staff themselves were monitored, but this was not perceived as a threat to clinical freedom, reflecting the perception of the Clinics' role in controlling an infectious condition.

Establishing norms

After the first year or so, the Clinics settled down; staff were more experienced, the group of existing addicts were absorbed into the caseloads, and the panic about the epidemic began to pass. The balance of tasks of the Clinics changed from controlling the epidemic to treating the individual, and practices within the Clinics began to change.

The regular meetings between the doctors running the Clinics established an informal code of practice for Clinic operation, and began to construct norms for treatment policies (Connell and Strang 1994, Mitcheson 1994, Connell 1991, BJA 1988).

The operation of this code and the construction of norms can be analysed in terms of Foucault's analysis of the workings of power (Chapter One). Practices were agreed between the Clinics which identified the individual addicts, and located them within the treatment population. That population was arranged to be visible to and manageable by the Clinics. There was close communication between the Clinics, and the Home Office Index was available for consultation about an individual's identity. Individual clients were required to come into the Clinic on a weekly or fortnightly basis for examination, interview and urinalysis. Although in the early days the practice in some Clinics was to dispense drugs directly and to provide 'fixing rooms' (Stimson 1973), a technique was employed to shift the physical act of drug consumption out of the Clinics, while maintaining control over that act. Prescriptions would be posted to a given pharmacist, for daily dispensing, so that the individual would have to present at that place each day. The total population was dispersed over a number of pharmacists, to prevent addicts congregating in chemists' shops (Connell and Strang 1994). As well as these operational practices, the meetings began to scrutinise prescribing practices. In Mitcheson's recent description of this can be seen the operation of an 'intentional and nonsubjective power' (Foucault 1981b:94):

Statistical information was provided at these meetings, regarding the number of patients receiving prescriptions at each clinic and the total quantity of heroin and methadone prescribed from each clinic. Even prior to the advent of cheap pocket calculators it was relatively easy for doctors attending these meetings to calculate a mean dose of opioids per patient for each clinic. (Mitcheson 1994:178)

The effect of this information was to lower the average dose of heroin prescribed across the Clinics, not by any edict from a subjective power, central government for example, but by each doctor adjusting the basis on which s/he calculated the rationality of each decision. However, the statistical data had to be coupled with a basic rejection of the practice of prescribing except as an unavoidable measure in the face of worse alternatives, or else the effect would not necessarily have been to lower the dose. The same exercise of power might, in the case of a practice that carried professional approval, have had the effect of a raised average dosage.

Knowledge of colleagues' prescribing practices was not the only factor in the rational calculations individual practitioners had to make. Within the medical, and particularly the psychiatric, discourse around drug use was the view that prescribing, and in particular prescribing of injectable heroin, was not an appropriate task, but was one that had been undertaken by the Clinics in the face of the epidemic, and in fear of worse social consequences if individuals were not kept out of the illicit drugs market.

Changing the task of the Clinic

The control over prescribing that the Clinics had did control the flow of pharmaceutical heroin and cocaine that had been the responsibility of the medical profession. What it did not do was to prevent the growth of the illicit market in non-pharmaceutical drugs (Power 1994:34), and this wider goal was abandoned as the Clinics became inward looking and focussed on their own practices (Strang and Gossop 1994:346). The reception given to a piece of research carried out at one of the London Clinics, and first presented to staff of other Clinics in 1976, demonstrates the changed priorities in decision making about prescribing practices.

This research was a random controlled study comparing the outcome of prescribing patients injectable heroin with that of refusing heroin and offering oral methadone. Patients were followed up by a social researcher, away from the Clinic. What the study showed was that on many variables there were very different outcomes from the two treatments. Patients prescribed heroin attended the Clinic more regularly and showed some reduction in their criminal activities. On other variables, such as accommodation, employment or diet, they showed no change following treatment. Patients refused heroin and offered oral methadone instead, polarised into a majority who continued to inject illegal drugs and only used the Clinic for specific services, and a sizeable minority who either stabilised on oral methadone (one-fifth), or stopped all drug use (one-fifth) (Hartnoll et al 1980, Mitcheson 1994).

These findings, employing scientific means of establishing the truth, confirmed the parameters of decision making about prescribing that had been intuitively but explicitly drawn since the start of the Clinics. To prescribe heroin would stabilise and keep addicts in contact, but not change them, while to refuse heroin would be more challenging, and potentially more therapeutic, to the individual, but risked adverse social consequences and loss of contact with the addict. The authors of the study have always claimed that the findings were presented neutrally, and were not intended to indicate that

one treatment was superior to the other. Nevertheless, [the] research was perceived by many staff in London clinics as clear evidence for replacing injectable heroin maintenance with oral prescribing. (Mitcheson 1994:183)

Following this, in the mid to late 1970s the earlier downward pressure on average doses of heroin was joined by a shift right away from heroin and injectable methadone to oral methadone, with most London Clinics refusing to prescribe injectable drugs to new clients. Again, this has to be seen not as a decision made by some central holder of power, but as the exercise of a locally rational power, that of the London psychiatrists, with the effect of changed local practices. What had altered was the relative weight given to the Clinics' conflicting tasks. Epidemic and contagion had disappeared from the discourse, as the psychiatrists had focussed their gaze on what was happening within the Clinics and to their own patients. Challenging those patients therapeutically, and perhaps changing some of them, 'curing' them of the disease of addiction, was more important than trying to control society's drug use.

The practices for this therapeutic intervention were prescribing to help with withdrawal symptoms (detoxification) and those of more normal psychiatry and psychology (counselling, psychotherapy and groupwork) as the Clinics became principally services for the individual addict's mind. Smart, reporting on a national survey of Clinics carried out in 1982, provides evidence of this reorientation of policy. Of the Clinics surveyed 90% described individual psychotherapy as 'important' or 'very important', and 87% gave help with withdrawal this importance. Conversely, 84% saw maintenance on injectable methadone as 'not important' or 'not [Clinic] policy', and 97% saw heroin maintenance in this light (Smart 1985). By the end of the 1970s, the Clinics were principally services for the individual addict's mind.

They were also the sites from which psychiatrists made their discourse and

from which this discourse derive[d] its legitimate source and point of application (its specific objects and instruments of verification). (Foucault 1974:51)

Diffusion and reconstruction: the epidemic of the 1980s

In the early 1980s, there was another reconstruction of the discourse about drugs use, and a corresponding shift in the sites of practice. There was again a panic about an 'epidemic'

of drug use, but this time the term did not imply contagion. The new epidemic was not visible to the narrowed gaze of the psychiatrists in the Clinics, and the explanation of addiction in terms of individual psychopathology conflicted with the epidemiological evidence. New speakers began to emerge, with a new discourse on drug use.

Illicit drug use was constructed as an epidemic in the same sense as coronary heart disease, existing in the population at a worrying level, and was identified by research employing new techniques of estimating prevalence and mapping its epidemiology.

Central government began to speak on and take responsibility for responding to illicit drug use. While much of this was punitive and framed in the terms of criminal justice, within it a new discursive space for talking about the treatment of drug use was opened up. In this space, the construction of the 'problem drug taker' emerged, recasting drug use as a behaviour which carried risks and could lead to harm, to the individual, to those around him/her and to the wider community. 'Addiction' did not feature in the new discourse, instead the problem was 'drug misuse' or 'problem drug taking', and its outcome 'harm'. 'Harm' was conceptualised as not just psychological and physical, but also social, legal and financial. As in the case of illnesses such as coronary heart disease, the means of prevention of that harm was located in the behaviour and choices of the individual, and was amenable to education and advice.

This new, diffused epidemic needed new institutional arrangements. A nationwide structure of services began to be built, employing the reconstructed concept of 'problem drug taking' and staffed by a wider range of people: nurses, social workers, probation officers, and generic 'drugs workers'. The new services provided sites throughout the country from which these groups began to speak their own discourse on drug use, away from London and away from the specialist Clinics.

Mapping the new epidemic

In the early 1980s, an increased incidence of illicit drug use began to be visible in a range of ways. Through the 1970s, the numbers of addicts on the Home Office Index had continued to rise slowly, but provoked little reaction. However, in the early 1980s the rise became dramatic. Between 1980 and 1985, the average yearly increase was 30%, with a single increase of 50% in new notifications recorded for 1983. The key to the importance of this was not just the numbers but, as in the 1960s, the changes in the patterns of drug use that the Index suggested.

One aspect of this was changes in the sources of notifications. The proportion of new notifications coming from general practitioners rose. In 1975 GPs had been responsible for 29% of notifications from all doctors; by 1984 this had risen to 55% (Glanz 1994:157). A survey carried out in 1985 suggested that in any given four week period, a fifth of all GPs in England and Wales saw at least one opiate user, and that GPs as a whole saw 40,000 cases over a twelve month period (Glanz and Taylor 1986). Drug use was clearly no longer simply a matter for specialist services – it was appearing in 'normal' populations, where these were visible in GPs' surgeries.

Another aspect was age. People under the age of 21 increased to 24% of all notifications in 1985, compared to 17% in 1979. The significance of this is not so much the numbers in this age group, but that the rise reversed the trends of the 1970s. It indicated that young people were continuing to start using notifiable drugs, rather than there being a cohort of people using drugs who were steadily growing older. Both these factors, age and source of notification, suggested that, far from being contained by the specialist psychiatrically based drugs services, illicit drug use was becoming a more widespread phenomenon.

However, the Index as a means of surveillance by now had limitations. As I argued earlier, at a time when most drug use involved illicitly acquired but licitly produced drugs, when addicts had relatively easy access to legal prescriptions, and the main means of constructing the Index was by scrutiny of prescribing and dispensing records, it was reasonable to see the Index as a realistic, if somewhat delayed, picture of what was going on, at least in terms of heroin use. By the 1980s, however, a main source of heroin was illicit imports, largely from South West Asia, following turbulence and dislocation in this region after the Iranian revolution and the Soviet Union's invasion of Afghanistan. The availability of this heroin meant that its users remained largely invisible to the form of surveillance offered by notification.

The official statistics' limited usefulness, beyond giving very general pointers to trends in drug use, was recognised and attempts were made to create more accurate and useful epidemiological knowledge. One such was the Drug Indicators Project, within Bloomsbury Health Authority, funded by the Department of Health and Social Security (Hartnoll et al 1985, Hartnoll 1985). Recognising that the sort of intensive case-finding exercise which had been a norm of previous research into drug use (de Alarcon 1969, Plant 1975, Kosviner et al 1968) was 'not realistic in an large metropolitan area' (Hartnoll 1985:203), the project's aim was to generate techniques for estimating prevalence that

would be useful in assessing the extent of drug use, and the adequacy of existing services. A variety of methods was employed, which made use of existing data from different sources. The project suggested that Home Office notifications under-represented the number of *regular opioid* users by at least a factor of five, and possibly one of ten. This gave a figure of around 40,000 people who had used opioids regularly for at least part of the year in 1982, and, the authors argued, a figure nearer 50,000 for 1983. This project is important because its multiplier became a 'truth' about the extent of drug use, and one of the assumptions built into discussions of drug use in the 1980s. The DHSS circulated a manual on how to estimate prevalence based on the project's work to health authorities (DHSS 1984), and frequently referred to the five-ten multiplier. By 1989, Plant could write that:

It is widely accepted that throughout Britain there might be at least 100,000 regular opiate users. (Plant 1989:60)

I have stressed that the research involved numbers of regular opioid users because alongside the figure this suggested was another figure, usually given as the same again, for people who were either 'casual' (ie not regular) users of opioids, or were predominantly users of other drugs.

Conceptualising the new epidemic

The multiplier generated by the Drug Indicators Project gave a set of parameters to the quantitative change there had been in drug use in the UK. Other studies looked at the qualitative changes. Two of the most important, in terms of the way they influenced understandings and perceptions of drug use, were carried out in Merseyside by Parker et al (1986, 1988), and in the North of England by Pearson et al (1987, Pearson 1987). One of the key points made by these studies was what Pearson et al referred to as the *normalisation* of drug use: that for large proportions of young people growing up in the early 1980s, drug use, including heroin use, was a 'normal' part of their experience. This is not to say that the majority of young people had themselves used drugs, but that they knew other people who had among their friends or acquaintances (Newcombe 1987:10). Drug use was no longer something alien, part of a sometimes romanticised subculture or linked only to the exotic. Although much research since the 1960s has established the diversity that exists among drug users, and the fact that by no means all drug users conform to the stereotype of the junkie (Stimson 1973, Stimson and Oppenheimer 1982),

the argument put by Pearson et al was different, and not solely about diversity. The drug using population had

increasingly come to resemble the general population, or what one might call 'ordinary people'. (Pearson et al 1987:10)

Other commentators described this normalisation; for example Dorn and South (1985, 1987) perceived the emergence of the young white working-class male drug user as a significant feature of the early 1980s, while Parker et al talk about the involvement of 'ordinary youths' (1988:24).

O'Bryan (1989) illustrates this change when he contrasts the group of heroin users in North London whom he researched between 1984 and 1986 with the 'largely middle-class hippies' of an earlier age written about by Willis (Willis 1978).

Consciousness raising drugs such as cannabis and LSD played a central role in the values and concerns of the hippies. Heroin was defined by them as a kind of final and unalterable closure of relations with mainstream society in both a physical and symbolic sense ... By contrast in the 1980s, heroin users in inner North London were extremely conscious of style, their clothes a smart 'classic' style popular with other young people in the area ... One of the group revealed that heroin was popular among a group of football supporters on the terraces of a first division football club a few seasons ago. This is a significant change from the 'dropout' hippie style. The range of appropriate settings for using heroin shows that here the drug had arrived in the mainstream. (O'Bryan 1989:66)

The epidemic was geographically diffused. Historically drug use had been seen very much as centred on London, and particularly, in the 1960s, in public or semi-public areas of the city: Piccadilly for example, or Camberwell Green in South London. The case histories and descriptions in Stimson and Oppenheimer (1982) demonstrate this. A feature of the descriptions of drug use in the 1980s was the geographic spread involved. While London may have remained the 'centre of gravity' (Pearson et al 1987:5), illicit drug use was found to exist, to varying degrees, in cities and towns across the UK.

Another aspect of the geographical location of the epidemic was the way that, rather than existing as an identifiable 'scene' associated with a public space, drug use came to be seen as linked to residential areas, to a large extent the rundown peripheral housing estates of

towns and cities. Barker (1985), discussing the situation in South London, argued that illicit drug use could become part of the character of a community, rather than a separate 'scene' existing within the community, and that in parts of London

it is impossible to grow up without being exposed to or involved in illicit drugs and substance abuse. (Barker 1985, quoted in Stimson 1987)

The nature of drug use itself was seen as having changed from being mainly about injecting heroin. While heroin remained the focus of much attention, it was the new 'brown' heroin, street heroin, smuggled in from South West Asia. A key feature of this imported heroin, apart from the quantity, was the mode of administration involved. Whereas pharmaceutical heroin is prepared for dissolving and injecting, this smuggled heroin was prepared for smoking and required further treating to make it soluble and therefore ready for injecting. Traditionally, heroin use in the UK had been dominated by injecting as the main mode of administration. While this remained the norm in some places, and particularly in Scotland, elsewhere new forms of use, such as smoking, inhaling fumes ('chasing the dragon', 'tooting'), sniffing or snorting and dabbing on the gums became popular (Stimson 1987, Black 1988, Parker et al 1988:17-18). The fact that this heroin could be used without injecting removed one of the main cultural symbols of the 'outsideness' of drug use, the needle, just as the new words used to describe it ('smack', 'skag' for example) distanced it from the stereotypes of previous decades (Pearson et al 1987:14).

Another change in the way drug use was perceived in the 1980s was the growing importance that was given to drugs other than heroin. That most drug users used a variety of substances had long been recognised, but the focus on heroin use was built into the way statistics were collected, services operated and, to a large extent, the way research was conducted. The notification system, from which the Index was constructed after the 1971 Misuse of Drugs Act, required all medical practitioners to notify the Home Office of any person they considered to be addicted to heroin, cocaine or any of several other drugs, all of which were either natural or synthetic opiates. Services were geared principally to heroin users, with the main form of treatment, by the end of the 1970s, being the prescription in reducing doses of the synthetic opiate methadone. Research tended to focus on drug use as defined by the dominance of heroin and many of the main studies in the early 1980s were still focussed on heroin (as evidenced by their published titles: *Living with Heroin*, *The Heroin Users*, *The New Heroin Users*). But the emergence of solvent abuse among school children, the extent to which heroin users also

used other drugs, the widespread use of stimulants, particularly amphetamines which in some areas were more prevalent than heroin (Black 1988), all contributed to a widening of the focus.

Another set of issues arose from concern about prescribed drugs and particularly the benzodiazepines, initially hailed as safe substitutes for the barbiturates and by the 1980s the most widely prescribed drugs in Britain (Lader 1981). There was a growing recognition of the creation of another class of 'therapeutic addicts', and a search for a framework in which to understand tranquilliser dependency and create appropriate services.

What all this added up to was a move away from a very tightly defined focus which identified drug use as heroin addiction, and saw this as a problem affecting a small minority of pathological individuals who were best treated within the individualised models of psychiatry. This re-framing of the question of drug use led to more diffused conceptualisation; drug use existed in 'normal' settings, and was practised by people who were, in other ways, also 'normal'. The numbers, even just those thrown up by the Index, but especially those generated by using the Drug Indicators Project multiplier, showed that existing services were inadequate.

Responding to the epidemic

That this new perception of drug use led to a 'panic' is documented; MacGregor (1989) outlines the public form this took. While she points out that a lot of the fear centred around the threat that growing drug use posed to social integrity, and its association in the public mind with 'things lethal, subversive and alien' (1989:11), it was the idea of drug use becoming endemic in a whole generation that was especially frightening:

It was feared that the whole problem was spreading, getting out of control, extending beyond the expected social groups and into new geographical areas. (MacGregor 1989:11)

The link that was made with unemployment and the disillusion and hopelessness of young people 'who had borne the brunt of the recession' called into question issues of stability and cohesion:

whole areas of the cities, the so-called 'inner cities', and of the country, 'the North', are seen as somehow slipping the bonds that link them to the mother ship of state. (1989:11)

At the beginning of this section I stated that a key issue was the government response to the perceived epidemic of drug use. Historically, at least since the Rolleston Report in 1926, UK governments have left the medical profession an almost entirely clear field in determining the nature of drugs policy outwith the criminal justice system. As I argued earlier in this chapter, the changes that occurred in the 1960s were the result of the medical profession's definition of the problem and view of what was an appropriate response. The government, and specifically the Home Office, did not have a view on what should happen, other than the need to control the worst excesses of the prescribing practices of the doctors at the centre of the problem.

However, from about 1984, the Thatcher Government began to develop an interest and a perspective on drug use as an issue. Although drawn together in a 'strategy' (Home Office 1985, 1986), this contained several disparate threads. The five elements described in the government document *Tackling Drug Misuse* were:

- a) reducing supplies from abroad
- b) making enforcement even more effective
- c) strengthening deterrence and tightening domestic controls
- d) developing prevention
- e) improving treatment and rehabilitation

The first three of these demonstrate a concern with the supply side of drug use, while the last two are about demand. The whole strategy was overseen by a Ministerial Group on the Misuse of Drugs, set up in July 1984. This included the ministers responsible for drug matters at the Home Office and at the DHSS, and ministers from the Department of Education and Science, the Foreign and Commonwealth Office, Welsh Office, Scottish Office and the Treasury. The actual people changed, as ministers' careers waxed and waned, but over time the Group's membership included David Mellor, Edwina Currie, Tim Eggar, Michael Forsyth and Peter Lilley.

The strategy represented a new division of labour between central government departments. Historically, drugs policy had been 'owned' by the Home Office; specifically, the Home Office Drugs Branch maintained the Index and the notification

system, and the Advisory Committee on the Misuse of Drugs was convened by and met at the Home Office. The strength of professional autonomy allowed to the medical profession is symbolised by the lack of a direct role, historically, for the Ministry of Health and its successor the DHSS. As I described earlier in this chapter, by the 1970s actual treatment policies were a matter for individual consultants, within the framework of Home Office licences and the Drug Dependency Clinics. Any overall policy which did exist was the result of the meetings of the consultants responsible for the London Clinics.

The early 1980s saw a diffusion of responsibility for drug issues through central government, symbolised by the Ministerial Group. The Home Office, the Foreign and Commonwealth Office and the Treasury (who held responsibility for the Customs and Excise service) were responsible, ultimately, for the control and enforcement measures described above, while other departments were responsible for the prevention, and treatment and rehabilitation elements of the strategy.

In the supply side measures, and the international aspects of policy, the British government's response was focussed on increased surveillance and intelligence about the production, transport and sale of drugs, and involved increasing the penalties for those convicted of offences relating to these activities.

Customs' ability to deal with drug smuggling was improved by increased specialist staff and the development of intelligence work. Within the police force, each regional crime squad developed a drugs wing, with additional officers, and local forces' drugs squads were strengthened. One of the most controversial measures was the creation of a National Drugs Intelligence Unit, to replace the Metropolitan Police Force's Central Drugs Intelligence Unit. This was controversial because it happened at a time when the concept of local autonomous police forces was seen as being under threat, with the creation during the 1984 miners' strike of the National Reporting Centre and more sophisticated means of collaboration between forces. (This suspicion was perhaps justified as, in 1990, the National Drugs Intelligence Unit became a National Crime Intelligence Unit, with a more generalised remit.) Both Customs and several police forces introduced 'hotlines' for the public to pass on information.

Deterrence and domestic controls were aimed at making the penalties for trafficking more severe. A general restriction on the right of parole for people with sentences of more than five years, and the raising of the maximum penalty for trafficking in Class A

drugs from 14 years to life imprisonment meant that sentences actually served were increased dramatically. The Drug Trafficking Offences Act 1986 enabled the seizure of any assets deemed to be the proceeds of trafficking; in effect this meant any assets that someone convicted of trafficking could not account for.

These controlling and punitive measures formed the supply side of the government's strategy. They were aimed at the production, transport and selling of drugs, rather than at their use. This split is important, conceptually. The idea of 'trafficking', of the 'trafficker' and, at a level closer to the individual drug user, of the 'pusher', enables the reconciliation of what might otherwise appear to be contradictory elements in policy. This split has always existed in British drugs policy, and relates to the dichotomy between 'treatment' and 'control' in British drugs policy (Stimson and Oppenheimer 1982); while this dichotomy may be contested (Smart 1984) in terms of theoretical concepts of regulation and social control, in terms of the individual experience of drug users and the effects of policy on their lives, there is a difference between being 'treated' and being imprisoned. This is not to say that in practice this split is so clear; particularly at the lower end of the drug market, closest to the individual user, the distinction between a 'pusher', ie someone who sells or supplies drugs, and a user is often not tenable. Most people who use drugs will at some time or another 'supply' other users, either to finance their own use, or simply as part of the social organisation of whatever network they belong to. Nor do I wish to suggest that policy towards individual users is not punitive. In terms of sheer numbers, far more people are convicted of, or cautioned for, drug offences other than trafficking, than are convicted of trafficking offences. However, this split between supply and demand, while based on a 'commonsense view that the more readily available drugs are, the more likely people are to experiment with them' (Home Office 1986), opened up a new space for the treatment of individual users to be talked about, alongside the punitive talk about trafficking. Control measures were informed by the need to be tough; government descriptions of the strategy always began with the supply side, enumerating numbers of new police officers and customs officials, extolling the new intelligence work involved in enforcement and the new technology in use, and describing the ways in which the British government was cooperating with other governments in the international fight against the drugs trade. However, the strategy also involved significant measures on the demand side, and these were informed by a different set of perceptions about drug use, rather than about the drugs trade or trafficking.

Education

Prevention had two main elements. The first of these was national education and information campaigns, one in England and Wales, and a second, different campaign in Scotland. The second was the appointment by every education authority of advisory teachers in drug education, and the provision of in-service training and teaching materials.

Of the two national campaigns, the one run in England and Wales and launched early in 1985 focussed very much on heroin use, under the title 'Heroin screws you up'. The main message of the two television advertisements was about the insidious effects of heroin use, that everyone thought they could 'handle it' at first, but ended up controlled by their heroin use. This was accompanied by posters (eg 'Make up by Heroin', featuring a wan, spotty teenager) and three leaflets, two of which were aimed at parents. This campaign was evaluated using fairly conventional market research techniques (Research Bureau Ltd 1986), and was regarded as a success by the DHSS (Black 1988). The evaluation showed that there was high awareness of the campaign and some hardening of attitudes against heroin; the number of young people who said they would reject an offer of heroin rose from 83% before the campaign to 94% after the first year.

The first mass media campaign was the only one when drugs alone were tackled; by the second wave of advertising the message was complicated by the need to address HIV/AIDS prevention.

The effectiveness and appropriateness of the 'Heroin screws you up' campaign was doubted by many in the field (Power 1989). Quite apart from the evidence of past failures in such campaigns, Power argues that the campaign was 'conceived in a hurry'; the Health Education Council had wanted time to do research and consider the idea, but was pressured by the House of Commons Social Services Committee. Power argues that:

Ultimately, the decision to go ahead with the campaign was a political one. It is interesting to note that Andrew Irving Associates' (AIA) [the agents for the campaign] report on the targeting of the advertising states that one of the key intentions of the campaign was to 'reassure the public that the Government is taking effective action'. (Power 1989:133)

The campaign has also been criticised for concentrating so much on heroin use that it possibly disassociated other drugs from the negative consequences of use (Hart 1990:121).

That the campaign employed stereotypes is pointed out by Power (1989:137). However, what is interesting in the light of my earlier discussion of the idea of 'normalisation' of drug use, and particularly some of the research into drug use in the early 1980s, is that the stereotypes were of young white working-class men and what Power calls the 'dreary, minimalist settings' used were representations of the peripheral housing estates. The television commercials, whatever their merits or failings as a form of health education, certainly captured a particular image of drug use and the drug user which was crystallising at the time. The fact that the mass media campaign was run at all is indicative of the way drug use was beginning to be perceived as amenable to health education.

The Scottish campaign was devised by the Scottish Health Education Group and ran under the slogan 'Be all you can: choose life not drugs'. Rather than concentrating on the negative aspects of drug use, it was part of a wider campaign based on promoting 'healthy lifestyles'.

The other main part of the prevention campaign was the appointment of the Local Education Authority Drugs Education Coordinators, and the provision of in-service training and teaching materials for other teachers. Education about drugs was seen as relevant to all teenagers, not just an 'at risk' minority. The ACMD's report on prevention had argued that drug education should not be something separate and special, but should be incorporated into broader health and social education, in schools as well as in the mass media (ACMD 1984:para 4.41).

However, the most important part of the strategy in terms of the concerns of this thesis, were those that were defined as *treatment and rehabilitation* measures. As I have said, the interest and intervention in drugs policy by central government was new, and this was particularly true of the Department of Health and Social Security. Put starkly, the DHSS in the early 1980s accepted a definition of drug use as an issue in which intervention was needed, adopted a view on what an appropriate model of services was, created a structure within the statutory authorities and particularly the NHS to enact that model, and provided unprecedented amounts of money to fund services. In this sense, it could be said that the Department had a 'drugs policy' for the first time.

The problem drug taker

A key document was the report of the ACMD's working group on Treatment and Rehabilitation (ACMD 1982), published in December 1982. This working group had been established in 1975

to undertake a comprehensive review of the treatment and rehabilitation services for drug misusers and to make recommendations for dealing with both immediate problems and the situation more generally. (ACMD 1982:para 1.1)

Although the working group had been initiated so much earlier, the report when published was highly relevant. It set out clearly a particular construction of drug use and the drug user and of the task of services, and described a model of service development and a structure for achieving that development. The report was largely adopted by central government and its publication was accompanied by the announcement of a £2 million initiative for services. An account of the main elements of the report was published by the Institute for the Study of Drug Dependence early in 1983 (ISDD 1983), and four commentaries on the report were published in the *British Journal of Addiction* (Ghodse 1983, Slater 1983, Stimson 1983, Yates 1983), making the key ideas of the report accessible widely in the field.

The report introduced the term 'problem drug taker', one quite consciously borrowed from contemporary thinking in the alcohol field:

Thus a problem drugtaker would be any person who experiences social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption and/or dependence as a consequence of his own use of drugs or other chemical substances (excluding alcohol and tobacco). (ACMD 1982:para 5.13)

The significance of this is to re-define drug use away from the narrow conception of addiction, it also opens up the range of aspects of a drug user's life of legitimate concern to services. The implications of this in service delivery terms was the need for multidisciplinary teams, crossing the medical/psychological/social divides, and the involvement of general practitioners and other medical non-specialists in the treatment of drug users. The report also pointed to the fact of multiple drug use; services geared to

primarily heroin users were unable to respond to people using a wide range of substances.

The report pointed away from conceptualising drug problems as 'short term diseases', which contact with services could 'cure'. Instead, it conceptualised them in terms of 'chronic handicaps and disorders of behaviour' (para 5.19). The problem drug taker, then, is different to the addict, whether defined in the individual somatic terms of the Rolleston Report, the social and psychiatric contagion of the second Brain Report, or the psychopathology of the psychiatric discourse of the 1970s.

Another important aspect of the report's construction of the problem drug taker is the implication that problems *may* arise from drug use; drug taking itself is not necessarily a problem. This is not stated explicitly in the report; the nearest is a statement containing echoes of the Rolleston era's stable addicts, that:

for a small number of cases stabilisation of behaviour involving drug use may be a more immediately realisable goal [ie than completely stopping drug use]. (ACMD 1982:para 5.19)

However, if the issue around drug use, and the focus for intervention, are the problems that may arise, where does that leave drug use itself? One of the problems of the narrowly focussed Clinics was their inability to deal with what had become the perception of the 'reality' of drug use: far larger numbers using a range of substances. Any definition which saw drug use itself as the problem, in the context of this 'reality', would mean casting the net for potential intervention so wide as to be unmanageable. By focussing on the problems arising from drug taking, and not on drug use itself, the discourse of the *Treatment and Rehabilitation* report made intervention manageable. This is important because, by the late 1980s, the language of the report was being used quite explicitly to distinguish between drug use itself, and its attendant potential problems (Chapters Three, Four and Five). This distinction is at the heart of the discourse and practice of harm minimisation.

This distinction was echoed in a later ACMD report, on *Prevention* (ACMD 1984). Although the bulk of this report was about the prevention of drug use itself, it did refer to the concept of harm reduction (paras 1.13-1.14) as a focus for prevention work.

Creating a new structure

Following the ACMD's *Treatment and Rehabilitation* report, the DHSS created a new structure of services within England, based on the concept of the problem drug taker, and reflecting the multidisciplinary model this implied, described by one of the Department's senior medical officers as:

a flexible locally based network of services able to respond to the wide range of drug related problems. (Black 1988:84)

This structure had two elements: agencies providing direct services, and advisory and coordinating bodies. The structure was based on the newly created NHS structure of regional and district health authorities, with the regions given responsibility for implementation, within national guidelines. Regions and districts were first asked to establish a figure for local prevalence of drug use, and were provided with suggestions based on the Drug Indicators Project to do so. They were also required to carry out an audit of existing provision, and to make plans for the development of services within a regional strategy for tackling drug misuse (DHSS 1984, 1985).

Ultimately, multidisciplinary drug problem teams were expected to be set up at both regional level and district level. These teams were to be direct service providers, but were also to have an important task of involving other professionals, particularly general practitioners, in the care of drug users, what one consultant involved in setting up such teams called 'turning the generalist on to drugs' (Strang 1989:143).

At both levels, Drug Advisory Committees (RDACs and DDACs) were to be set up, comprising representatives of health, local authority social services and education departments, police, probation and relevant voluntary sector groups.

To fund the development of services, the DHSS provided pump priming money, in the form of the Central Funding Initiative. The amounts available through the CFI grew from the £2 million announced in December 1982, to a total of £17.5 million in the six years from 1983 to 1989. This money provided a total of 188 grants and was

of crucial importance in adding a layer of community services to the previously existing hospital and residential provision. (MacGregor et al 1991:6)

The expansion of drug services in the period after 1984 was dramatic, with 71% of all services in existence in 1991 having been set up since 1984. The emphasis was on the development of multidisciplinary teams, and advice and counselling services, in both the statutory and independent sector:

In the statutory sector over the past six years, 125 new services have started: 13 of these are drug dependency clinics; 15 are other hospital-based services; 67 are community drug teams; and 26 are advice and counselling agencies. In the non-statutory sector over the same period, 102 new services have opened. Here, 15 new residential services have been established ... The other main area of non-statutory sector growth in drugs services has been in advice and counselling, with 88 new agencies becoming operational in the past six years. (MacGregor et al 1991:28)

Community drug teams was the name used to describe many of the multidisciplinary teams set up at district level to embody the 1982 report's model (Strang et al 1991). The name was used particularly in the North West region, but spread elsewhere.

Summary

By the middle of the 1980s, the discourse about drugs was changing again. The narrowed gaze of the psychiatrists and the discourse spoken from the Clinics were being challenged. The emerging discourse constructed drug use as a behaviour which could lead to harm, in the same way as smoking, poor diet or lack of exercise, rather than as a disease entity in its own right. This perception of drug use emerged from the new ways of mapping and conceptualising the phenomenon, and can be located in the wider framing of ill-health as linked to behaviours that I described in Chapter One. The discourse of individual psychopathology failed to explain the new epidemic, and the Clinics could not respond. The epidemic was perceived as so threatening by central government that it justified intervention in a previously professionally defined field, opening up a new space and creating sites for the new discourse. I would not want to suggest that by 1986 this was yet the predominant discourse within drugs policy, but that it was emerging. There was no necessity for it to take root; with hindsight, the figures appear to show a peaking of the heroin epidemic in 1985, and a decline in the latter half of the 1980s (Power 1994:35).

What I have tried to show in this chapter is that there were significant shifts in the discourse about drugs throughout the twentieth century and that these can be understood in terms of the wider theory discussed in Chapter One. In the final section, I have argued that by 1986 a further shift was taking place, one which created a particular set of possibilities for the future development of services.

CHAPTER THREE: THE EMERGENCE OF SYRINGE EXCHANGE

Introduction

This chapter discusses the introduction of the practice of syringe exchange and the discourse of harm minimisation in England between 1985 and 1989. It is divided into four sections.

1. The policy story 1985-1989 is discussed and a chronology of key events outlined.
2. Drawing on fieldwork with the official pilot syringe exchange schemes, I provide an analysis of the discursive practices of staff in those exchanges.
3. The key policy document, the ACMD's report *AIDS and Drug Misuse Part 1*, is then similarly analysed, showing the entry of harm minimisation into the official discourse of drugs policy.
4. Finally, I use data from a national survey of syringe exchange schemes, carried out in early 1989, to demonstrate the diffusion of the practice of syringe exchange and the development of models of delivery.

The policy story 1985-1989

The story of the UK response to HIV infection among intravenous drug users starts in late 1985. Testing for seropositivity among groups of injecting drug users in Edinburgh, reported in the medical press, revealed alarmingly high rates of infection: 38% (Peutherer et al 1985) and 51% (Robertson et al 1986a), at a time when the overall rate for England was believed to be around 5% (Robertson et al 1986b).

The implications of AIDS for drug users had been much slower to be realised in the UK than in the USA, where, according to Des Jarlais et al (1985), concern had started in the Spring of 1983. Drug users in New York were experiencing AIDS related illnesses, most notably tuberculosis and pneumonia. Ethnographic interviews carried out in the Autumn of that year with intravenous drug users who were not in treatment showed that there was an awareness among New York drug users of AIDS and the link with shared needles. This awareness had led to a demand within the illegal drugs market for new injecting

equipment, to the point where demand could 'support a supply of counterfeit new needles', ie packages of needles were being resealed and sold as sterile (Des Jarlais et al 1985:758). Des Jarlais et al pointed to how this response ran counter to most stereotypes of drug users as incapable of behaviour change in the interests of health, and called for public health measures to facilitate changes which had already taken place.

The McClelland Report

In the UK, the published results from Edinburgh were a significant turning point. The implications for drug users were compounded by the discovery that blood donated within the Lothian Health Board Region was infected, the first instance of HIV infection in the domestically produced blood supply. The Scottish Home and Health Department set up a committee under Dr D. McClelland, Director of the South East Scotland Regional Blood Transfusion Service, to review the situation and to make recommendations to halt the spread of HIV among drug users. The McClelland committee reported in September 1986. Many of the report's recommendations related to the specific pattern and management of drug services in Scotland. Historically psychiatrists in Scotland had not seen the treatment of drug users as within their remit. Instead, what medical services as existed had been largely provided by a few general practitioners. However, central to the McClelland committee's report was the recommendation that:

Injecting drug misusers who cannot or will not abstain from misuse must be educated in safer drug taking practices. It is of the utmost importance that those who continue to inject are persuaded to use clean equipment and never to share it. Clean equipment should therefore not be denied to those who cannot be dissuaded from injection. In this connection authorities should be reminded that threat to life of the spread of HIV infection is greater than that of drug misuse. On balance, the prevention of spread should take priority over any perceived risk of increased drug misuse. (SHHD 1986:12)

This recommendation had different resonances in Scotland than in England. Robertson (1990) has described the combination of circumstances which had contributed to the rapid spread of the virus among drug users in Edinburgh. Among these were the active policy of restricting access to injecting equipment pursued by the police, and the implementation of the Pharmaceutical Society's ethical recommendations to its members not to sell equipment to suspected drug users. Lack of availability of equipment had

reinforced patterns of drug use where sharing had very much become the norm. The barriers to access to equipment were more legal and formal than in England, and consequently the practical aspects of implementing the recommendation were different. In England, the barriers were more a result of professional control by pharmacists than a result of direct police action.

The McClelland Report did not provide a very clear model of how equipment should be made available other than saying that it 'should be done on a one-for-one basis for a needle and syringe' (SHHD 1986:12). Provision of equipment on this basis had existed within the Amsterdam Municipal Health Service's drug services since 1984 (and on an informal, 'unofficial' basis before this). The Municipal Health Service's provision of needle exchange had been started as a response to an epidemic of Hepatitis B Virus among injecting drug users, initially in cooperation with the Junkiebond (Addicts' Union). Buning et al (1986) described the role that needle and syringe exchange played in the city's measures to contain the spread of AIDS in an article in *The Lancet*, stressing the philosophical basis of the wider context of Amsterdam's 'pragmatic' drug policy:

If it is impossible to cure a drug addict, one should at least try to create a situation that greatly reduces the risk that the addict harms himself or his environment. (Buning et al 1986:1435)

The Amsterdam exchange scheme had distributed 100,000 needles and syringes in 1985, on a strict exchange basis, from the methadone buses and clinics that formed the city's frontline drug services. Buning et al reported that there had been no evidence of an increase in needlestick injuries to the general public, that the number of injecting drug users had not increased and that there had in fact been an increase in the number of people seeking treatment for drug addiction. The provision of injecting equipment through such schemes looked like a possible means of implementing the McClelland Report's recommendations, and Norman Fowler, the then Secretary of State for Social Services, visited Amsterdam in the Autumn of 1986.

While central government deliberated how best to respond to the McClelland Report, workers in drug agencies in both the statutory and the voluntary sector in England were beginning to debate the idea of syringe exchange and to make plans to provide equipment to clients. This is discussed in the section below, based on interviews with such staff. An account of one service's decision to provide equipment was given in *The Lancet* in March 1987 (Marks and Parry 1987).

The first House of Commons debate on AIDS

In late November 1986, the House of Commons held its first debate on AIDS, during which the Secretary of State, Norman Fowler, outlined the government's approach as being based on health education with the 'individual's own behaviour' as the key to controlling the disease (Hansard 1986a col 802). The 'line' was to be:

Stick to one partner, but if you do not, use a condom. Do not inject drugs, but if you cannot stop, do not share equipment. (Hansard 1986a col 804)

Pressed by a Scottish MP, Gavin Strang, for the government's response to the recommendations of the McClelland Report, and particularly the need to distribute clean injecting equipment, Fowler answered that:

Any such scheme would need careful supervision and would need to go hand in hand with expert assessment, counselling and treatment. The Government are considering the matter seriously and urgently. (Hansard 1986a col 805)

Although much of the debate was about the wider implications of AIDS, the specific question of injecting drug users and the recommendations of the McClelland Report were referred to by several MPs, particularly by Scottish MPs whose main concern was to stress the need to act before other cities experienced the levels of seropositivity found in Edinburgh. No MP argued against the idea of syringe exchange; one, Anna McCurley, argued that even while she believed that the issuing of needles would lead to an increase in drug use, she endorsed the idea of a trial needle exchange (Hansard 1986a col 844). The issue was constructed in the debate as a crisis which had to be met by extraordinary means; Gavin Strang spoke of the risk of a 'terrifying explosion' of AIDS in Glasgow, and argued that there was no time for caution and pilot schemes and that 'the case is overwhelmingly for biting the bullet' (Hansard 1986a col 851). Frank Dobson, Labour frontbench spokesperson on health, argued that the recommendations of McClelland

may be a recognition and a legitimising of drug use, but on balance it is the lesser of two evils. (Hansard 1986a col 861)

The debate ended with the Secretary of State saying that the government would continue to consider the question of needle exchanges, and that points made in the debate would be taken into account (Hansard 1986a col 864).

Three weeks later the Secretary of State announced in a written reply to Roy Galley (MP for Halifax) that the government intended to 'establish a number of special schemes in different parts of the United Kingdom'. These would provide counselling as part of a wider programme of information and counselling on AIDS to drug users, and would also include the exchange of used and possibly infected needles and syringes (Hansard 1986b col 703).

This was the official 'birth' of the syringe exchange schemes, however the statement acknowledged the fact that such schemes were already in existence:

In taking this initiative ... the Government are taking into account that there are already some projects in operation that provide clean needles and syringes. We will wish to build on at least some of these projects in carrying forward the proposals. (Hansard 1986b col 703)

The need for evaluation was stressed:

An important part of these schemes will be to assess the effectiveness of such steps in preventing the spread of AIDS among drug misusers and hence to the general community. (Hansard 1986b col 703)

The 'pilot' syringe exchanges 1987-1988

Reflecting the very different pattern and history of drug services in the two countries, there were differences in the ways the pilot schemes were set up in England and Scotland (no schemes were established at this time in Wales or in Northern Ireland).

In England, health authorities and other agencies in the field were invited to submit bids to the DHSS to run one of what became known as the 'pilot' schemes. Financial assistance was offered for the first year (April 1987 - March 1988), in return for the projects' cooperation with a monitoring and evaluation process. Bids were received from statutory and non-statutory agencies, and from these twelve schemes were chosen in England. In Scotland, in contrast, health boards were asked to set up schemes, and they did this by selecting sites and planning the service, rather than asking for bids. The main reasons for the differences between the two countries were: the relative lack of services, particularly in the statutory sector (Macrae 1989:11) on which to build in Scotland, the perceived legal problems over the issuing of equipment (Donoghoe et al 1992:2), and the requirement of the Scottish Home and Health Department that the service should have a

medical input. Three sites were chosen in Scotland, one of which closed within a few weeks of opening ¹.

The government requirements for the pilot schemes were:

- To provide injecting equipment on an exchange basis to drug misusers already injecting and unable or unwilling to stop
- To provide assessment of, and counselling for, clients' drug problems
- To provide advice on safer sex and to offer counselling on HIV testing
- To collect information on clients and collaborate with a monitoring and evaluation project. (Donoghoe et al 1992:4)

As mentioned above, the Scottish Home and Health Department also requested that the Scottish schemes have a medical input.

Eleven of the pilot schemes were statutory sector services, all within the NHS. Of these, three were run by drug treatment services, on the same site as other services including prescribing; two were run by treatment services but at separate sites to the main treatment facilities; five were newly established services, the prime function of which was as a syringe exchange ('stand alone' services), this included the two surviving Scottish schemes; and one was an advice and counselling service. Of the remaining three, two were voluntary sector projects; one a long established project with a methadone maintenance prescribing service; and one an advice and counselling service. The final project was a hybrid, a joint venture between a statutory treatment service, a voluntary sector project and some commercial pharmacies. This last was the only one of the pilot schemes where users paid for their equipment.

However, these very simple definitions cannot convey the diversity of agencies involved. Even among those schemes run by the treatment services, the operating philosophies and practices of the 'parent' service varied enormously. For example, the two that I defined as 'run by treatment services but at separate sites to the main treatment facilities', were both run by staff of Clinics, but one was a clinic which operated a strict contract system

¹ The circumstances of the closure are described in the preliminary report of the evaluation, (Stimson et al 1988a) and are discussed more fully in the context of a wider analysis of Scottish services' response to HIV among drug users (Macrae 1989:27). As this thesis is about the English response, I see no need to discuss them here.

with clients, and would generally only prescribe on a reducing basis. The other offered a 'low threshold' oral methadone maintenance programme, on the first part of which clients did not have to submit to urine testing or agree to stop using street drugs. All the other statutory treatment services were Community Drug Teams or Drug Problem Teams rather than Clinics.

In spite of this diversity, as I will show later, what was striking about the schemes was the uniformity of language and description used by staff in discussing their work at interview.

The ACMD Report - AIDS and Drugs Misuse Part 1

The ACMD had set up a working group on AIDS in May 1987. This group was taking evidence and deliberating during the pilot year, and the first part of its report was published at the end of March 1988, just as the pilot year ended (ACMD 1988). The report had actually been completed three months before, but was not made public by the government immediately.

The terms of reference of the AIDS and Drugs Misuse working group were:

To examine the implications of AIDS for drug misuse services and report urgently on measures which can be taken by services to help combat the spread of HIV infection. In particular, to report on action which can be taken to:

- a. provide more drug users with the opportunity of contact with appropriate helping services.
- b. to help to keep people who continue to misuse drugs in contact with treatment or other appropriate services with a view to preventing or minimising unsafe injecting and other harmful behaviour.
- c. to examine and report upon the wider implications of AIDS and HIV for all services for drug misusers including the provision of treatment and other services to drug misusers who have HIV infection or AIDS or may be at risk. (ACMD 1988:82)

Within this remit, the working group looked first at the question of HIV transmission, and the containment of the spread of the virus through injecting drug misuse. Part 2,

published the following year, focussed on issues of the clinical management of drug users who had already become infected (ACMD 1989).

The most often quoted of the report's conclusions was that which echoed the earlier McClelland Report:

The spread of HIV is a greater danger to individual and public health than drug misuse. (ACMD 1988:75)

This led to three general sets of considerations, and two very specific ones. The general considerations related to: the need for services to be expanded to meet the potential demand that would be generated by making contact with the majority of users; changes in working practices of services to make them more attractive and effective; and measures for those drug users who would never make contact with drug services.

The specific considerations were a recommendation to increase the number of syringe exchanges, and the suggestion that condoms should be made available confidentially within prisons. The working group had considered and rejected the idea of injecting equipment being made available within prisons.

There were also specific recommendations to do with the development of services in Scotland, and wider considerations for the care and treatment of drug users in prisons.

The report, when finally published by HMSO, was launched with a press conference at the offices of the Standing Conference on Drug Abuse (SCODA), after the ACMD was refused a government venue (Stimson 1988). The accompanying press release stressed the need for 'a more imaginative and realistic approach' to drug misuse.

Government response

The government's initial response to the report's main recommendations was mixed. On one level there was an endorsement of the basic argument that prevention of HIV was a priority, as the Under-Secretary of State for Scotland confirmed in an adjournment debate two days after the report's publication:

The hon. Gentleman [Gavin Strang MP] asked me to acknowledge the imperative that the fight against the spread of AIDS should take precedence over the Government campaign to end drug misuse. I am

happy to assure him that it is indeed the predominant priority, and our policies are geared towards that. (Hansard 1988a col 1298)

But on a practical level, the government's immediate response seemed to mean very little that was positive. In terms of resources to increase services, no new money was forthcoming. Instead, ministers pointed to the extra £1 million provided in 1987/8 for HIV prevention within drug services, confirming that this would continue to be available in future years, and that, with the £5 million provided since 1986/7, this meant a total of £6 million of central government money for drug services annually (DHSS 1988). In terms of changes in the nature of services, government endorsed the need for services to be attractive, but in general argued that such changes were for local or professional judgement.

On the first of the two specific recommendations the government argued that there was 'as yet insufficient evidence about the benefits or otherwise of syringe exchange schemes to recommend an expansion of schemes' (DHSS 1988); the evaluation research had not yet reported. On the second, there was an unequivocal rejection of the idea of condom distribution within prisons, on the grounds that such distribution would result in increased homosexual activity and thus increased risk of HIV transmission.

This last argument was described by the Chair of the working group as 'sillier than words, like saying providing umbrellas will make the weather worse' (Runciman 1988). Her interpretation of the government response other than this was that while it was disappointing, it was not wholly negative. The government had broadly accepted the report, but failed to accept the need for increased resources. The response on syringe exchange she saw as guarded rather than an outright rejection.

The press, both the quality daily newspapers and the scientific/professional press, interpreted the government's response as negative and as evidence of a loss of nerve on the part of ministers in tackling the sensitive issues involved with both HIV and drug use. The Secretary of State for Social Services, John Moore, was compared unfavourably to his predecessor, Norman Fowler, by many commentators. Fowler's 'pragmatism' was praised, and contrasted with Moore's 'political cowardice' by *New Scientist* (1988:16), while the *Health Service Journal* commented that:

The imaginative and adventurous approach to tackling the spread of AIDS that marked the last months of Norman Fowler's incumbency at the

Department of Health has been brought to an abrupt halt with the government's rejection of [the ACMD report]. (*Health Service Journal* 1988:381)

An *Independent* editorial, calling for 'pragmatism over AIDS' argued that:

Mr Moore faces his own ideological problems. He is reluctant to hand out free syringes, free condoms or free drugs because that might be seen as soft – at least by some of his backbenchers. But there are good pragmatic reasons for doing these things. (*Independent* 1988)

The press interpretation was probably a fairly accurate one: that the personal stance of ministers had a lot to do with the tone of the government response. Much of the debate centred around the pilot syringe exchange schemes, and much was made, particularly by Scottish ministers, of the apparently low attendance at the two Scottish schemes, with very little qualifying information about the restricted hours these were open (Hansard 1988 col 1300). In the event, John Moore did not remain the relevant Secretary of State; the DHSS was split later that summer and the new Department of Health emerged, with Kenneth Clarke as Secretary of State, and David Mellor and Edwina Currie as the responsible junior ministers.

Berridge reports that:

The summer of 1988 saw intense pressure from civil servants for a more positive response from ministers which brought a turn round in the Autumn. (Berridge 1991:189)

In September, guidelines on the setting up of syringe exchange schemes were circulated in circular HC(88)53, and a further £3 million were made available to health authorities for measures to prevent the transmission of HIV among and from injecting drug users (DoH 1988).

This announcement followed the submission to the DoH of the Monitoring Research Group's evaluation report, which showed that drug users who remained in contact with syringe exchanges did change to lower risk behaviours (Stimson et al 1988b).

The spread of syringe exchange

Even before this official endorsement, there had been a growth in the number and models of syringe exchange. A survey I carried out in early 1989, as part of the MRG's ongoing monitoring, identified 55 exchanges operating at that time. The data from this survey are discussed below and were published in Lart and Stimson (1990). By the end of 1989, there were an estimated 120 exchanges in England as a whole.

The following table summarises the sequence of events discussed above.

Table 3.1: Chronological sequence of events 1985-1989

late 1985	First reports of HIV seropositivity among UK drug users McClelland Committee set up
September 1986	McClelland Committee reports
November 1986	House of Commons debate on AIDS
December 1986	'Pilot' syringe exchange schemes and evaluation announced
April 1987	'Pilot' year starts (though not all pilot schemes established yet) Monitoring Research Group evaluation begins
May 1987	ACMD working group on AIDS and Drug Misuse set up
late 1987	ACMD report <i>AIDS and Drug Misuse Part 1</i> completed
end March 1988	'Pilot' year ends ACMD report published £1 million for development of services announced
August 1988	Guidelines on setting up of syringe exchanges circulated (HC(88)53)
September 1988	Monitoring Research Group report submitted to Department of Health Further £3 million for services announced
February - April 1989	National postal survey of syringe exchange schemes

The discourse of syringe exchange

Returning to the pilot syringe exchange schemes, I now analyse the material drawn from semi-structured interviews carried out with staff of the exchanges towards the end of the pilot year. As I discussed in Chapter One, my analysis is structured around the premise that what was said in these interviews was not a key to some 'reality' about syringe

exchange, but was speech presenting the practice. Who the speakers were and why they had authority to speak on syringe exchange is discussed, and then the object of the speech, the task in relation to that object, the nature of the relationship and the site of the task are drawn out.

1. The speaker

The people speaking in the interviews analysed here are eighteen of the people who were involved in planning and working in the first syringe exchange schemes in England and Scotland.

In England the person interviewed had made the initial proposal, or been involved in planning the exchange, and had been involved in the actual running of the service and face-to-face contact with clients. In contrast to this, in Scotland at one exchange the workers had had no involvement at all in the planning stages and so a second interview was carried out with a doctor who had been involved and who took a close interest in the running of the exchange, but had no direct contact with clients.

The eighteen interviewees were ten men and eight women. In terms of their occupations and qualifications: twelve were nurses, either registered mental nurses (of whom some were community psychiatric nurses) and/or registered general nurses; two were doctors (one consultant psychiatrist and one senior registrar in community medicine); and the remaining four were 'drugs workers' with backgrounds as social workers or community workers. The preponderance of nurses among the interviewees reflects the importance of nurses in the staff of the pilot exchanges overall; only two of the exchanges had no nurses on the staff. On the other hand, the two doctors interviewed were two out of a total of only three involved closely in the running of the exchanges. All three were at exchanges in Scotland. None of the English exchanges had doctors involved in the actual running of the syringe exchange. Most of the pilot exchanges were added on to existing services which were already managed fairly autonomously by nurses or drugs workers. In the three English exchanges which had grown out of traditional consultant controlled treatment services, the consultants were described by staff as having deliberately taken a backseat, leaving nurses to create and run the service. One of these was the 'hybrid' service, where exchange mainly happened in the community pharmacies. The other two were the services described above, where exchange took place at a site away from the

main Clinic ². Syringe exchange was not seen as a medical service in England, or at least not one requiring the presence of a psychiatrist.

This absence of doctors in England makes discussion of syringe exchange different to most past discussion of drugs services which has been dominated by medical speech. In Scotland, by contrast, syringe exchange was, right from the start, a medicalised service, requiring the presence of a doctor. Writing from the Scottish experience (although generalising from that to the whole UK), McKeganey and Barnard have commented that needle and syringe provision 'has...been seen as something which ought to be under the control of medically trained staff' (1992a:114) and have questioned the appropriateness of this. It is perhaps important to emphasise this difference between the English and Scottish experiences.

Syringe exchange has to be seen within the context of the historical re-orientations of English drugs treatment services described in Chapter Two. The expansion of drugs services following the *Treatment and Rehabilitation* report of the ACMD (1982), and specifically under the Central Funding Initiative, had created the space away from the institutionalised, medically oriented setting of the Clinics, where it was possible to think differently about drug users themselves and services for them. New people, from diverse backgrounds; nurses, social workers, advice workers, a few with personal experience of drug use, employed in these agencies, were given a site from which to speak on drug use and drug users.

It was in this space that syringe exchange and harm minimisation originated in England. Most of the people interviewed in the English exchanges said that it was they and their immediate colleagues who had had the initial idea of offering the service. They had already, or were in the process of developing, ways of working with drug users and thinking about drug use from which the idea of syringe exchange seemed a natural development.

² The views of these consultants as reported by the nurses running the exchange schemes are interesting, although there are limits to their usefulness. One of these consultants, in the service described above as using contracts as the basis for work with clients, was known to be opposed to the idea of syringe exchange, and the nurse interviewed commented that he felt the consultant had supported the setting up of the scheme 'so that he may be able to say in the long run that it doesn't work.' The nurse interviewed in the 'hybrid', community pharmacy based scheme, commented that his Consultant had no objections as long as the users paid for the syringes, and that anyway he believed they should have access to heroin, so long as they paid for their prescriptions.

So the people who had the 'authority' to speak on syringe exchange were these workers, many of them nurses, who had gained a site from which to speak in the expanded, non medical services.

Scotland provides a contrast to this. The people who worked in the Scottish exchanges had not been involved in planning them, and were all fairly new to the field of drug use. Although one of the exchanges here involved a consultant psychiatrist, she had also been a GP and the other doctors involved were specialists in community medicine. This reflected the way HIV had emerged in the field of infectious diseases and general practice in Scotland, because of the different pattern of drug services. It was general practitioners and specialists in infectious diseases who had become the people to 'speak' on drug use in Scotland. While there was new money for services in the early 1980s, it was not so much and did not have the same effect of creating a new space as in England (Macrae 1989).

2. The object

Behind what the staff in England said about their work stood a specific construction of the drug user. This was as a rational actor, with both the right and the ability to make choices about his or her own health and body, based on information and knowledge, and the right to have access to the means (clean injecting equipment) to implement those choices.

This construction of the drug user is close to that found in the ACMD's report *Treatment and Rehabilitation*, where the 'problem drug taker' is defined and the idea of drug use as inherently abnormal is challenged with the statement that the majority of drug takers:

are relatively stable individuals who have more in common with the general population than with any essentially pathological subgroup.
(ACMD 1982:para 5.3)

The 'problem drug taker' is defined as:

any person who experiences social, psychological, physical or legal problems related to intoxication and or regular excessive consumption and/or dependence as a consequence of his own use of drugs or other chemical substance (excluding alcohol and tobacco). (ACMD 1982:para 5.13)

As discussed in Chapter Two, an inference that can be drawn from this is that any individual drug user will not necessarily experience problems in all or, indeed, any of these areas. One interviewed worker expressed this quite explicitly when he described how, because his agency had wanted 'to make contact with people who may never have [had] a drug problem', a distinction was made between the exchange and the rest of the services:

so that people would be attracted to it without feeling a need to talk about altering their drug use which may or may not be a problem to them.

(Interview 05)

In other words, using drugs itself did not automatically mean that the drug user would have problems as a result. The risk of acquiring HIV was a problem, but one that could be dealt with by the practical means of obtaining and using clean equipment.

This idea was expressed in the terms staff employed to denote the users of the exchange. Stress was placed on how they saw clients as 'ordinary people' and 'normal human beings'. In all the English exchanges the terms 'clients', 'injectors', 'drug users', 'users', 'customers' or simply 'people' were used. All these terms reflect this normalising, de-problematising theme. In contrast, in the Scottish exchanges workers were more likely to talk about 'addicts' or to use slightly humorous terms like 'punters'. One of the doctors several times referred to her clients as 'rosy-cheeked kids' and referred to her own children who were of a similar age, stressing how normal the clients were.

My impression was that in the English agencies workers were more familiar with and less conscious of the use of the particular construction of the drug user. In Scotland, where the pattern of drugs services has been different, the staff were consciously trying to change the image of the drug user and to challenge that held by their colleagues outside the exchanges. They were less familiar with the alternatives to 'addict' as a term and so were looking for substitutes.

3. The task

The main theme of what staff said about the nature of the task in relation to this construction of the drug user, was the importance of giving information and knowledge to enable clients to choose what was seen as a healthier, safer way of life, and the means to implement that choice. This did not mean trying to persuade clients to stop using drugs; several workers quite explicitly stated this:

Our aim isn't to get people off drugs. (Interview 16)

[Staff] knew where they stood regarding realistic treatment services for drug users. Nobody had any strong abstinence beliefs. (Interview 13)

[We] did not have any abstinence beliefs to start with. (Interview 02)

We don't preach, we don't have an axe to grind. (Interview 11)

The task was not to control drug use itself, but to control the spread of a physical disease with which the individual drug user may or may not have already been infected. The health of the drug user was therefore an issue.

Controlling the spread of the disease did not depend on controlling the client's drug use, but on changing the way they used drugs. As these workers put it:

Saying to them 'we are not condemning what you do, we just want you to do it more safely'. (Interview 11)

Basically what we are saying to them is that we accept that you are taking drugs and that you are not going to stop because of us, but we would like you to do x, y and z and change your habits, and we give the reason why. (Interview 09)

Two phrases were used to describe this kind of approach: 'risk reduction' and 'harm minimisation'. At the time of the interviews, 'risk reduction' was usually used to refer specifically to reducing the risk of HIV transmission, both for the individual and at a wider social level, while 'harm minimisation' referred to the broader range of adverse effects, particularly physical, that drug use could have. Subsequent redefinitions of these terms have distinguished between 'risk' (the behaviour) and 'harm' (the outcome) (Strang 1992). This distinction enables the concepts to be used more widely, to cover the comprehensive range of harm (physical, social, legal) that can accompany drug use, and to focus intervention on behaviour. However, within the definitions as understood at the time of the interviews, syringe exchange was primarily and most obviously a risk reduction measure. The primary aim for syringe exchange was, one worker said, to ensure

that everyone gets a clean needle, syringe and all the necessary equipment for each hit. (Interview 03)

However, as the same person said:

We are about more than just providing clean needles.

'Harm minimisation' was used to describe a range of measures which were aimed at the wider spectrum of health risks associated with injecting: abscesses, septicaemia, damaged veins and so on. This involved providing not just clean equipment but also things like sterile water or medical swabs which might not immediately appear to have a direct relevance to the prevention of HIV transmission. It also involved workers in giving information and advice on injecting sites and techniques, with the aim

to promote a healthier lifestyle (Interview 13)

to reduce the risks associated with injecting both in relation to HIV and AIDS and other complications (Interview 14)

and to get drug users to

be more healthy in their drug use ... and reduce the harm that they are doing to themselves (Interview 16)

inject in a more sensible way, to have a more sensible attitude towards injecting (Interview 09)

The task, then, was seen as improving the physical health of clients by giving the information and means necessary for choices to be made about both HIV and other health risks. One of the main aspects of this which emerged in the interviews was that the intervention was aimed at the drug user's body and not the mind.

This is in contrast to the orientation of the psychiatrically organised treatment services. If the 1960s and 70s saw the psychiatrisation of services for the drug user, *services for the mind*, then syringe exchange represented a re-location, *services for the body*.

The work staff described in the syringe exchanges was not aimed at changing the mind of the drug user but at keeping the body healthy. The fact that so many of the staff were nurses seems to me to be significant here; they were used to dealing with bodies and practicalities, in a way that other workers were not. For example, the need for physical 'proof' of injecting had caused difficulties at one exchange staffed by a nurse and a social worker. The social worker had not felt that the physical examination of clients' bodies

for signs of injecting was within her role and competency, whereas the nurse felt able to do this, commenting that it was a question of 'different disciplines and different skills'.

At another exchange, however, where none of the staff had a nursing or medical background, they had sought help from a nurse at another agency, arranging teaching sessions in which they learnt how to handle syringes and about injecting techniques.

The way the task was discussed was in some contrast to the sense of emergency and crisis that had been present in the McClelland Report and underlay the defining of HIV and AIDS as of greater danger than drug use itself. Staff in the exchanges did not define the practice of syringe exchange as something different, but as a natural extension of their previous work, a concrete expression of what they felt they had been trying to do anyway.

This emphasis on the practical was welcomed by many staff interviewed; one nurse commented that syringe exchange had given him the chance to do something practical and show that he was:

not just here to listen to problems and police scripts (Interview 10)

(ie counsel, supervise and monitor clients receiving substitute prescriptions), an unselfconsciously cynical description of the nurse's role in a psychiatrically orientated drugs service.

Other nurses said that they had always assumed that syringe exchange would involve primary health care and health education, an assumption not always shared by managers and others around them, for example:

I took it for granted that we would be getting involved in primary health care ... other people involved, I think, regarded syringe exchange schemes as being something that just meant dishing out works to people. (Interview 14)

It was this re-orientation of aims, from attending to the minds of drug users to trying to prevent physical harm from coming to their bodies, which enabled staff to do things which would have been unthinkable a few years previously, if not for these particular individuals, then for workers in the drugs field generally.

Again, workers in Scotland were more conscious of this. One nurse described his personal experience of this re-orientation like this:

You know it's quite difficult to sit and discuss with an addict which vein they should be hitting and say 'you have got a phlebitis there, lets not inject using the larger needle, lets go for smaller veins and use the diabetic needle'. It's quite a hard thing to do. (Interview 09)

All workers interviewed saw their task as risk reduction, and most said they also had the wider aim of harm minimisation. This emphasis on harm minimisation, with its acceptance that people were going to continue injecting, had for several workers raised the question of substitute prescribing of injectable drugs. Once the step away from syringe exchange as purely an HIV risk reduction measure had been taken, workers began to talk about the contradiction of giving people clean equipment with which to inject 'dirty' drugs.

This is a line of argument which was being put very forcibly in the field by staff of the services in Liverpool. Within the interviews, the argument was expressed most clearly by this worker:

What we try to provide here is a harm minimisation service, in addition to risk reduction, such as safe injecting and all the rest of it. Now we feel that although it is useful to be able to teach people to inject more safely, it's much better to be able to give people appropriate prescriptions that would also reduce the physical complications of using ... [Some people think that] needle exchange schemes is *the* tool to assist people in preventing them from becoming [HIV] positive; what we need to do is to illustrate that it is just *a* tool, part of a package, that flexible prescribing needs to be incorporated, not just for people who are positive, but to attract people into services. (Interview 14)

Most of the other workers who talked about prescribing did so in terms of it being an 'issue for future discussion', as one person put it. There was a feeling of a debate which had been submerged for several years and which was now emerging. Only one person described himself as not in favour of more flexible prescribing, in the context of the agency where he worked. This was a service which served a largely rural population where drug supplies were sporadic and users consequently were not regular injectors. To

prescribe injectables would, he felt, risk creating a regular supply where none at present existed.

The task, then, was seen as improving the physical health of clients by giving the information and means necessary for choices to be made about both HIV and other health risks. In all the English exchanges, staff talked about this aspect of their work as a natural development of their previous orientation, but one which HIV had accentuated.

4. The relationship

As I have tried to show, what stood behind the work of syringe exchange was the concept of the drug user as a rational actor, with the right and ability to make choices about his or her own health and body, based on information and knowledge. In this construction, drugs services should not be agents of control but enablers or facilitators, empowering drug users with both knowledge and means.

The issue of the sort of behaviour expected of clients, the question of what, if any, rules were applied to clients' behaviour, how these were communicated to clients and what sanctions existed for the breaking of these rules, was explored at interview. The most striking feature of the exchanges in this respect was the reported lack of conflict and the absence of explicitly stated rules of behaviour. Indeed, most of the exchanges seem to have had more detailed rules of behaviour for staff than for clients.

The emphasis was on the normality of relations with clients: treating them as 'ordinary people' and expecting 'reasonable', ordinary behaviour from them. Even where explicit rules had been thought necessary (about dealing or using drugs on the premises, and outlawing sexist, racist or otherwise offensive behaviour), it was stressed that they had been framed with and were supported by the majority of clients at the particular exchange.

A worker at one of the busiest exchanges argued that:

There shouldn't be that many rules that you need to enforce, beyond no dealing or using ... the more rules you make, the more problems you run into because then you have got to enforce the rules. You have also got to ask for whose benefit the rules are in place. (Interview 03)

The 'no using or dealing' rule was quoted in most exchanges, although one worker commented that the rule about using on the premises

seems a bit silly to me, but on the other hand they understand the rationale behind that, that we cannot have bodies in toilets. (Interview 11)

One worker's comment summed up most responses:

I would expect normal behaviour, responsible behaviour. (Interview 16)

'Normal behaviour' could mean that clients had to accept some limits. Staff at two exchanges said that there were times when they were just not available to see clients, and clients had to be patient.

Another element of the relationship mentioned was the degree of honesty between staff and clients. This was particularly commented on in agencies where methadone prescribing was also offered. As one worker said in relation to their other work:

They know what they have to say in order to get what they want, and we want to hear it, so we hear it. Whereas now it is so much more honest. (Interview 11)

This honesty, it was felt, added credibility to their work:

They can see that we're not just here to get people off drugs ... that we are ready to work with them whether they are using or whether they are not. (Interview 13)

A lot of them have sighed a big sigh of relief that there has been a place that they can come to without fear of being lectured or having the finger pointed at them. (Interview 04)

The relationship was not a didactic or punitive one, which it seemed to be felt were part of other professional/client relations, but a more equal one:

responding to what the users bring to us, not defining what they have to bring (Interview 03)

attempting to gain a person's confidence, to become more of a friend and counsellor to them (Interview 09)

having a non-judgemental approach, making people feel easy about being here (Interview 14)

were all ways workers characterised the relationship they tried to establish with clients.

5. The site

There was an emphasis on the importance of the exchanges not being seen as part of an institution, a hospital or a clinic for example, and of the need for them to be 'accessible' and 'non-stigmatising'. In practice, this had proved difficult in several cases, as the only available space had been on health service premises, and this was cited as a reason for low attendance by some of the smaller exchanges. What had been possible, and has been discussed above, was the distance put between the syringe exchanges and the more traditional Clinics, where these were the 'parent service'.

'Outreach work' was given as a very important area for exchanges to develop in future, when staff were asked about their plans, and this seems to reflect the ideal of the de-institutionalised service, although at the time of the interviews it had not developed very much.

The responsible drug user

So, from the interviews there emerges a model for the response to HIV within drugs services. It is a response grounded in the individual actor's responsibility for his or her own body. The actor is 'normalised' and assumed to be capable of rational sensible choices, with the role of health professionals being to give information and advice about those choices; to act as health educators and health promoters. This has to be contrasted with the response within drugs policy twenty years previously, in the 1960s, in response to what was also perceived as an epidemic. Then drug use was constructed as the socially infectious condition of addiction, and medically dominated policy went the route of the public health measures of notifications and specialist services. Here drug use is constructed as a choice made by a free actor, who can therefore make rational decisions about their health.

The theoretical discussion of twentieth century discourse on health provides a framework for understanding this (Chapter One). We can understand the syringe exchanges in terms of *management of the self*: if drug use is constructed as a behaviour which may lead to harm (including HIV), but not as a disease in its own right, then the individual drug user

is responsible for his/her own choices and actions in relation to that. The role of services is guidance in relation to that self management.

The official discourse

Returning to the ACMD report, I now want to analyse it in a similar way, demonstrating its role as a major encoding of the ideas of harm minimisation within the broader framework of what it was possible to say about drug use in the official discourse.

1. The speaker

Earlier I argued that within the interviews that represented the presentation of syringe exchange and harm minimisation, the voice of doctors and specifically that of psychiatrists was absent. What I argue here is that the published report of the ACMD's working group on AIDS and Drugs Misuse is a point of re-entry for medicine to the discourse surrounding drug use, but that this was a medicine of the body as much as a medicine of the mind.

Half the membership, seven out of fourteen, of the AIDS and Drugs Misuse working group were doctors: four consultant psychiatrists, one specialist in genito-urinary medicine, one specialist in infectious diseases, and one general practitioner. This was a higher proportion of members who were doctors than there had been on the two previous ACMD working groups: four doctors (three psychiatrists) out of eighteen members of the Prevention working group, and seven (four psychiatrists) out of sixteen members of the Treatment and Rehabilitation working group. The Chair of the AIDS and Drugs Misuse group, Ruth Runciman, was not a doctor, but was from an advice work background.

2. The object

AIDS and Drugs Misuse Part 1 built on the structure of services outlined in *Treatment and Rehabilitation* (ACMD 1982), recommending further expansion of community based, multidisciplinary services, backed by good links to specialist services and hospital facilities, and including general practitioners as an important element of frontline intervention (ACMD 1988:28-32 and Annex C). However, the report widened the definition of those whom services should seek to address, reconstructing the object of the problem drug taker. The risk of HIV transmission had broadened the definition of 'problem' drug use to the point where it included almost any drug user, unlike 'problem

drug taking' which implied that drug taking per se might not, or at least not yet for any individual, carry problems.

The advent of HIV requires an expansion of our definition of problem drug use to include any form of drug misuse which involves or may lead to, the sharing of injecting equipment. This in turn means that services must now make contact with as many of the hidden population of drug misusers as possible. (ACMD 1988:para 4.3)

So while under the earlier definition services had been able to focus on serving drug users who saw themselves as having problems, whether health related, legal or financial:

In addition to [services'] present role of providing services to 'problem' drug misusers it is now essential that they should reach drug misusers who do not perceive themselves as having a drug problem. (ACMD 1988:para 4.8)

This idea was present in the way syringe exchange staff talked, as I discuss above. However, in the interviews there was an insistence on the difference between those problems which drug users might well have brought to services anyway, and the new and specific problem of HIV risk which could be dealt with by the practical means of obtaining and using sterile equipment. Where this distinction had begun to blur, it was between HIV risk and other physical problems, in the identification of harm minimisation with health related advice and, in a few exchanges, with the provision of primary health care. Where the object of the ACMD report differed from that of syringe exchange staff was in the need to also consider the wider population in terms of HIV risk. This had effects on the definition of what I earlier called the task of services in relation to the drug user.

Before turning to this, it is also important to discuss the use of the term 'drug misuse'. *Treatment and Rehabilitation*, by using the term '*problem drugtaker*' had explicitly avoided the other available terms for describing drug use. However, the later report, *Prevention*, had employed 'misuse', and this was in the terms of reference of the ACMD. *AIDS and Drug Misuse Part 1* used the term 'misuse' throughout, except when referring to the specific act of consumption. 'Misuse' had become the official term; all DHSS and DoH circulars employed this construction, and the ACMD's reports were drafted by the same civil servants. The 'truths' about drug use and the constructs of harm minimisation

produced in the field, in frontline services, were reconstructed in the official discourse. Some things that it was possible for staff in the syringe exchanges to say, could not be repeated by the civil servants and the members of the ACMD working group speaking to a different audience.

3. The task

The ACMD report outlined what it saw as four principles upon which the response to HIV should be based. Firstly:

the spread of HIV is a greater danger to individual and public health than drug misuse. Accordingly, services which aim to minimise HIV risk behaviour by all available means should take precedence in development plans. (para 2.1)

This echoed the words of the McClelland Report, and the construction of HIV as an emergency and a crisis that was present in the House of Commons debate. The second principle was a statement of the basis of harm minimisation. Accepting that drug users were going to continue to use drugs and to inject them, the report argued that:

We must therefore be prepared to work with those who continue to misuse drugs to help them reduce the risks involved in doing so, above all the risk of acquiring or spreading HIV. (para 2.2)

This work involved a range of approaches. Rather than the single goal of abstinence, with all other measures simply steps towards that goal, the report outlined a *hierarchy of goals*. These were given as:

- a. becoming drug free
 - b. switching from injecting to oral use
 - c. avoiding sharing equipment.
- (ACMD 1988:para 5.2)

Steps along the way, any change which moved drug users from one level of risk to a lower level, were valid outcomes in their own right, and there should be 'a readiness to work initially towards goals which fall short of abstinence' (para 2.2).

The third principle the report identified was the need to make contact with the hidden population of drug users who were not visible to services. In Chapter Two, I outlined

how both academic and policy research had mapped an epidemic of use that was not visible to the means of surveillance that relied on drug users presenting to services. The new construction of all drug use as potentially risky made it an imperative that this hidden body of people be exposed to health education advice to persuade and enable them to change their behaviour.

Personal contact with drug services was seen as the best setting for this (para 2.4), but acknowledging that there would always be some people who did not come to services, the report argued for the sale of injecting equipment and the provision of means of disposal through community pharmacists (para 5.17), and for national and local education campaigns (para 5.27).

Finally, the report argued that:

prevention of drug misuse is now more important than ever before and in the longer run the success or failure of efforts to prevent young people from embarking on a career of drug misuse will have a major effect on our ability to contain the spread of HIV. (para 2.5)

This summed up a dilemma inherent in the overall policy of harm minimisation, and echoed the earlier report on *Prevention* (ACMD 1982). What is the appropriate balance of attention between harm minimisation for those already injecting drugs, and the prevention of new recruits to the drug injecting population? It was not known what impact making injecting equipment more easily available would have on the numbers injecting. If increased availability of injecting equipment did have the effect of increasing the numbers injecting, then even if the average level of risk behaviour was reduced, the numbers at risk would go up, and the aggregate result might actually be a wider spread of HIV (Shaw 1987). Unlike the talk of the staff of the syringe exchanges, the object of which was the existing local populations of drug users, the ACMD report looked to this wider potential population, and so prevention of drug use was one of the tasks of the response to HIV.

The report dealt at some length with the issue of substitute prescribing, arguing for the use of more flexible prescribing (of oral drugs) as both a means of attracting users to services, and as a tool in enabling and supporting change towards less risky behaviours.

4. The relationship

The relationship between services and users implicit in the ACMD report is a very similar one to that described by syringe exchange staff. The imperative of contacting the hidden population of drug users meant that a change in attitude was needed in some drug services, and in wider, generic services, to make them more accessible. The need for 'sympathetic, non-judgemental staff' was stressed (para 4.6), whose role was to enable and support change, by giving advice, information and the practical means to change.

5. The site

Similarly, the report echoed the need for the site of frontline services to be accessible and non-institutional, in particular away from hospitals. In the model of community based services described in the report, town centre premises, existing advice centres or health centres, or a flat or house on a 'problem' estate are all suggested as possible bases for services. Mobile units were suggested, particularly for rural areas. Finally, outreach was recommended, although, as in the interviews, there was at this time comparatively little experience within UK drug services on which to draw (Annex C).

The effect of the ACMD report

The report put into wider circulation many of the terms that characterised the harm minimisation approach: the primacy of the dangers of HIV, the hierarchy of goals for services to aim at, the importance of reaching the hidden drug user. As outlined earlier in this chapter, by the Autumn of 1988 its acceptance by ministers, along with the evidence from the evaluation, was informing the language of government circulars. The report was used by workers in the field, in frontline statutory services, to justify service developments that their immediate, non-specialist managers might not have agreed to. The non-statutory sector also used the language and recommendations of the report in bids for funding. Syringe exchange as a practice had received its official endorsement.

The diffusion of the practice of syringe exchange

Between February and April 1989, I carried out a postal survey of organisations running syringe exchanges in England. The object was to track the spread of the practice, map the extent of that spread and establish the characteristics of syringe exchange, two years after the first schemes had started. The survey identified 55 schemes operating at that

time. By the end of 1989, from updating the contacts of the MRG, it was estimated that there were 120 syringe exchanges operating in England (Lart and Stimson 1990).

The majority (two-thirds) of the syringe exchanges identified by the survey had started operating before the DoH guidelines issued in August 1988 (DoH 1988) and the extra £3 million allocated. However, about two-thirds had received some additional funding, mainly from the earlier regional and district allocations.

Compared to the pilots, there had been a change in the pattern of services operating syringe exchanges. Although the majority (42) were still drugs agencies, there had been a significant development of pharmacy based schemes (8) and a new siting of syringe exchange in other health settings: one in a health centre, run by a health promotion unit, one in a genito-urinary medicine clinic and one in a primary health care project for homeless people. The model which had not developed was that of the 'stand alone' scheme; there were no new examples of this, beyond the two that had been pilot schemes. What the survey revealed was certainly the spread of syringe exchange through the network of drug agencies, but also some diffusion into generic settings.

There had also been a spread outwith the NHS. Notably, there were as many voluntary sector drug agencies offering syringe exchange as NHS agencies, and local authorities had begun to be involved, collaborating with pharmacies and contributing to the running of drug agencies.

The importance of nurses in the exchanges was less marked in the survey than it had been in the pilots; approximately a third of the people involved in running exchanges were nurses (of whom half were registered mental nurses, a quarter were registered general nurses, and a further quarter held both qualifications). However, not all of these were employed formally as nurses, reflecting the growth of voluntary sector involvement. Another third were 'drugs workers', with a range of experience: social work, youth work, community work and personal experience of illicit drug use. The final third had specific roles within their project: either a substantive area of work (eg 'family support worker'), or an administrative/clerical post. Within the pharmacy based schemes, actual exchanges were done by qualified pharmacists, in accordance with professional guidelines (Royal Pharmaceutical Society 1989), but support and coordination was provided by a range of agencies: drug services, local authority environmental health departments and, in one case, a health authority community medicine department.

The numbers of clients seen each week ranged from less than 5 to 150, with a mean for the drug agencies of 21. The stand alone agencies were seeing 68 and 80 people a week respectively, while the pharmacy schemes saw between 10 and 100 per week. Most schemes operated an exchange policy based on an idea of 7 syringes a week as a reasonable amount to issue, and two weeks' supply, or 14 syringes, as a total amount to be given to a client on any one visit. From this and the weekly average number of clients, I calculated that the syringe exchanges in the survey would in total issue just under one million syringes in a year. Taking the ACMD's estimate that there were probably between 37,000 and 75,000 injecting drug users in the UK as a whole at that time (ACMD 1988), for each of these to have one clean syringe a day would require the distribution of between 13.5 and 27 million syringes annually. A survey of community pharmacists carried out at about the same time suggested a figure of two million syringes for annual sales through retail pharmacists (Glanz et al 1989). While syringe exchange had spread rapidly, there was clearly a need for further expansion.

The survey demonstrated the existence of two distinct models of the practice of syringe exchange, one with a public health orientation, and one with a prime focus on the individual. While these two models of practice were not necessarily in conflict or competing, they were based on different perceptions of the purpose of syringe exchange, and the object of intervention.

Pharmacy based schemes reported characteristics that suggested that they were noticeably more anonymous and accessible. None of them required 'proof' of injecting in the form of physical signs. In several of them, once a user had made the initial approach, they would be issued with a card which was all they had to produce in future, and equipment was issued in pre-packed paper bags. The whole transaction could look very much like the presenting and dispensing of a normal prescription. However, these schemes were limited in what else they reported being able to offer, other than the usual knowledge and advice of the pharmacists, and information about other agencies. McKeganey and Barnard (1992) provide interesting qualitative data about the operation of one particular pharmacy scheme in Glasgow, confirming the importance of the ease of access that locating syringe exchange within a retail pharmacist provides. They also discuss the way that the pharmacy they studied had extended the range of physical attention available, offering sterile dressings and non-prescription medications for the treatment of abscesses, for example. The limitations on action which went beyond the 'norms' of a pharmacy setting are also discussed in McKeganey and Barnard's paper.

By contrast, the drug agency based schemes reported that counselling and advice about drug use, pre and post HIV test counselling and other forms of advice were available. A wider range of services, focussed on the individual were available, but drug agencies presented more barriers in terms of access. The hours they were open were more limited, they were identifiable as services for drug users, and at half of them physical proof of injecting was required.

Summary

By the end of 1989, syringe exchange was widely diffused. In the space of three years, the practice of frontline drugs services in England and the official discourse of drugs policy had changed. However, this change had been 'bottom up'; syringe exchange emerged in the new discursive space opened up by the *Treatment and Rehabilitation* report and the development of new sites for practice that followed, supported by the Central Funding Initiative. From the construction of the 'problem drug taker' emerged the 'responsible drug user', to whom services could give guidance and practical means for the management of the self.

CHAPTER FOUR: DESCRIBING THE THREE PROJECTS

Introduction

This and the following two chapters (Chapters Five and Six) are based on field work in three relatively large and well-established syringe exchange schemes, two in voluntary sector projects (projects A and B) and one a 'stand-alone' NHS facility (project C). The three were originally chosen to tie in with further research by the Monitoring Research Group on the impact of syringe exchange schemes on injecting drug users' behaviour, and were the sites for recruitment of cohorts of clients for that work (Dolan et al 1992).

This chapter provides factual descriptions of the three projects: their histories, locations and staffing, and the next three explore the two key themes I have drawn from the analysis of power presented in Chapter One: the interrelationship of discourse and practice, and the importance of examining the local exercise of power.

A much more detailed analysis of the idea of harm minimisation and its practice was possible in this fieldwork, and in Chapter Five I draw this out, suggesting that the projects varied in the way they constructed the object of their work, the drug user, and therefore their task and the focus for that task. Taking up the themes of 'care of the body' and 'self-knowledge' as means of self management (Foucault 1988a), I argue that both these were visible in the way the projects worked. All three were engaged in producing the 'self managing drug user' (though I will argue that this was qualified in some respects in the case of project C). My argument here is that staff at project A sought to do this by constituting the drug user as a body, and by encouraging the individual to take care of that embodied self, while at project B staff constituted the drug user as a mind, and encouraged self knowledge and reflective speech. Staff at project C employed a mixture of these approaches, although weighted towards a construction of the drug user as a body.

Chapter Five then explores the issue of the exercise of power within the projects, looking at the notions of surveillance and resistance in the professional/client relationship. This exercise of power had two dimensions; power over what clients did within the project and power over their drug using behaviour away from the project. I discuss the strategies used to exercise that power and some of the ways clients could and did resist. This chapter draws on Bloor and McIntosh's work to identify typologies of surveillance and resistance (1990).

Finally Chapter Six examines the nature of the projects themselves as sites. I have defined them in terms of 'openness' and 'closure', looking at dimensions such as the strategies used to exercise power and counteract resistance, the nature and use of space, and the concern for boundaries both within the project and in their relationships to other agencies. I argue that projects A and B lay at opposite ends of a spectrum of closure and openness. Project A I have characterised as enclosed, clearly delineated and with a concern for boundaries and control. Project B, I characterise as open, with fluid boundaries and a diffused coherence. Project C, I would place somewhere towards the closed end of the spectrum, but with less of a concern for control.

The rest of this chapter consists of straightforward descriptions of the three projects, to orientate the reader and set the scene for the material presented in the following chapters.

Project A

The building

Project A was housed in a two-storey brick building just off a main road in South London, between a police car pound and a railway bridge. The area was well served by buses, and was a few minutes' walk from a tube station. Externally, the project appeared like any other office building. The front window was screened off with a blind, and the front door was solid. Handwritten notices on the window identified it as the drug project, with details of opening times, and stressing that the project was drop-in and that appointments were not necessary.

The front door was kept shut, even during the drop-in times, and clients had to knock. The door was opened by whoever was nearest, usually a member of staff, but other clients did open it if they were nearer. The door opened straight into the main room, the front part of which was divided lengthways by a counter. Behind the counter there was a long desk with telephones and a word processor, and behind this a notice board the length of the room covered in large pieces of paper with telephone numbers and addresses of a huge range of services, both drugs specialist and others. The back part of the room was open with two low sofas. Behind this room was a staircase, and beyond this was the needle exchange room and a narrow kitchen area with, right at the back, the clients' toilet.

The needle exchange room had been carved out of the kitchen area and so was internal, with no windows but a glass panel above the door. At one end was a desk

with looseleaf folders holding the paperwork for the exchange and shelves above with boxes of equipment. Yellow 'Cin Bins' stood on the floor by the door for disposal of equipment. Although, as discussed later, some basic first aid type health care was done, there was no couch and no sink. One of the workers' bicycles stood at the far end of the room, surrounded by boxes of equipment. Three low chairs completed the furniture.

Upstairs there were two counselling rooms, each with armchairs and a coffee table, the staff toilet and the administration office. This last was a big, square airy room with large windows, the size of the main room downstairs. All members of staff had a desk in here, there were filing cabinets and a noticeboard full of memos, information leaflets and posters.

The project's history

The project was a voluntary sector advice and information service that had existed since the late 1960s. Sited where it was in South London, it served an area that fell within the catchment areas of three Clinics, one a regional and national centre. Over time the project had undergone several changes in style and focus, the last following the arrival of the current director, Tom, in early 1987.

The model of service in place in 1989 was a building based service, targeting 'high use/high risk' drug users: those using large amounts of illegal drugs, especially if they were injecting and if there were other factors, like homelessness, which amplified the effects on their health. Initially the changes in service delivery involved the project being open on a drop-in basis, as well as for appointments, and with an emphasis on practical aspects of health and of reducing harm in the advice given to clients.

However, in spite of this emphasis on health and harm reduction, the project, or rather the director, was cautious about starting a syringe exchange. The specific concerns were the issue of return rates for equipment and questions about public safety and worries about discarded equipment. There was also concern that if a scheme was successful in attracting new clients, the project's staffing at the time (just three full-time workers) would not be adequate to deal with demand.

The project was not, therefore, among the pilot syringe exchange schemes. The scheme started as a disposal point, rather than an exchange; the project provided a sharps box where clients could leave equipment safely, and issued 'receipts' for people to take to their normal exchange to prove they had disposed of the equipment safely. The distribution of equipment was introduced initially as a response to a request for

help from one of the central London exchanges, who shared many clients with the project and were experiencing severe staff shortages for a time. The project then tried running a scheme in their own right, as a pilot measure, opening in January 1988, and monitoring attendance and return of equipment very closely. After six months' operation the project asked for regional health authority funding for the cost of supplies and for an extra drugs worker, which was forthcoming for one year starting in March 1989.

During 1988/9, the project's staffing had increased to five; the director, Tom, a part-time administrator/finance worker, Alison, and two generic drugs workers, Jill and Dave, plus this new post. Immediately before the fieldwork period, Dave, the last remaining member of the team that Tom had taken over, had left and Fiona had taken his place. The new post, created in 1989, was titled 'health and harm reduction worker', and held responsibility for the operation of the syringe exchange. The worker appointed, Adam, was an experienced registered general nurse (RGN) although he was not formally employed as a nurse. Although all the drugs workers carried out exchanges when necessary, requests were usually referred to him and most clients approached him when wanting to exchange. The other workers had all worked in other voluntary sector drugs projects; in the director's case his career in the drugs field went back to 1978, by far the longest involvement of anyone at the three schemes.

Various other people also came into the project to provide services. The HIV/outreach worker from the local community drugs team, who had been involved in planning the exchange, dealt with supplies of equipment and was present for two sessions a week. A female doctor (senior registrar) from the community drugs team also attended the project for a session a week to provide primary health care services. An adviser from Release had just started attending for an afternoon each week, offering legal advice.

Time

Staff worked from 10.00am to 6.00pm, with an hour for lunch. The mornings (10.00am - 1.00pm) were described as 'worker controlled time', while the afternoons were drop-in time, with the needle exchange available. Two mornings a week were taken up with staff meetings; on the other days staff saw clients by appointment, did paperwork, made phone calls and visits and attended outside meetings. The exchange was available during the mornings when staff were free, otherwise, if clients came to the project in the morning without an appointment, it was up to individual workers to decide whether to see them or tell them to come back during the drop-in time.

During the drop-in, the health and harm reduction worker was available all the time, and other staff took it in turns to be 'on duty' in the drop in. The project had just started opening between 6.00pm - 8.00pm one evening a week just for syringe exchange, staffed by the health and harm reduction worker and the CDT outreach worker.

Meetings

Every day ended with a handover meeting. A brief running record was kept throughout the day in a day book of everybody who came to the project and of all telephone calls, whether clients, visitors or other professionals. This provided the framework for the handover, which involved a quick discussion of everything that had happened during the day. This gave the whole staff team an overview of what had gone on and some background on all clients. Some days there was time for more leisurely discussion, for example on the day the outreach worker was present issues were discussed in more depth, but on the whole the aim was a brief and efficient transmission of information, to close the day.

Two other meetings were held each week, one to discuss administrative and staff oriented concerns like training and attendance at conferences, and one to discuss clients. This last demonstrated the very strict definitions and frameworks the project worked to; a structured system of filing was adhered to, with all clients seen in the last two weeks regarded as the 'live' caseload and their files kept in one place. At the meeting all these files were looked at and if the person had not been into the project in the previous two weeks the file was moved to another filing cabinet. If they had been in, they were discussed. A list of every client who had been recorded in the day book over the previous fortnight was used as a checklist, and at the end any names on this without active files were discussed. In most cases they were people with previous contact and so their files were reopened; otherwise they were given a new file. Files that were not 'live' were kept for two years after the last time the person was seen and then destroyed. At a meeting observed during fieldwork, the 'live' caseload the previous week had been 130, this was reduced to 103, 30 cases were removed and three new ones opened.

Behaviour and rules

Space at this project, particularly in the drop-in area, was limited. This area was constantly in the view of staff at the desk or crossing to go into the needle exchange room or upstairs, and was often very crowded. In particular, there were several women with small children who used the project and there were often pushchairs and

toddlers in this area. Clients would come in and make use of the needle exchange, the phones or perhaps the kitchen – to heat up a baby's bottle for example. Often other than a fairly brief exchange with one of the workers, they would just get on and do whatever it was they had come in for and leave again. Although people could stay in the drop-in for long periods, on the whole there was a fairly quick throughput of clients.

A feature of the pilot syringe exchanges as a whole was the apparent lack of friction or difficult behaviour on the part of clients. However, projects B and C in this study had been the only two among the pilots with explicit rules, prominently displayed. In contrast to the concerns of the other two projects, client behaviour was much less of an issue at project A. There were rules, no violence including sexual or racial harassment, and no dealing or using on the premises, but these were not displayed publicly. The project did not ban people, even for violence, as this would 'take away responsibility'. Instead the sanction used was to allow people in for 'appointments only'. They would not be allowed to stay in the drop-in. On the whole staff reported feeling 'harassed', but more by the pace of work and the demands of clients than by any unpleasant behaviour. Although there were no rules displayed, the basic one of no drug use on the premises was understood and was enforced one afternoon during the fieldwork, by locking the clients' toilet, because people were believed to be smoking drugs in there. Staff had 'no qualms' about this; there was a public toilet opposite the building that people could use.

Project B

The building

This project was located in the centre of a major provincial city in the West Country. It was housed in a tall and rather rambling building down a lane off a main thoroughfare, well served by bus routes and very easy to reach. A sign with the name of the project and a telephone number was visible from the main road. The building was shared with the local branch of Shelter, and until very recently had also housed a local AIDS charity. The front door had an intercom, and during drop-in times was opened by the workers on duty. At other times a caller had to announce themselves by the intercom to be allowed in.

The front door opened into a stairwell. Through this on the ground floor was a very large room used as the drop in. At the front of the room was a glassed in cubicle used for times when clients at the drop-in wanted to talk more privately, and a desk with a phone. Towards the back of the room was an area with old sofas and armchairs, a

coffee table and a trolley with a kettle, coffee and tea. This end of the room was quite far from the windows and was dependent on artificial light. The needle exchange was in a small room which opened off this area. As at project A, this room was internal, in this case with no natural light or ventilation. It contained a desk, several chairs and a wooden cupboard where the equipment was kept. When this was shut, the equipment was not visible and only the yellow Cin Bin on the floor suggested that this was not just a normal counselling room. The paperwork for the exchange was kept in looseleaf files on the desk.

Beyond the drop-in room was another large room with no windows but a glassed in roof, like a somewhat gloomy greenhouse. This led to two rooms at the front of the building, one the children's playroom and the other a room used by another organisation. Also through here were the clients' toilets, another flight of stairs and an entrance that was kept locked.

The first floor contained the offices of Shelter, and rooms previously used by the AIDS trust, along with two counselling rooms, with armchairs and coffee tables. The top floor contained five large rooms used for staff offices, and a further room used as a 'resources room', where books and leaflets were kept.

The most obvious comparison with the other two projects is the sheer amount of space this project had. But it is also important to convey the very strange nature of the premises, rooms opening off rooms, odd levels, peculiar arrangements of windows and light. Whereas both other projects had very limited, compact space, this building seemed to ramble; it was several days before I discovered the second staircase, for example. A lot of it was fairly shabby, an exception was the children's room which had been painted in bright fresh colours. The space was shared with other organisations, in a jumbled up, slightly haphazard way.

The project's history

The project was a voluntary sector advice and information service, started in 1986 with Central Funding Initiative money. The initiative for the project had come from a group of probation officers, disillusioned by the almost complete lack of resources for people with drug problems in the City. The initial team were: the coordinator (Jennie), administrator (Christine) and two project workers (Sarah and Peter). A third project worker (Pan), with a remit to work with ethnic minorities, was appointed in January 1987, and a few months later a part-time child care worker was appointed, but this was not a success as the remit of the job was unclear and the postholder found it difficult to be part of the team when she was not there full-time. Eventually she left

and was replaced in summer 1988 by a full-time worker with the title family support worker (Louisa). This was the team when fieldwork started, but during this time an outreach worker for the syringe exchange (Bill) was appointed, although he did not start work for some weeks.

The project aimed to work with people who had problems with the whole range of drugs: solvents, prescribed drugs like benzodiazepines and over the counter medicines, as well as illicit drugs. When the project started, the only other specialist service in the city was another CFI funded project, a small research project offering methadone prescribing and group therapy, which was coming to an end. A lot of the project's initial work had been in encouraging the growth of other services for drug users. One important aspect of this was working with general practitioners, using a form of contract, whereby the GPs prescribed for drug users and the project provided counselling and support. The project had also put a lot of effort into setting up small weekly sessions on some of the peripheral estates of the city and elsewhere, particularly for women with children, and into providing a service within two local prisons: both groupwork and some individual work for prisoners. Another area of work which had been significant at the beginning was with people experiencing problems with prescribed tranquillisers. Before running the syringe exchange, the project had only been open as a drop-in one afternoon a week, and the building had served as a base for these wider activities.

However, after the syringe exchange began operating as one of the pilot schemes in July 1987, there was a fairly dramatic change in the way the project worked. In order to offer syringe exchange five days a week, a decision to run the drop-in every afternoon had been made. This meant that two workers were on duty for each session, and so the project became much more focussed on the building. Much of the wider, developmental work was curtailed. Similarly the work with tranquilliser users became much less important as the project attracted more injecting drug users.

Another change which had an important impact on the project was the development by the health authority of a drug problem team. A well known consultant psychiatrist was appointed as regional specialist in 1988, with a remit to build up a Drug Problem Team (DPT) at district level. The project had a close working relationship with the drug problem team, although at times this was with somewhat mixed feelings. At the time of the fieldwork, the DPT was about to set up a low threshold methadone prescribing clinic in the centre of the city and the project was to contribute to the counselling and social work support of this clinic, by the attachment of two of the project workers, each half time. This was not a move that was really welcomed by

the project, but was one they felt they could not resist; by this time the CFI funding had ended, and for the first year after this local funding had come mainly from the health authority, because the county had not agreed to joint finance. The alternative to the attachment of a full-time equivalent worker to the clinic would have been a redundancy within the team. It was felt that a preferable option would have been for one person to move full-time, but none of the workers wanted to do this, and so a compromise was reached whereby the two male project workers, Pan and Peter, would share the post.

The converse of this was that for the previous year, the senior nurse from the DPT, Celia, had been attending the drop-in one afternoon a week to give health advice to clients.

Time

Staff worked from 9.30am to 5.30pm, with an hour for lunch. As at project A, the mornings were taken up with meetings, paperwork, phone calls. Staff worked a rota for answering the phones, as advice and information by phone was an important part of their work. Clients were seen by appointment in the mornings. The drop-in and needle exchange were open between 2.00pm and 5.00pm every weekday. The project was also open as a drop-in one evening a week from 6.00pm to 8.00pm, but the needle exchange was not open then. During the fieldwork, the family support worker was planning a 'women's morning' each week, when the drop-in and needle exchange would be available. She had used a questionnaire with women clients and their friends to get views on what sort of service women would like, and had obtained funding for creche workers from the city council women's unit.

Meetings

There was no daily meeting at this project. Two meetings were held weekly: the staff meeting and the 'callers' meeting. The staff meeting opened with an hour of 'staff support'; each member of the team was given equal time to talk about themselves, and any worries or anxieties, or any good things which might have happened in or out of work and which they wanted to share. The rest of this meeting was about administrative and operational issues to do with the running of the project. The 'callers meeting' was about client centred work. The pattern was for staff to talk about particular clients and their work with them, rather than for all clients to be routinely discussed. All contacts would have had some basic information recorded on them, but the worker involved with each person made decisions about when it was appropriate to open a more extensive file, when to close that file, and when to discuss

the client with colleagues. So, for example, in contrast to the equivalent meeting at project A, where over a hundred names were mentioned and a brief discussion held about most of them, thirteen clients were discussed in the meeting observed at project B, most in depth.

Behaviour and rules

The enormous amount of space that this project had, and its arrangement, meant that the drop-in area was a distinct space and not a throughfare. There was a feeling of the drop-in being an event, of something deliberate happening. The two staff who were on duty each day stayed in the drop-in or the needle exchange for the whole afternoon, and other staff would come in and sit down to talk with clients for periods when free. Many clients stayed for the whole afternoon. One particular feature was the number of dogs clients brought into the project; a significant number of clients were homeless or living in squats and other temporary accommodation, or travelling, and many of them had dogs as companions – there were two, sometimes three dogs every day in the drop-in.

This project had rules displayed on the wall of the drop-in. These were: no using or dealing in drugs (including alcohol) on the premises, and no violent, racist, sexist or otherwise abusive behaviour towards other clients or staff. The mood and behaviour of clients in the drop-in seemed to vary enormously at this scheme; staff spent a great deal of time amongst themselves and at interview discussing the issue.

Project C

The building

This project was located in ground floor shopfront premises in a street beside a large teaching hospital in London's West End. The shopfront had once been the surgical appliance store for the hospital, and so was designed for easy access by members of the public. From the street, the building presented screened off windows and a door, with a opening times displayed but nothing specifically announcing its function. The other floors of the building were occupied by offices of other health staff, dieticians for example, and were reached by a separate entrance with a coded lock. The door to the exchange itself was always kept locked; clients had to knock and be allowed in by a member of staff. Occasionally when all staff were busy other clients would open the door, but with an air to indicate that this was not the norm.

Inside the main area was a completely internal room, with a sink, a fridge and two rows of low, vinyl padded chairs. Coffee and tea making facilities (ie a kettle and

mugs) were available to clients here. The walls of this area were covered with posters and displays of information about drugs services and health issues. This was the 'drop-in' area; off it opened an office to the front, a clinical room to the back and a locked door to the staircase to the rest of the building. The injecting equipment was kept in a large, walk-in cupboard in this area, which staff sometimes called 'the box'. This was packed to the ceiling with boxes of needles, syringes, medicated swabs, ampoules of sterile water, condoms and sachets of lubricants. On the floor of the cupboard were several large yellow 'Cin Bins', for return of equipment. Looseleaf folders with the basic record keeping system for the exchange were kept on the shelf at waist height in the cupboard.

Unlike the drop-in area, the office and the clinical room both had windows. The office looked out onto the street, and contained a desk, phones, and more chairs. The clinical room at the back contained a sink, an examination couch and other paraphernalia like a dressings trolley, plastic boxes holding sterile packs, coloured plastic bags in metal holders to separate clinical waste from normal waste and to return re-sterilisable hospital equipment, a sphygmomanometer, scales and a height measurer. It was a reasonably well equipped treatment room where a range of procedures could take place, by sterile technique if necessary.

A store room in the basement was kept full of equipment, from which the box was restocked at intervals during the day. On this floor there were also toilets for the staff to use. Clients did not have access to any toilets in the building. There was also a large office on the first floor, for staff of the exchange, although in fact very little use was made of this.

The project's history

The exchange had started operation in March 1987, within the Accident and Emergency (A&E) department of one of the teaching hospitals within the health authority. It had been initiated by a nurse working as a clinical nurse specialist for drug and alcohol problems, within the A&E department. This nurse, Clare, remained with the project, being responsible for many of the initiatives and developments over the next three years, and by the time of the fieldwork was coordinator for the project, a managerial role. After running the exchange in A&E for a few months, she had put together a bid to the DHSS for funding as one of the pilot schemes, with help from a clinician from the local drugs services and an academic (a medical sociologist) from the medical school. When this was successful, the project underwent several changes. Staffing was increased to two full-time posts, drug and health education workers (DHEWs), one of which was filled by Clare, and the project moved, both physically

and managerially, out of the A&E department. Managerially, it became part of the Mental Health Unit and physically, a new home was found for it in the premises described above, in September 1987.

By the end of the pilot year, 1987/8, the health authority had agreed not only to continue funding the project, but to increase staffing to four DHEWs. By this time, the project was receiving on average 687 client visits per month – about 25 visits per working day (Hart et al 1989:128). Much of the work of the project related to physical care for clients, and staffing was not adequate to meet this. The health authority agreed to make the new posts specialist nursing posts. This decision coincided with the nurses' regrading exercise in 1988, and so there was a delay as the posts could not be advertised until that was settled. In the meantime, the project was staffed by the two DHEWs and two long-term temporary staff, working to the same job description.

The two new nursing posts were created and filled during 1989. They were a clinical nurse specialist (primary health care) and a clinical nurse specialist (mental health). The CNS (primary health care), Susan, started work in May 1989, and the CNS (mental health), John, in October 1989. At the beginning of that year Clare was appointed senior nurse coordinator for harm minimisation, which meant she was now a manager and had responsibility for both the exchange and for another project, the Health Improvement Team (HIT). The HIT was a primary health care service set up by the health authority to provide primary health care to drug users, but located away from the exchange, near to the Drug Dependency Unit of the authority. Her promotion left another vacancy in the basic team at the exchange, which was not filled permanently until January 1990. During the fieldwork, the project was staffed by Susan, the CNS (primary care), Polly, a DHEW, and two long-term relief staff, both nurses, one with a long and varied experience of working with drug users and one with no previous experience. The CNS (mental health), John, started work shortly afterwards, and so was interviewed with the other permanent staff.

My reason for going through the staffing changes was to illustrate several points. First is the lack of stability. Although Clare remained with the project throughout, the other original DHEW post was filled by three different people in the first twenty months, and for over a year the project was dependent on relief workers. When the new DHEW joined in January 1990, this meant that all four permanent members of staff (ie other than Clare) had started work within the previous year.

The other key change is that from generic drug worker posts to specialist nursing posts. Earlier (in Chapter Four), I identified the role that nurses played in all the

syringe exchanges, even when not necessarily formally employed as nurses. Here, a conscious decision had been made at the outset to employ people with experience rather than professional qualifications. However, because Clare herself was a nurse, even though initially employed as a DHEW, this meant there was always a nursing input to the project, and the primary health care side grew from that. After a year or so this was formalised into the CNS (primary health care) post, eventually filled in May 1989.

The other, perhaps more significant, move was the creation of the other specialist nursing post, that of CNS (mental health). Initially there had been a stress on the fact that drug users did not need more psychiatric services, and that the traditional siting of drug services within mental health meant that their physical health needs were unrecognised and unmet. Later, however, the need for some sort of mental health expertise was recognised and the CNS (mental health)post was created.

Implicit in the model of staffing described above is the fact that the exchange was, of course, much more than just a needle exchange. Although at the centre of what staff did was the distributing and receiving back for disposal of injecting equipment, they saw the project as much more than this, offering primary health care, and advice and information about other drugs services.

One afternoon a week a doctor (registrar) from the Health Improvement Team was present in the project offering primary health care.

Time

The hours worked at the project reflected its location within the NHS. Staff worked from 10.00am to 6.00pm, with only half an hour for lunch, and a further 15 minute tea break in the afternoon. This is very much a nurse's working day and was different to the norm in other projects.

The exchange opened to clients at 12.00. For three days a week clients could stay in the drop-in area for as long as they liked (and behaved according to the rules, discussed later). This many people did, staying several hours or even the entire afternoon. For the other two days the drop-in was not open; the chairs were piled up against the walls and the kettle put away.

Meetings

The day started with a 'handover' meeting, at which all one-to-one contacts, and any other salient points of the previous day were discussed. Clare usually attended this

meeting and outlined her movements for the day so that staff could contact her if necessary. The meeting was held in the drop-in area, and was interrupted frequently by telephone calls and the odd caller, on one occasion an elderly gentleman looking for the old surgical supplies store. Members of staff were often missing from the meeting; for example Susan was spending a morning a week in a family planning clinic as further training. During the fieldwork period, staff decided it was preferable to move this meeting to the end of the day; closing the exchange to clients at 5.30 and having half an hour together to deal with any issues that had arisen.

Once a week this meeting was much more detailed, involving a discussion of the whole of the previous week's work and any specific items that staff needed to discuss as a team. One such subject each week was that of clients who had asked for help and support in referring themselves to private doctor for a prescription; staff would discuss this and decide on an appropriate course of action for that client. Similarly clients who had asked about rehab services were discussed and decisions made about which services to suggest.

Behaviour and rules

It is important to convey the atmosphere of this project during the drop-in days. As I have said the main area was windowless and lit by florescent lights. Upwards of twenty clients could be in the building at once: arriving, being given equipment at the box, asking for a particular worker, being seen in one of the other rooms, sitting drinking coffee and talking to other clients, waiting for a worker and jumping up every time that person appeared, or leaving. There was no appointments system – people would be seen by a worker as soon as possible, but this often meant they had to wait some time. Giving out equipment was the priority and at least one worker was 'on duty' for this all the time. However, three or even four workers might be standing around the door way to the box, giving out equipment simultaneously.

Rules were prominently displayed. These were: no dealing or exchanging money on the premises or the street outside; no taking drugs including alcohol on the premises or directly outside (except antibiotics); no injecting on hospital property and preferably not in any property close to the project; no violence to persons or property in the project; no racism, sexism, language or behaviour likely to intimidate or offend either workers or clients; no 'gouching' in the project. This last was defined by being 'too stoned to hold a conversation'; if someone was in this state they would be asked to leave, if they could walk, or else watched until they were able to leave. These rules were made very clear to clients on their first visit, when they were always seen individually by a worker.

Summary

To sum up, this chapter has *described* the three projects in terms of their buildings, history and staffing, the organisation of time and workload and the issue of explicit rules. The following chapters *analyse* the material from the fieldwork, to explore the key themes of the thesis.

CHAPTER FIVE: CONSTITUTING THE SELF OF THE DRUG USER

Introduction

In this chapter I discuss the development of themes drawn from the work with the pilot syringe exchanges. In Chapter Three I argued that the discourse of syringe exchange contained a specific construction of the drug user, as a responsible actor, and of the role of services, that of enabling clients to choose what was seen as a healthier, safer way of life. I linked this to the notion of the production and management of the self; discussed in Chapter One. This is central to the idea of individualising and totalising power (Foucault 1982); the techniques of self management are those by which the individual is integrated into the disciplinary society.

I also defined syringe exchanges as *services for the body* rather than for the *mind*, contrasting this with the psychiatrically oriented Drug Dependency Clinics. Within my discussion of the production and management of the self in Chapter One, I outlined the two main practices through which the self is constituted; *knowledge of the self* and *care of the body*. What was being articulated in the interviews with the staff of the pilot exchanges was a concern to pass on to drug users the techniques of care of the body.

That work raised, therefore, certain key ideas: the importance of the *practices* of syringe exchange and harm minimisation in constructing knowledge about the drug user and the theme of the drug user's *body* as the site for intervention. Here I explore this further. I argue that in fact the three projects had different ways of constructing the self managing drug user and problem drug use. Project A constituted the drug user as an embodied self, and saw 'problem drug use' as that which damaged, visibly, the body. Project B in contrast, constituted the drug user as a mind and social being and saw 'problem drug use' as that which damaged self esteem, relationships with others and the ability to reflect on life. Project C, while in its practice dominated by a focus on the body, constituted the drug user as a bio-psycho-social being and so included in its definition of 'problem drug use', not just that which damaged the body, but also both the social being and the mind.

Having analysed the different constructions of the drug user that the projects employed, I then discuss the exercise of power within the relationship between staff and clients of each of the projects; how did staff act on their clients in order to produce them as this

object, and what, if any, forms of resistance did clients employ? The aim of the exercise of power in all three projects was that clients should take on the identity of the self managing drug user; responsible and aware of and acting to mitigate the negative consequences of his/her drug use. This identity would affect their behaviour both within and outwith the project itself. An immediate issue was the question of the way clients behaved in and made use of the projects and the forms of surveillance and resistance this involved are discussed briefly. A wider issue was that of their drug using behaviour away from the project, the forms of surveillance that the projects could exercise over this, and client resistance to that surveillance. This issue is central to the thesis' explanation of syringe exchange and harm minimisation, and so is discussed in more depth.

In Chapter One I described the process of the opening out and diffusion of surveillance, from the relationship described in Bentham's Panopticon where the individual was made the object of visibility, to that which involved the self surveillance of the subject. Bloor and McIntosh suggest that for practical analysis '[w]e can distinguish three techniques of surveillance; covert or naturalistic surveillance, supervisory surveillance, and surveillance by proxy or by the encouragement of self-reporting' (1990:165). My discussion of surveillance will draw on this typology, although I have some differences with the emphasis they give to these techniques. Bloor and McIntosh then suggest that, within the settings they studied, 'resistance could take a variety of forms and included collective ideological dissent, individual ideological dissent, non-cooperation, escape or avoidance, and concealment' (1990:171). Again, I shall employ their typology as a starting point for my discussion.

Care of the body

What I mean by saying that project A was focussed on the body is that although the practical, hands-on aspects of this were limited, the object staff had in mind in talking both to and about a client, was of a body, upon and within which the effects of drugs could be discerned.

The focus on the body of project A was visible in the practical arrangements such as the appointment of the health and harm reduction worker, and the input of the doctor. Adam was an RGN with experience of working in an intensive care unit. Before his appointment as health and harm reduction worker, he had been working at the project as a relief worker for a few months, but otherwise had very little experience of working in

the drugs field. His expertise, then, was the care of the body. His job description, over and above that of the other drugs workers, was 'to promote health and harm reduction techniques among clients, and to administer minimal primary health care'. The sort of care he could provide was in fact extremely limited; the needle exchange room did not contain either a couch or a sink, and he was not able to carry out dressings or other procedures by sterile technique. All the dressing materials he had were donated by a 'friendly GP', and the only antiseptic available was Dettol. During the observation, I saw two instances of hands-on, direct care to clients, both dressings accompanied by advice, in one case of an abscess and in the other of a cut.

In discussions between staff, clients were described in terms of what drugs, and how much of a drug they were using. For clients waiting to go to residential rehabilitations services, or on detoxes, discussion focussed around the bio-chemical aspects of their treatment; how physically addicted were they, could they cut down without suffering, how long would it be before they were ready to move on? For clients continuing to use drugs, again the issues were of the physical aspects; if they were injecting and using the needle exchange, this was an opportunity to monitor their condition. Using the needle exchange made both the drug user and their drug use visible. The amounts of equipment people took out could be a clue to their drug use:

We make no judgements, but we will point out if, for example, the amounts go up, and will ask questions about their habit and their control.

(AH)

The needle exchange was an opportunity to monitor the health of the user; for this to be useful, they had to come in frequently. This was something Tom stressed in a staff meeting, having done the statistics for the previous month and noticed that fewer visits had been made, but larger amounts of equipment taken out.

Tom said 'there's no need for anyone to do that' – they should come in more often, they would then be seen more often and their state of health could be kept an eye on. As some individuals had large deficits he also stressed the need for pressure to be put on them for return. Nobody else said anything, except Adam agreed he would put pressure on. Tom then described the exchange as a carrot. (Observation notes, staff meeting)

In the needle exchange, Adam's discussions with clients focussed around practical issues like the size of needle or syringe wanted, the progress of an application to a rehabilitation service or appointments with treatment services. Many visits to the exchange were very brief, and almost 'on the run', with clients not coming right into the room but standing in the doorway to talk to Adam.

However, there had been money allocated to make structural changes to the room, opening up a doorway at the back through to where a sink was available, and to buy a couch. Both these would also make it possible for the senior registrar who came in every week to do more direct care. At interview she described wanting to do cervical smears and family planning work, as well as being able to take blood for screening. At present she had to make appointments to see clients at the drug clinic if she wanted to do these, or else urge users to make use of general facilities.

As described above, the orientation of the project to health and harm reduction predated the syringe exchange, and was seen as central to the project. Tom described physical health as a basic issue for drug users:

I don't think the needs in terms of people who are using drugs, keeping their health and body together, will alter. It hasn't changed all the time I've been in the drugs field. (TT)

With the limitations on actual physical care, one of the key ideas behind the health and harm reduction work was that users needed advice about using:

A lot of people learned practices from other drug users who may not be doing it right in the first place (JP)

and that a lot of the work was giving knowledge and advice:

Bits of physiology that might be useful (AH)

Showing me the boxes, he said 'these [blue needles] are for relatively fucked veins, and these [greens] are for groining'. He went on to talk about injecting in the groin, saying that many agencies will just tell people not to, but he thinks it is better to teach them how to find the vein; 'teach them about vein, artery, nerve, find the artery first and stop if the needle bounces'. He also prefers to give out longer needles so that 'if they break

there is something to grab, but that a nurse's wariness'. He went on to say that if most agencies' workers were not knowledgeable enough to talk about injecting in the groin, then 'I wouldn't know how to inject in the neck. If someone wanted to inject in the neck I would say 'why not go down the Walworth Road and annoy someone and get them to blow your head off for you', but that's because of *my* lack of knowledge.
(Observation notes)

The project also produced and distributed a booklet *The User's Guide to Safer Drug Use*. This contained advice on injecting: using clean equipment, choosing sites carefully, filtering drugs, and disposing of or cleaning equipment; on safer sex and avoiding AIDS, hepatitis and septicaemia; on dealing with overdoses; and on 'looking after your body'. This last section included diet, taking vitamins, smoking and drinking and the importance of relaxation and exercise – 'the body you are wearing has to last the rest of your life, so take care of it!'.

The drug user's body then, was constructed in the *talk* of the project, rather than being an actual space, touched and treated by staff.

Project C was also set up with a focus on the body. Here there were the practical arrangements to do far more actual care: the treatment room, the institutional location within the NHS, and the formal nursing role of the CNS (primary care), Susan. The identity of the project was closely linked to its ability to offer physical care:

I feel that describing ourselves as a primary health care service or a street agency is much more likely for people to recognise what we actually do, rather than just referring to ourselves as a needle exchange scheme. (CW)

The primary health care work had two foci: dealing with or preventing problems which were the sequelae of injecting drug use, and making more general health care services available to drug users. The first of these was the most obvious. Dealing with problems involved first aid work like dressings, assessing abscesses and leg ulcers and either treating them or referring people to other agencies for treatment. An important physical condition that Susan talked about at length was that of leg ulcers, resulting from long-term injecting into deep veins. These could take up to ten years to form, and were not amenable to self care. *Prevention* was important for younger drug users, but those who had already developed such ulcers needed quite specialised *treatment*, for which she

referred people to a leg ulcer clinic at the hospital. In this work, treatment, the client's body was present as a tangible entity; either treated by Susan or taken to a specialist clinic. This was where some of the limits of self care and self management became visible.

Prevention involved a lot of education, mainly aimed at helping people to keep using peripheral veins, avoiding both the short-term and long-term risks of using deep veins. Susan was a physiology graduate as well as nurse, and, like Adam, had worked in intensive care. She described her educative role in this way:

I think all clients should have basic knowledge of anatomy and physiology, and I've got that knowledge so I can actually broadcast it, so to say. Just the way that the superficial veins lie, and the deep veins, and the valves within the superficial veins, which way the blood flows, rotating sites, using smaller needles, clean equipment, clean drugs and trying to get people back on peripheral veins. With that little bit of knowledge, hopefully you're preventing people, especially younger people that haven't been using for ten or twenty years, you're preventing them actually having to go for a deeper vein. (SS)

This emphasis on knowledge as prevention was shared by other staff:

Specifically telling people about safer drug using techniques ... the best works to use, things like filters, sterile water, kettle water. In the actual chain of events that leads up to somebody injecting themselves there are health risks as each stage, along the chain. And it means stopping that, letting people know about those and trying to get that to sink in, get that message across. And then when something does go wrong, catching it as early as possible, getting it treated appropriately, quickly. (JJ)

The other side of the primary care work was more general health care and health promotion. A specific focus was nutrition: Susan had put up a weight and height chart in the clinical room, and gave out both advice on diet and actual food supplements. However, this advice had to be geared to the needs of drug users, and at times was at odds with the sort of dietary advice given to the rest of the population:

Most of the information that is available about diet talks about low fat milk, and having skimmed milk and all the rest of it, but we want our

people to have full fat milk. We don't want them to have skimmed milk. So you actually have to contradict what the general [advice is] ... You give somebody a Build up, and they go out and buy skimmed milk ... [we have to say] 'we don't *want* you to have skimmed milk, we want you to have not nice, *fatty* milk'. (CW)

Another area was contraception; Susan was training as a family planning nurse. For the moment she referred people wanting more than advice, either to the Brook Advisory Clinic (if they were under 23), or to the Health Improvement Team or the Margaret Pyke Centre, all of which were in the vicinity.

In contrast, at project B, there was no nursing expertise on the team:

We have lots of discussions about that, and I think we are actually the only syringe exchange scheme that doesn't have any kind of nursing input at all. (JT)

Unlike project A, this project had chosen not to employ a nurse, and not to go down the route of providing direct health care. The weekly input of the senior nurse from the DPT had only confirmed for them that this was an appropriate choice to have made. The perception of most of the staff was that what a nurse could offer was extremely limited:

There doesn't seem much difference between me saying to someone 'that's really nasty, you need to go to the doctor, or you need to go to casualty', and a nurse who can only say the same thing really. (JT)

Looking at the information that Celia gives, if a person, you know, is in a mess or something, or if they've got an abscess that's hardening up or something, there's not a lot Celia can do, just general advice and maybe see a GP or go to accident and emergency. She's just ferrying them on somewhere, and that's why I think with training we should be competent enough. (PS)

It does make me wonder why we're all saying 'oh come in with your bad abscess on Wednesday,' we should *know* what to say to someone with a fucked up injection site. (LW)

These perceived limits on what a nurse could do meant that the team felt that what was really necessary was access to a doctor, and to proper clinical facilities. Providing this within the project was not seen as appropriate:

We would have to have a properly equipped treatment room, and a couch and so on, and that would also change what we do, I think. If you're actually doing syringe exchange in a room which has got a couch and a wash basin and lots of white tiles and things, that perhaps gives a wrong impression of what you do. (JT)

We looked at having a sort of clinically equipped part for the syringe exchange, you know a couch and all that, all the tiles and everything there, and we thought that might make it too much like a hospital. (PS)

Knowing the self

Project B did not, and had no plans to, provide services for the body. The focus of attention was the drug user's mind and social being. While harm minimisation was, as in the other two projects, the overall aim and philosophy of the project, the means to achieving this were very different. Staff talked about 'safer drug use', and 'working with them [ie clients] towards ... injecting more safely' (LW), for example. When pressed to describe exactly what this meant, staff at project B talked in terms of how people felt, what drugs meant to them, the role drug use played in their lives and the things they might want to change in their lives. Only one worker said he routinely asked people about their body, asking to see injecting sites, and certainly I observed that he did this on every occasion I saw him working in the needle exchange. However, he also said that no one had ever shown him anything particularly worrying, and that all he could do if they did was to pass them on to Celia or a doctor. Doing it really had a different function, one related to the client as a social being:

I ask to see their injecting sites, and I think people like it that bit better if they can show them off to you. I do that fairly regularly, I think it's just a means of expressing – a way of showing some concern. (PM)

The general approach of the project, and one that was carried into the needle exchange, was a counselling approach. Encounters in the needle exchange followed a pattern which reflected this approach: when people came into the exchange, workers would always close the door, and both client and worker sit down. The worker would look up the

client's records, do the exchange, and then have a few minutes chat. This was usually started with very wide, open questions, like 'how are you?' or 'how have you been', which often led into quite long discussions about issues like housing, court cases, referrals to the DPT or to other services. Sometimes the conversation was about nothing to do with drug use, one young man talked at length about the flowers he had planted in his window box, while another talked about his partner's pregnancy and their plans for the birth.

In discussions between staff, in the 'callers' meeting' for example, clients were constructed as reflexive beings, whose ability to have insight and self knowledge was the central issue. Staff also were constructed as reflexive and their role was to empower people to enable them to have that insight and to take control of their lives:

To sit down and help them explore their lives, and explore ways they want to change if they do want to change, or make that life more comfortable, more healthy; a happier life. So it might not necessarily be making changes, it might be just sort of exploring with them what's actually happening for them, and just making things clearer for them ... to help them to make changes, so giving them power and the confidence to do it really. So very much about promoting self confidence and self esteem, (CM)

This is in contrast with the extremely focussed way in which staff at project A discussed clients. At project A, feelings and emotions were more or less proscribed, as the following incident demonstrated:

In the clients' meeting, a young woman with two children who had gone into a rehab was discussed. She had phoned Jill who had talked to her for a long time, and now reported that the woman was feeling trapped because she wanted to leave the rehab, but that if she left her children would probably be taken into care. Tom cut across her description, saying; 'She feels trapped, but that's what having two kids and a drug problem is about, what does she expect?'. Jill shrugged and stopped talking. (Observation notes)

On another occasion it was Jill who played down the idea of feelings and work aimed at the mind:

Jill and I were talking about what she had been doing that day and she mentioned seeing a particular client. I asked whether that had been for a counselling session and she replied 'you could call it that - he rambles on a bit and I listen'. (Observation notes)

The drug user as a social being or a mind was ruled out of the knowledge of the project; it was the body which was the focus for intervention. In describing the way he had reoriented the project, Tom argued that:

You could get counselling for your drug problem anywhere, what you couldn't get was someone who could talk sensibly about how you could do less damage and avoid killing yourself. (TT)

At project C, while physical health was the central focus, importance was given to other aspects in people's lives. At interview, staff referred to the World Health Organisation definition of health as physical and mental well-being, and in discussing clients, they did talk about physical, social and psychological aspects of the client's condition; feelings and emotions were legitimate subjects and were intertwined with people's actions and health:

We try to address as much as possible all the other problems people had before HIV came on the scene, and we consider that an important part of promoting safer practices anyway. Because if people don't actually have very much self-esteem, then they're not actually going to be that motivated to ensure that they've got a clean supply [of works]. So it's not just about availability, it's also about everything else as well. The fact that if you're homeless, it's much, much more difficult to carry clean needles and syringes with you. (CW)

This wider focus was built into the staffing structure of the project:

The two nurses in this project would have a responsibility for developing links and liaising with the different projects in their clinical area. So Susan would be liaising much more with A&E, or the GPs and health clinics and that sort of stuff. And John is in the process of setting up links and referral networks with psychiatric settings. The DHEWs would have a greater responsibility for liaising with specialist drugs services ... the greater emphasis for the DHEWs would be on drugs services, being

updated and ensuring that the other workers in the team are updated on developments and that sort of thing. (CW)

However, in practice, the project was very much focussed around the primary health care work. There also were competing definitions of what the mental/social health work should look like. The formalising of the two nurses' posts had had an effect on the rest of the work and particularly that aimed at clients' social beings: the work of the DHEWs. Polly, as the only DHEW in post, argued that the nature of the project was changing and that the non-nursing work was being marginalised. She had devised a set of games based on discussion and wanted to use these and others based on physical movement (the old party game of Twista, for example), as ways of shifting the focus in the drop-in:

It's about social interaction – a lot of people's social skills aren't wonderful. (PT)

She also felt that:

It is very important that people have a place where they can talk about what is going on for them – whether you want to call that counselling or not. (PT)

Both these were very different approaches from the mental health work envisaged by John, the mental health nurse, who saw the 'games afternoons' as 'groupwork':

They're the nearest you're going to get to groupwork in a unit like this. You've got to accept that we have quite a lot of chaotic users, and that that chaotic lifestyle is reflected sometimes in the way the unit is run, and it also limits what we can do. (JJ)

The direct client work of the mental health nurse was around both crisis intervention, when people experiencing psychotic episodes presented to the project, and offering a form of assessment and long-term planning to people with less florid mental health needs. Both Clare and John stressed that this was not a return to a psychiatric definition of drug use as psychopathology:

The decision to establish that post was essentially in recognition of the fact that, although we aren't working to a psychiatric model, a medical model, there are people who use the project that do have mental health

problems who are not in contact with existing services. So really the intention in the decision to set up that role was to cater for the unmet needs of the people that were using the project. In the same way that the decision to set up the primary health care nurse's role was to cater for the unmet primary health care needs of the people that were visiting the project. (CW)

My post has been set up in response to a need that has been recognised; that some drug users do develop mental health problems ... the traditional view has been that if you are a drug user, you *have* a mental health problem – drug using *is* a mental health problem ... There have been drug dependence units in the past that have employed general nurses specifically to help with physical problems. This is swapping it the other round and saying there is a range of problems, mental health is one of them. So mental health is no longer the umbrella catchment. (JJ)

While arguing that drug use itself was not a mental illness, John employed a particular language to describe the people he did see as his main concern, locating the causes and effects of their drug use in the mind:

[The project has] had people coming in with full-blown psychotic episodes before now. I have had experience in the past as a CPN in a primary health care setting of having to get people sectioned or start talking them down, or dealing with paranoia ... Some people will be taking drugs to actually keep the lid on their [pre existing] psychotic symptoms ... There are other people who have simply taken so many that they will have induced some sort of psychotic episode, and that will maybe go on to some kind of long-term psychotic problem, the damage they've done. (JJ)

I think within the ethos of the needle exchange you've got to respect that that is that person's choice and they might have been coping like that for years and years ... [I would] try and get them to accept that sometimes they cannot totally judge accurately what's going on ... Every psychotic, no matter how well medicated he or she is – I say every, perhaps ninety five per cent – will at some point have some sort of psychotic episode ... I think what you could have is people having crises and that's really what I

would like to prevent, and say 'I realise that when you take this it helps keep you together, or if it doesn't stop the voices it helps you handle them, but things are actually getting worse. Why don't we try something that will stop the voices and help you too'. (JJ)

The significance of this is the shift from a positive construction of mental *health* to that of mental *illness*. Just as some long-term damage to the body, leg ulcers for example, was not amenable to self care, so some forms of damage to the mind were not amenable to self knowledge or the form of self medication he described.

The exercise of power

In Chapter Three, I argued that syringe exchange was a technique of *management of the self*, and that in it the role of services was to give guidance and advice to drug users to enable them to take control of their lives. So far in this chapter I have shown how the development of syringe exchange varied between the three projects studied. I argue that projects A and B were primarily enablers, but constituted the drug user and drug use in very different ways. Project C was trying to integrate different conceptualisations of the drug user, and offered treatment as well as enablement, suggesting some of the limits to self management of both mind and body.

Project A sought to make of its clients responsible, health conscious drug users. This was to be done by the imparting of knowledge, and by the monitoring of the physical condition of the drug user's body.

Drug use was seen as coterminous with and having effects upon a body. The focus of intervention was the drug user's body and the syringe exchange operated as a means of surveillance and production of knowledge about the body. The mind and emotions of the drug user were of less importance, and were ruled out of the discourse of the project. The form of self management that project A encouraged was *care of the body* and it was as a body that the drug user was constructed in the talk of the project.

Project B sought to make its clients self aware and reflexive. Drug use was seen as existing within the drug user's social being. While the body was implicated, the focus for the project was on the mind and self image of the drug user, and on their ability to maintain social relationships. The mind and emotions of the drug user were therefore of importance, and were constantly constructed in the discourse of the project. Staff exhorted users to talk, to examine their lives and to make choices. The form of self

management project B encouraged was *self knowledge*, and the production, through talk, of the self.

At project C, the explicit construction of the drug user was a broader one, encompassing mind and social being, as well as the body. In practice the work done focussed very much on the body and there were competing definitions of the legitimate role of other work. While much of the work was intended to give people the knowledge they needed to look after their own bodies, the provision of direct physical care was more developed here than at project A, and the provision of direct care to damaged minds was beginning to replace the work aimed at enabling the development of social skills and awareness.

Having described the ways in which the drug user as an object of discourse differed between the projects, I now go on to examine the notion of the exercise of power in professional-clients relationships within the projects.

Forms of surveillance

Earlier I referred to the forms of surveillance that Bloor and McIntosh (1990) discuss: naturalistic or covert surveillance, supervisory surveillance and surveillance by self report or proxy.

Naturalistic and supervisory surveillance are both forms of direct observation. Naturalistic or covert surveillance is 'subsumed under other naturally occurring activities' (1990:165), that is it takes place while the observer is apparently engaged in other activities. Discussing its use in therapeutic communities which emphasised 'reality confrontation', Bloor and McIntosh see its operation as deliberately covert 'because acting out might be inhibited by the subject's consciousness of being subject to scrutiny' (:165), and 'acting out' provided the material with which the processes of the community could work to change the client. Here I shall argue that in relation to behaviour within the projects a great deal of surveillance was naturalistic, but this was not in order to observe that behaviour without affecting it. Observing behaviour in the course of doing other things was simply the only way that staff could operate during busy times. In relation to behaviour away from the project, I shall argue that syringe exchange and other activities provided opportunities for staff to observe aspects of the clients' wider lives, particularly in relation to their drug use, without overtly raising the issues with the client.

Supervisory surveillance is that in which the function of surveillance, to oversee and direct client behaviour, is overt and acknowledged. Its exercise may consist in detailed

routines and timetables, with specified tasks and expectations, the performance of these being directly overseen and commented on. Bloor and McIntosh describe supervisory surveillance as being central to the work of therapeutic communities which take an 'instrumental approach'; it is through these processes themselves that client behaviour is changed (:167). Here I shall argue that supervisory surveillance was used to manage client behaviour within the project, but was also a technique for the exercise of power over client's bodies and behaviour away from the project.

The third form of surveillance Bloor and McIntosh discuss is that exercised through self report by the object, or through report by proxy; a peer of the object. Bloor and McIntosh discuss this in terms of a strategy that professionals are 'forced to rely on' when neither naturalistic nor supervisory surveillance is available to them, giving the example of the way in which health visitors have to 'encourage their clients to furnish them with the information they need to monitor child care' (:167-168). However, self report, or 'confession' of the self, as I discussed in Chapter One, is central to the form of disciplinary power which I have said takes the self managing drug user as its object. It is not just a technique which gives access to a truth which is not accessible through other routes, but is a means by which truths are constructed about the self. Used in this way, it is one of the techniques by which professionals produce the self managing drug user.

Forms of resistance

Bloor and McIntosh stress the need to see forms of resistance in the context of the particular exercise of power that provokes them (1990:169). They outline five forms resistance took in the settings they studied; ideological dissent, whether collective or individual, non-cooperation, escape or avoidance, and concealment, commenting that '[t]he types have only a conceptual distinctiveness; empirically there is much association and overlap' (:179).

Ideological dissent consists of a challenge to the whole enterprise for which power is being exercised and can be practised by a group of clients. Here I shall argue that it was more in evidence in relation to the exercise of power to control behaviour within the projects than in relation to the wider enterprise of producing the self managing drug user. Non-cooperation as resistance is either an overt refusal to behave in a certain way, or a covert non-compliance with advice or requests, without a confrontation, while escape or avoidance involve leaving a service or ceasing to attend. Bloor and McIntosh comment that in the settings they studied, concealment was the most common form of resistance

practised; 'a way of avoiding control without confrontation' (:176). This would mean hiding a practice from the professional, or giving misleading or false information in relation to it. It may involve a form of 'deviant conformity' whereby the client appears to conform to norms, but in reality behaves differently, or keeps private thoughts or views which would conflict with professional expectations.

Here I draw out those forms of resistance which I either observed or which were reported by staff as being practised by clients within the projects. However, my main focus was on the staff and their behaviour, speech and accounts. I acknowledge, therefore, that there are limits to the data I have specifically about clients, and so would stress that my discussion of resistance is not exhaustive. A different study, which took the clients of the projects as its object would have produced more, or different, observations about resistance, as opposed to the exercise of surveillance.

Behaviour within the project as the object of surveillance and resistance

All three projects had the same basic rules for client behaviour within the building. These were: no dealing or using illegal drugs on the premises, and no violent, sexist or racist behaviour towards either staff or other clients. In the case of project C, these had been extended to behaviour in the streets and hospital buildings immediately surrounding the project, and to include using the project when heavily under the influence of drugs; 'gouching out'. At projects B and C, these were displayed prominently on the walls of the project, and were explained to clients when they first attended. In project A, the rules were not visible but were said to be understood by all users of the project. The first level of surveillance then, involved enforcing these rules. Beyond this, there was a level of behaviour which related to the way clients used the projects and concern that this might be abuse.

Naturalistic surveillance

Naturalistic surveillance was the main form that surveillance of client behaviour within the project took at projects A and C. Project A was based in a compact building, with every inch of space accounted for. The drop-in area was visible to workers answering the phone or dealing with enquiries at the front of the room, and had to be crossed to reach the rest of the building. Jill described it as 'a pretty good layout, you can police it'; not much could happen in the building without workers knowing, and the one space

accessible to clients which was not immediately visible, the clients' toilets, they were willing to close if suspicious of what was happening there.

Space within the building of project C was also limited and very clearly defined: the drop-in/exchange area, the clinical room and the office. As at project A, the drop-in area was constantly supervised and monitored by staff as they went about their work. The 'box' from which actual exchanges were done opened directly into the drop in area, and there was always at least one member of staff standing here. This gave them an oversight of the room, although for most of the time they were engaged in discussions with clients about exchanges. If a member of staff suspected that a rule was being broken, in particular the 'no dealing' rule, they would move to stand very close to the person concerned to let them know that they had been noticed. There was a particular use of language between staff and clients, a shared code used to enforce rules, as the following incident I observed demonstrates. A woman who had earlier been talking to one of the workers came and sat next to me in the drop-in area.

She started muttering to a man on the next chair. Clare came and sat rather obviously next to them for a couple of minutes and they shut up. When she moved away they started talking again – it was obvious that they were arranging a deal. Clare came over again and said 'Would you mind not changing money in here?'. They both looked up and then he said 'Let's go for a coffee'. She agreed; 'Yes, yes, let's have a coffee'. They and a couple of others left, very loudly talking about going for coffee. Clare smiled at me and said; 'It's all use of language'. (Observation notes)

By not directly referring to a breach of the rules, but letting clients know that they had been observed, staff usually managed to enforce the rules. It did not always work, however, and then a direct challenge had to be made and possibly a confrontation dealt with.

At project B, the space available and its use was very different. The whole building was much larger, and the drop-in was held in a room which took up most of the ground floor, with the syringe exchange room opening off it. This space was separated off from the offices and counselling rooms, and so there were not the same opportunities for naturalistic surveillance. Two members of staff were on duty within the drop-in each day, and between them they ran the syringe exchange. Other members of staff would come and sit in the drop-in between appointments. As at project C, the intention was that

the presence of staff would prevent clients from breaking rules. The importance of the separateness of this space is that whereas at projects A and C, the drop-in happened in space which very clearly 'belonged' to staff because they were constantly present in it in the course of carrying out the rest of their work, at project B, however, it was set aside as space devoted to the clients. This is returned to later in the discussion on resistance.

Supervisory surveillance

This lack of opportunities for naturalistic surveillance at project B had led the staff team to discuss ways in which they could change the nature of the drop-in to make it a more active process:

...even if it's just we have more activity type of things, board games to play or whatever. [At present it] just feels to me like an extension of what I imagine quite a lot of their lives are, basically sitting around talking about drugs...I would like to see the drop-in provide something a bit different. (LW)

As with the 'games afternoons' at project C, these activities were intended as part of the wider process of change in people's lives, but they would also have had the effect of changing the dynamics in the drop-in itself. The idea of introducing such activities was contested, however, within the team. Others saw the prime function of the drop-in, a very easy access point for clients, as being at odds with more structured activities, and felt that the problem of client behaviour had to be tackled in other ways:

I think a lot of it's to do with us just working it out better and working out a better way of working, that's the crux of it (PM)

There's a lot of negative things that can go in the drop-in and it's important that...whoever's facilitating...switch that from a negative thing to a positive thing (PS)

Whether through specific activities or just by changing to a more assertive response, staff at project B wanted to use the process of the drop-in better to affect client behaviour within the project. All three projects used other processes to do this; during exchanges for example, the paperwork involved in monitoring the syringe exchanges was used, particularly in projects B and C, to structure the encounter and ensure that it proceeded

the way the worker wanted it to. The routine of finding the individual's record sheet and recording what was returned and taken out meant that the worker was in control.

Self report or surveillance by proxy

At project C, a particular form of surveillance by self report or proxy operated in relation to behaviour within the building. The rules were made clear to all users and were held by most to be reasonable:

They are literally agreed, essentially because everybody is aware of the rules when they first come to the project – people are told about the rules and that essentially the only reason we have rules is to keep the place safe. So having been informed of the rules, then the client doesn't have any option but to agree. (CW)

Staff quoted several instances where clients had demonstrated their acceptance and appreciation of the rules. For example:

There was an incident today just outside, two people were obviously doing a deal of some sort. Somebody else came up and started asking in a very loud voice what deal they were doing, what he could get, and the other two people came in and they were really scandalised by this and said 'it's not just that we could get nicked, but it's everybody that gets nicked in [the street outside] gets this place a bad name'. (JJ)

Non-cooperation as resistance

The main form of resistance practised by clients was simply non-cooperation; breaking the rules. This was usually engaging in dealing or actually using drugs on the premises. An example from project C was described above, and during the observation period at project A the toilets were closed on one occasion because staff believed clients to be smoking drugs inside. Staff response to these actions was fairly straightforward; if more subtle forms of letting clients know they had been observed failed, then a direct confrontation had to happen. The only example of a client breaking the no violence rule observed was at project B where a very drunk man, brought to the drop-in by staff of a probation hostel, smashed the glass door of the interviewing cubicle. Staff at projects B and C had experienced incidents of more deliberate violence in the past, but at interview these were portrayed as very extreme and unusual. The ultimate sanction available to the

projects was to ban the person from using the service. However this was never done at project A, and only in very extreme cases at projects B and C. Instead, forms of partial closure of the project to an individual were used; making them come at particular times, or not allowing them to stay in the drop-in after appointments or use of the syringe exchange. These practices are discussed in more depth in Chapter Six, where the notions of closure and openness are discussed.

Ideological dissent as resistance

In many ways, staff found it harder to deal with forms of client behaviour which could be described as ideological dissent, both collective and individual. This was a particular problem at projects B and C and consisted of what staff considered abuse of the project or harassment of themselves. One particular aspect of this was sexism. A typical comment from women staff at these two projects was that 'the atmosphere is quite macho, very sexist at times' (PT). At both of these, the drop-in was dominated by male clients many of whom spent hours there every day. This is in contrast to project A, where the majority of clients who stayed for long periods in the drop-in were women, often with young children. Sexist talk or behaviour was explicitly banned in the projects, but breaking this rule was not just non-cooperation, it was perceived as a form of ideological dissent because it challenged the culture staff were trying to create. It was difficult to deal with because although:

it's unacceptable if the language or behaviour offends, and that's as much for workers as it is for clients. It is a problem. Women workers want to challenge it, but if we did that every time somebody was being sexist we'd spend all our time talking about that and never talking about anything else. (CW)

As well as sexism, a constant problem was behaviour which, while not actually breaking a rule, detracted from the atmosphere and intentions of the project. This was seen as abuse, and again, is classed as ideological dissent because it demonstrated a rejection of the staff team's aims and perception of the purpose of the project

The thing is sometimes you're in a real cleft stick, because if two people are huddling and muttering, and you know that if you say something they will think you are accusing them of dealing, and you know they're not dealing, but you know that if you let them get away with it, other people

will do it and will be dealing. So that sometimes is a difficult situation. And the other thing is that you know there are some people who will mutter, and you say 'no dealing' and they will start defending themselves very loudly, that they're not dealing, and they will blow it up out of all proportion. I always think, 'I've got to do this'; I know it's not going to be worth it, but we have to. (JJ)

Oh yes, they get so shifty, so furtive ... and they end up – they actually take it out on you, because if they know you're watching, it's sort of; 'oh this place isn't as good as it used to be' and all the rest of it, and you just get earache, and it's just covering up because they know they shouldn't be doing it. And everyone on the first visit is told. (SS)

Other forms of behaviour set out to test the rules and challenge the staff. For example at project B, staff described times when clients would roll cigarettes very elaborately, pretending to be rolling joints, even, on one occasion, going to the lengths of lighting a joss stick to provide a herbal smell.

Staff response to these behaviours had to be either to intensify surveillance; by being constantly aware of what was happening and ready to intervene, or to switch mode, as was being discussed at project B, to a more instrumental mode of surveillance. Behind the debate about this latter course of action were different views as to what the drop-in was for as it performed several functions. These were listed by staff as: a low threshold entry point to the project for new clients, access to the syringe exchange, a form of 'day centre' or safe place for people to be, particularly those who were homeless or in bed and breakfast and an opportunity for active intervention. Given the staff inability to agree on what the drop-in should be providing, it is not surprising that clients had been able to capture it and turn it into what Louisa described as 'an extension of what I imagine quite a lot of their lives are, basically sitting around and talking about drugs and doing fuck all else' (LW).

The use of power to constitute the self managing drug user

The aim that the staff of the projects wanted to achieve was for their clients to assume the identity of the self managing drug user and adopt the techniques of self care that this would imply. The wider exercise of power within the projects was towards this end.

Normalised surveillance

At project A there was an idea made quite explicit by staff that the syringe exchange was a 'carrot' to get people into the project and provide a link to parts of the service. In this sense it could operate as a form of naturalised surveillance, a way of exercising power while ostensibly doing other things. Tom, the director, was the strongest proponent of this view. As described in Chapter Four, he had been wary of starting the exchange in the first place, and part of its justification, for him, was the opportunity it gave for the project to observe clients' bodies and physical health:

I think that since part of the function is to link them into other services that we offer, the more times we see them the more opportunities we've got for doing that...at the moment there is a particular need ... for people to get clean needles and therefore reduce the risk of HIV, and that's very good in itself. I think more than that though, it's a lead in to other parts of the health and harm reduction stuff and also from there, into the other parts of what the project does. (TT)

This was echoed by Jill; 'we see the needle exchange definitely as a carrot, something that gets people through the door' (JP). Once through the door, there were things about the client that could be noted, which would give clues to what was going on in their lives, and particularly their drug using behaviour. However, Adam, who actually carried out most of the work within the exchange, expressed a slightly different view, one which suggested that he did not accept the exchange's primary purpose as a means of surveillance of the client, describing it as a service 'you can just use and leave, as is coming in and sorting out a housing bill.' (AH). This point will be returned to later in the discussion of resistance.

At project B, the idea of the exchange as a carrot was rejected by staff, who felt that they provided it as a service in its own right. However, they expressed the view that it had opened up opportunities to talk to clients that had not been there before, for example:

...what I find is that providing the needle exchange has provided really good opportunities to get hold of people and have a talk with them. It's certainly much easier to have a very important conversation with someone in the needle exchange, simply because you're there on a one to one basis, like a counselling session, but you're actually doing something opractical.

While you're doing something practical, you can be talking about all sorts of things, and I think people are much less inhibited while you're doing that (CM).

At project C, the point was made rather differently. As a new service, focused on syringe exchange and issues around HIV, the whole project was a point of visibility for people who would not use other services. Located in central London:

we're in contact with a lot of people who choose not to use other services...a lot of people's experience of other services goes back to the 1960s and 70s, and they have a fear of being made to cut down on their drug use. Needle exchange is different. (PT)

As at project A, this form of surveillance meant scrutiny of the client's body and here the staff, and in particular Susan, did examine people physically, looking for information not only about their drug use, but about their general state of health.

All three projects saw the syringe exchange as an added way to make the drug user visible; in the case of projects A and C this was the body of the drug user, while at project B it was their mind that was being made visible. Observation of the drug user could take place in the course of carrying out the syringe exchange. This surveillance could be described as naturalistic or covert, whether it was perceived by staff to be an intended function or just a fortunate spin off of the syringe exchange itself.

Supervisory surveillance

As well as being a means to make observations about the rest of their client's lives, and what was going on in them, observing the way clients used the syringe exchange itself was a form of supervisory surveillance. All three projects used standardised forms to record what clients took out and brought back. From these an individual's pattern of use of the exchange could be identified, and inferences drawn about their behaviour. At project A, great stress was laid on the need to return used injecting equipment; this was seen as an indication of client's level of 'responsibility':

We expect them to be reasonable and careful...if you're going to use syringes, and you're going to inject, I think people need to be responsible about them, particularly if they're getting them for nothing. I think they've got a duty to bring them back. (TT)

The exchange had started, not as an exchange, but as a place where people could dispose of equipment. Rather than giving out needles and syringes, the project had taken them in. Across all the pilot schemes, return rates for equipment had averaged 78%, with some as low as 30%. Once project A was giving out equipment, the strict policy meant that returns were very high: usually well over 100%. Adam described how this was achieved, showing the 'yellow card' to anyone who started to fall into deficit;

If we feel they are getting too much in deficit we will start nagging them and hassling them and then they will probably collect everyone else's for a week or two and bring back 30 or 40, and so it works out. (AH)

If individuals persistently failed to return equipment, the sanction was to refuse to give them more:

If they fail to deliver their part of the bargain, which we do see as important, we will refuse ... We don't feel responsible for what they do. (AH)

We don't give them out if they don't give them back. We can bully people we know (JP)

By achieving return rates of over 100%, the project was drawing in equipment acquired elsewhere. Because of this the project did not give advice about other means of safe disposal:

We need the figures, we need the works back, so we don't say too much. (AH)

At the time of the field work, however, the overall return rate had dropped to 95%, which concerned Tom:

I think a lot of the feeling in terms of not pushing people is about the fact that they wouldn't come back, that it was better that at least they had clean needles themselves, regardless of what happened to the needle. I don't know that I would necessarily subscribe to that. (TT)

The issue was not just return rates. Tom also disliked the idea of giving out large amounts of equipment in one go, even to people who scrupulously returned every syringe. This was for two reasons, one about keeping control of the equipment, and one

about keeping the user visible, as discussed above. The more often somebody came into the project, the more often they were subject to the scrutiny of staff. In practice what this meant was that Adam could see them and make judgements about their health from what he saw. Again, this will be returned to in the discussion of client resistance.

In contrast to project A, where responsibility was symbolised by the return of equipment and the visibility to the project of the equipment was as important as that of the client, at project B, responsibility was implicit in the use of the exchange itself and staff were prepared to discuss means of disposal with clients. Many clients in fact did not bring their equipment back but gave accounts of how they disposed of them which satisfied workers. Several clients I observed said that they had small children in the house, and so preferred to destroy equipment immediately rather than leave it anywhere in the house. In most cases they reported burning them, either in woodburning stoves or open grates, perhaps an advantage of being outside London. Staff at project B were in the process of producing a leaflet on methods of cleaning and disposal of equipment.

Staff at project B also saw no problem with the idea of people taking large amounts of equipment, provided they brought them back, or could account for their disposal in a plausible way.

I don't think it would bother me ... I would be happy if at least he's coming in once a month to change his works and not going out there and using other people's works or being unable to come into the project. I mean, that's a service in itself, an independent service. (PS)

It's very basic and I think we shouldn't try and confuse the issue here. The important thing is that people don't share ... OK, because we provide clean needles doesn't necessarily mean we're going to prevent people sharing, but it at least gives the possibility of that happening. (PM)

Having accepted the possibility of clients disposing of equipment in other ways, the project did not then envisage any sanctions for non-return. Alongside this was an acceptance that people could take out relatively large amounts of equipment to pass on to others, making their social relationships visible. Specifically, during the observational period, two clients came in who were travellers and who took out boxes of needles, syringes and condoms to take back to the other people on their sites. Another man, who

lived in the red light district of the city, asked for two boxes of condoms which he said he would pass on to the 'girls' in his street

Here, the recording sheets were also used to record other kinds of information, for example a note that a client had a court case pending or had asked about a referral. This was not a formal recording process, but a habit staff had got into. Because a different member of staff was on duty in the needle exchange and drop-in each day, people coming in might see a different worker each time they came in. This was a system of communication about what went on in the exchange. As I described in Chapter Four, the self of the drug user that was visible in the exchange here was the mind and social being, made visible by talk:

there's quite a lot of people who just come in and collect works and do nothing else. I'd try to engage them in some level of conversation about how they were, what's happening for them, how things were going. And sometimes you get a very clear idea that someone does not want to use you in that way at all. In which case I would leave that, because it's more important to me that they maintain contact at least to get their syringes than we actually put them off and they disappear into the blue horizon. But I also think, maybe it's something we all could use training on, is how to maximise that five minutes you have with them, to make sure that if they do wish to talk that they know that that's on offer. (LW)

In fact, my observation was that all the staff of this project did make use of 'that five minutes', as described in Chapter Four, encounters here were unhurried and relaxed. The actual business of exchange was usually over fairly quickly and simply, and more general topics then raised. In this sense, the exchange could be said to provide less an opportunity for supervisory surveillance than another setting for surveillance by self-report, which will be discussed later.

At project C clients were perceived to use the exchange in various ways, and so responses in terms of supervising people's use were graded to match this. John outlined at interview the fine details of a schema for defining clients:

people who take out one, I think they actually split up, there's the people who dive in in a hurry, take out a syringe and a needle or two, dive out, come back half an hour later quite relaxed and bring it back. Then you've

got the people who dive in and take one and dive out again and you don't see them for a while. What I've noticed is that if you look at their return sheet what's happened is that a week before, say, they've taken 40-50 syringes, and returned 40 or 50 ... So I think that there are people who dive in, take one and dive out and don't return it, but I actually think they're only a percentage. (JJ)

The second group 'really' belonged to another group, those who regularly took out large amounts and brought them back, but who:

just happen to be in the area for a while so they've scored quickly, buzzed round here and they'll take the syringe and stuff home with them and return it with the next lot. (JJ)

The people who took out large amounts could also be sub-divided:

you've got the people who are really very organised and together, who might actually be supplying other people with clean needles and syringes and [who] come up once every month or two with two or three sharps boxes full, and go away with three or four boxes of each ... And then you've got other people who are taking out large amounts and are disposing of them some other way, ie they might have [access to] some sort of boilerhouse or something like that. Although I am sure they are disposing of them properly, that worries me because we don't actually see it. (JJ)

In spite of this concern about syringes which were not returned, this project would not refuse to give someone equipment:

The nearest I've ever come to a sanction is when somebody has, say, taken out a hundred, come back a month later and said 'I want to take out another hundred'. And I've actually said 'look I'll give you another ten for now, bring back the hundred next week'. (JJ)

Offering smaller amounts was the sanction for non-return, rather than outright refusal, as at project A. Project C was about to start a campaign of distributing small bottles of bleach with instructions on how to clean equipment. This grew out of their knowledge that even regular attenders were still sharing equipment, and a perception that while the

message to use sterile equipment for every injection might be the ideal, it was more use to their clients to give them some means of adjusting their injecting practice that fell short of this ideal.

Self-report

Implicit in much of the discussion above has been the use of self reporting as a form of surveillance within the projects. Earlier I said that self report was not just a means of access to knowledge that could not be gained from direct observation, but was a technique of power, one by which the client was invited to construct his/her self. As such it was most important to the exercise of power within project B. The object of this project's discourse was a reflexive being, and the means of achieving the project's end, that the client should assume that identity, was to invite them to speech, to give them space to talk and reflect on their lives. This could be about their use of the syringe exchange itself, for example in re-constructing how they had disposed of equipment. More importantly, by providing a physical space for talk to happen as well as an opportunity, the syringe exchange was a central mechanism for the wider exercise of the project's form of power.

At project C, staff also used the exchange as a means to invite speech, although this was more often about physical aspects of their drug use. For example, this encounter between Clare and a client:

Someone who had been using the exchange ever since it opened came in today, while Clare was there. He was pleased to see her, as she had not been around much since her job had changed, and they joked about how long they had known each other, with him making a remark about how much things had changed for him since then. She picked this up and turned it into a serious discussion of his current injecting sites; he was injecting in his groin, after having said previously that he would never do this. He said that he was worried that sooner or later he would not be able to do even this, and that then his only choice would be between injecting into his neck, or stopping. Clare urged him to start thinking about what he would do then, now. He said he knew he had been avoiding thinking about it and asked if he could come back and talk to her, now that he had said it. (Observation notes)

In project A, in contrast, self report and talk were given less importance. What was looked for was visible proof of people's behaviour, the return of syringes to the exchange, or committed use of a service, not a stated intention. To Tom, talk was a means to clarify needs and plan actions, not a way to explore feelings and construct the self:

I think there's a whole area of drugs work that is to do with support which is incredibly unclear. And I think it's important for workers that they go into a situation in a fairly systematic way. And at some point they sit down with people and they say 'what do you think your problems are?', and also give their impressions of what they think the problems are in relation to their client; 'what shall we do about it?'. And at any stage in their involvement with somebody, to be able to say, this is the stage we've got to and this is the next move we're going to make. (TT).

Through different practices of surveillance, the projects were exercising power over their clients' behaviour away from the projects. All three were engaged in creating their version of the responsible self managing drug user through this exercise of power. The next section looks at the issue of client resistance to this exercise of power.

Client resistance

The most obvious and strongest form of resistance to the projects' wider exercise of power was to stop using them; *escape or avoidance*. By definition, none of the projects had any way of compelling attendance, and particularly none of enforcing use of the syringe exchange. 'Dropout' was a serious worry for all syringe exchanges, and was used as a measure or not of their success. All the projects regarded themselves as 'low threshold' or 'user friendly', and so drug users who chose not to attend were in some way a threat to the projects' identities. In exercising this form of resistance clients were closing the relationship.

Most other ways in which clients practised resistance were forms of *non-cooperation* or *concealment*. At project A the two were linked because what was wanted was for clients literally to reveal themselves to Adam so that he could see their physical state. In fact this did not particularly happen; clients often did not even come fully into the needle exchange room, but hovered in the doorway, talking to him from there. He in return was

not assertive about this, unlike Susan and the other , temporary, nurse at project C, who would invite people to go into the clinical room where a fuller examination could be carried out. Adam did not really have the facilities to examine bodies, or materials to do anything even if he had. This suggests the limits to the form of surveillance that was so central to the project's discourse, that of the body, in the absence of the means for practice.

The other form of non-cooperation clients at all projects could practise was to fail to return equipment or to dispose of it safely, or, on a much wider level, fail to practise the kind of safer injecting use that the exchange was intended to promote. At project A non-return might provoke the counteraction of the refusal (or at least the threat of the refusal) of further supplies, and the total figures for the project suggest that most clients cooperated with this. The description of people collecting other people's syringes in order to redress their own balance is an interesting insight into the relationship between the project and its clients. Individuals might not bring back their *own* used equipment, but collectively, the client group as a whole cooperated. At projects B and C, this form of resistance had met a very different form of counteraction. Both projects were talking to clients about other forms of disposal and, perhaps more importantly, about cleaning equipment after use. This change in practice was predicated on the idea that clients *were* responsible and would seek to perform the most rational act possible in any given situation. Use of a new syringe for every injection, and the safe return of it once used, was not the only way in which clients could exercise their rationality and self care. By providing information about cleaning and safe disposal, and in project C's case the actual means of cleaning in the form of bleach, these projects were responding to client resistance by reconfirming the notion of self management, rather than trying to change client behaviour.

Concealment in response to surveillance through self report is always possible; what Bloor and McIntosh refer to as 'a kind of deviant conformity' (1990:177), whereby clients say what is acceptable to staff and conceal their real thoughts and actions. At its simplest, lying, this was what staff at project A sought to counteract by their insistence on the actual return of equipment.

I have not described any *ideological dissent* in this discussion of resistance to the wider dimension of the projects' exercise of power, although I earlier identified it as being practised in response to the projects' attempts to control behaviour on the premises. The entirely voluntary nature of clients' engagement with the projects has something to do

with this, in that clients who dissented from the enterprise of the projects would probably stop using them. The projects' exercise of power was towards the creation and adoption of an identity that would, on the whole, be regarded positively; a responsible, rational actor. This identity is at odds with that usually portrayed in the media or popular culture as belonging to the drug user, except in specific presentations aimed at popularising harm minimisation. However, I acknowledge, as I did earlier, the limited nature of my data on resistance and hence the limits of what I can reasonably argue in relation to this.

Summary

This chapter has examined the question of the exercise of power within professional-client relationships in the three projects. In Chapter One, I stressed the notion of productive power and the idea that the exercise of power was not inherently repressive or controlling. Earlier, I looked at the way the three projects each produced particular versions of the self managing drug user, through their discursive practices. Here I have looked at the way power was exercised through techniques of surveillance, firstly to determine what happened within the projects, and secondly to carry out the projects' aim of producing the objects of their discourse. Clients resisted certain of the specific elements of how the projects exercised power, and in particular those techniques which sought to control their behaviour within the buildings. However, I would argue that on the whole the projects' exercise of power was productive and positive for clients, and so resistance was limited.

CHAPTER SIX: SITES FOR PRACTICE

Introduction

In this chapter I explore the nature of the projects as sites for practice. The last chapter suggested that in various ways the projects had specific operating styles, related to their constructions of the drug user. Here I explore other aspects of these styles, and discuss the ways in which they were created; their origins, and the ways they were maintained. An underlying theme to my discussion is the notion of closure and openness, and this chapter attempts a synthesis of some of the material in the preceding chapter with that discussed here to characterise the projects in these terms. By 'closure' I mean a concern with identifying and maintaining boundaries; physical ones around space and nontangible ones around identity, roles and responsibilities. By 'openness' I mean a fluidity and a coherence that depends less on boundaries and more on a presence in multiple sites and relationships. Project A I have defined as being concerned with closure, and project B, with openness. Project C I would place closer to project A, but less definitively.

I would argue that there is a relationship between the practices which maintain these identities in the projects and the issues I addressed in chapter Five. The staff teams' own construction of themselves was analogous to the way they constructed the drug user. Project A and project C were defined by the project's physical presence; for both the building was the project. Project B, in contrast, had an identity that existed more in its presence within relationships with other agencies in the city, and a concern to disperse its practices across multiple sites.

I look firstly at the development of each project. In the case of projects A and B this includes an assessment of the syringe exchange and its impact on the project's other work. This discussion leads on to my second area of interest; the nature of the projects' relationships with other agencies. In the diagrams in the chapter, Figs 5.1, 5.2 and 5.3, I have tried to show the development of the three projects, and their activity and working (but not simple referral) relationships with other services. As can be seen, projects A and B might at first appear to have followed a similar course: from a model of a small core and a diffused periphery, to a large core, coterminous with the building. In the case of project A, this was deliberate, and, as I will show, was echoed in the way staff talked and worked. In project B, however, it was a model forced by the creation of the syringe

exchange, and was one staff worked against and hoped to overcome. Project C had grown over time, but remained coterminous with the building, with clearly defined boundaries.

I then explore the nature of the staff teams, looking at how these teams constituted their selves, and the exercise of power and resistance within that. I then go on to show how staff at each project used time and language in ways which reflected and maintained the project's identity.

Project A: boundaries and limits

In project A, the director, on arrival in 1987, had set out to pull all activity back into the core of the project and create a tight and cohesive team, with a clear focus to its work (Fig. 5.1). When he arrived, the project had been 'not functioning as a team, but as a group of people who happened to share offices and all went off and did their own thing' (TT). There had been an appointments system and the project had actually been seeing very few clients. Some of the posts were trainers' posts rather than direct client based posts. He described this as 'like a super nova'; bits shooting off in all directions and no core. He had taken a directive line about how he wanted the project to change, which resulted in staff leaving. By summer 1989, no one remained from the team he had taken over. Jill had joined the project soon after Tom, and the others at intervals since. Jill was the only person other than Tom who had been there through the changes; in her interview she talked about 'being there from the beginning', suggesting the importance of the change of style and the break it marked in the project's much longer history.

The project's focus was very specifically defined:

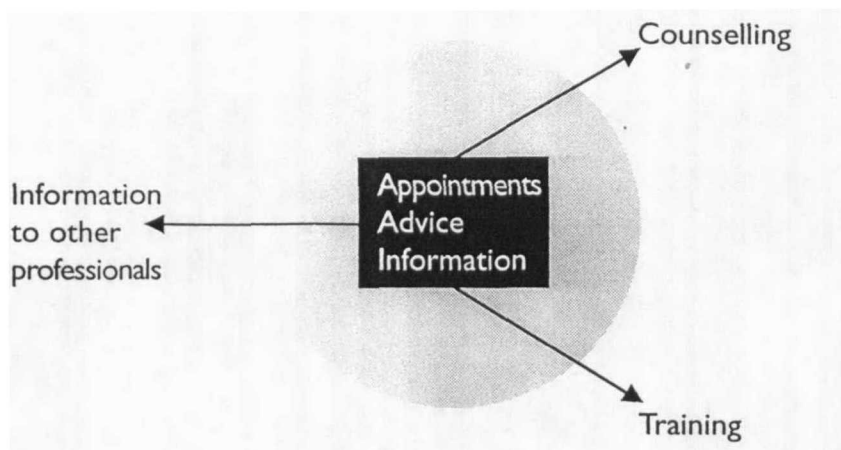
[F]irst of all making contact with our target group, which is high use, high risk users ... Secondly reducing drug related harm ... thirdly, sitting down with people, assessing what their needs are and making relevant referrals on to other agencies. (TT)

Maintaining this focus included being clear about the limits:

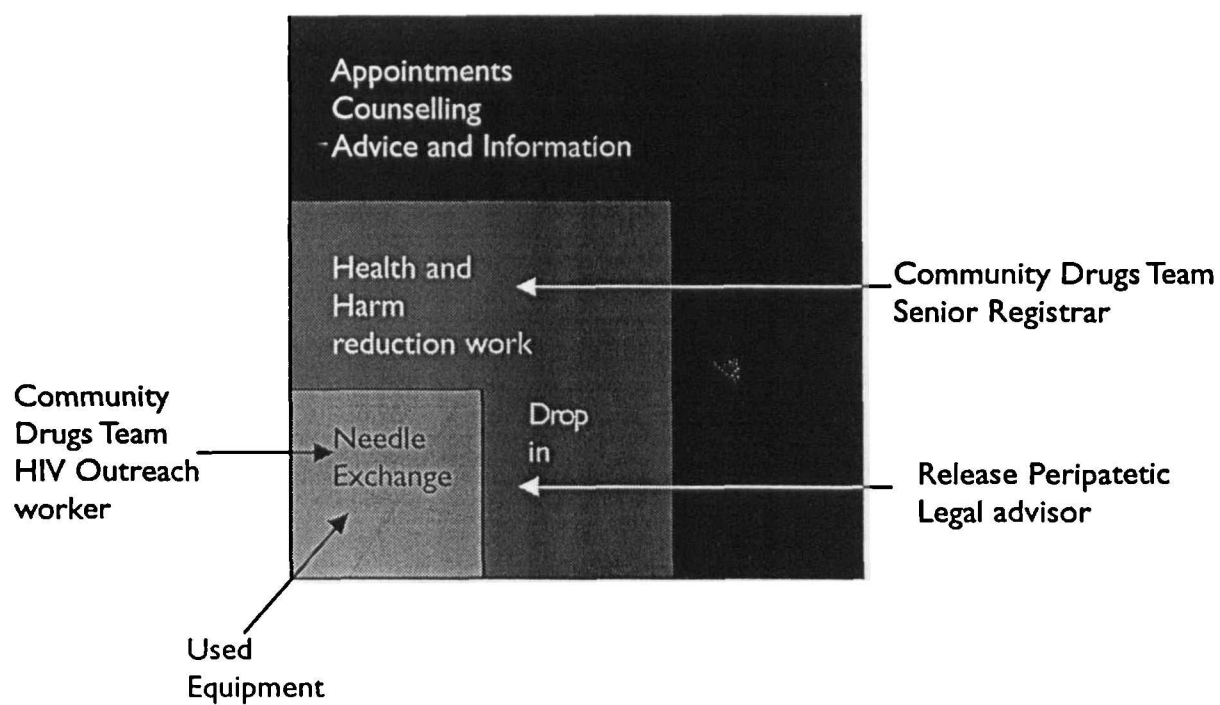
Like when I described the aims; one, two, three, that's what we do, anything else we don't do. (TT)

Fig 5.1: Development of Project A

Early 1987



1989



The cautious approach Tom had taken to the introduction of the syringe exchange has been described earlier. There was a sense of the exchange being enclosed and controlled within the rest of the project's work, and a need not to allow it to become an autonomous, disengaged activity, or to take over the project. It was embedded in the primary health care work and even within the health and harm reduction work, needle exchange was not seen as a *sine qua non*:

I wouldn't rule out the possibility of some stage in the future we might forget about needle exchanges and still maintain the health and harm reduction stuff. Needs might change, if we suddenly got a lot of people in who were not injecting. (TT)

Part of the project's style was clear boundaries between it and other services. The project had refused the offer from the local NHS Community Drug Team (CDT) to run a weekly walk-in clinic in the building, as this was seen as potentially compromising: 'I think it's a bit iffy, and I think we would rather stay more independent' (JP). Similarly, the project would not get involved in any formal way in supervising prescriptions from GPs, or in case conferences when clients had child care issues with social services.

The two members of the CDT who came into the building each week came in on the project's terms, as part of the health and harm reduction work. The outreach worker was part of the needle exchange, and the doctor provided primary health care, quite definitely not a medical drug treatment service. The CDT was a relatively new team, and its inception had formed the expansion of an otherwise very large and traditional Drug Dependency Clinic. It was perceived by staff as having benefited more from the relationship than the project had, in the sense that working with the project had provided a degree of street level credibility among drug users that the CDT would have struggled to build up.

Part of the style of the project was not to do things *for* clients but to enable them to do them for themselves. For example, clients were encouraged to make first contact with other services themselves, rather than waiting for a worker to do it. Phones were freely available, and clients would be shown where to find a phone number (most were already up on the wall). This applied to services like housing or electricity as much as to drugs services. It was not unusual for clients to come in and go straight to the phones, with no reference to staff. There were problems with the size; confidentiality could be difficult, and Adam commented that 'that is our responsibility', to ensure clients did not have

access to information about other clients. The lack of space meant that any further development would have to be carefully planned, as the building was at capacity. This concern with capacity had been one of the reasons for caution about starting the exchange.

The size of the project was becoming an issue because of space and the wish to keep the caseload manageable and visible to all staff. However, there was also a perception that there were still a lot of people 'out there' who fell into the target group and yet were not using the project. Two means of managing this were envisaged by the team, both using space; one was to split the project, separating the services they provided for people who had stopped using drugs from the work done with people still using. This separation already existed in embryonic form; people who had stopped using were encouraged to use the appointments system rather than the drop-in, and not to stay in the building unnecessarily, to limit their contact with people who were still using and what Tom described as the 'nudges and winks in the waiting room'. However, this suggested split was contested by Jill, who was adamant at interview that she would not want to see the different parts of the project's work split off from one another.

The second idea was to keep the same building but create a mobile service:

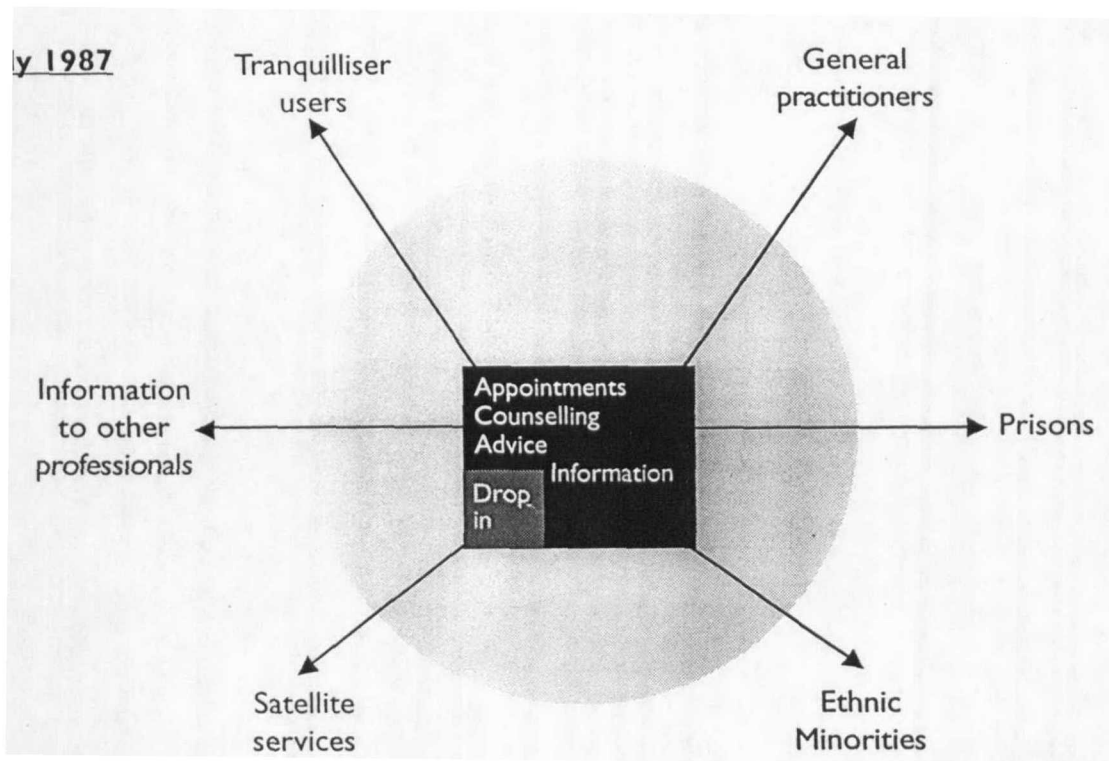
I've got this great idea at the moment of making the whole of [the project] mobile, all our services; needle exchange, counselling, whatever. Just doing it from a van and trundle round, save us getting a new building, also employ extra workers. (TT)

In both scenarios, the project would maintain its boundaries; in the first there would be clarity about who was served by which bit of the project, and a closure between the two halves. In the second, rather than a model of outreach where a bit of the project would go out and establish working patterns elsewhere, the van would actually be a microcosm of the whole project, visiting different areas, but self contained. Adam described this possibility as 'like a mobile library service'.

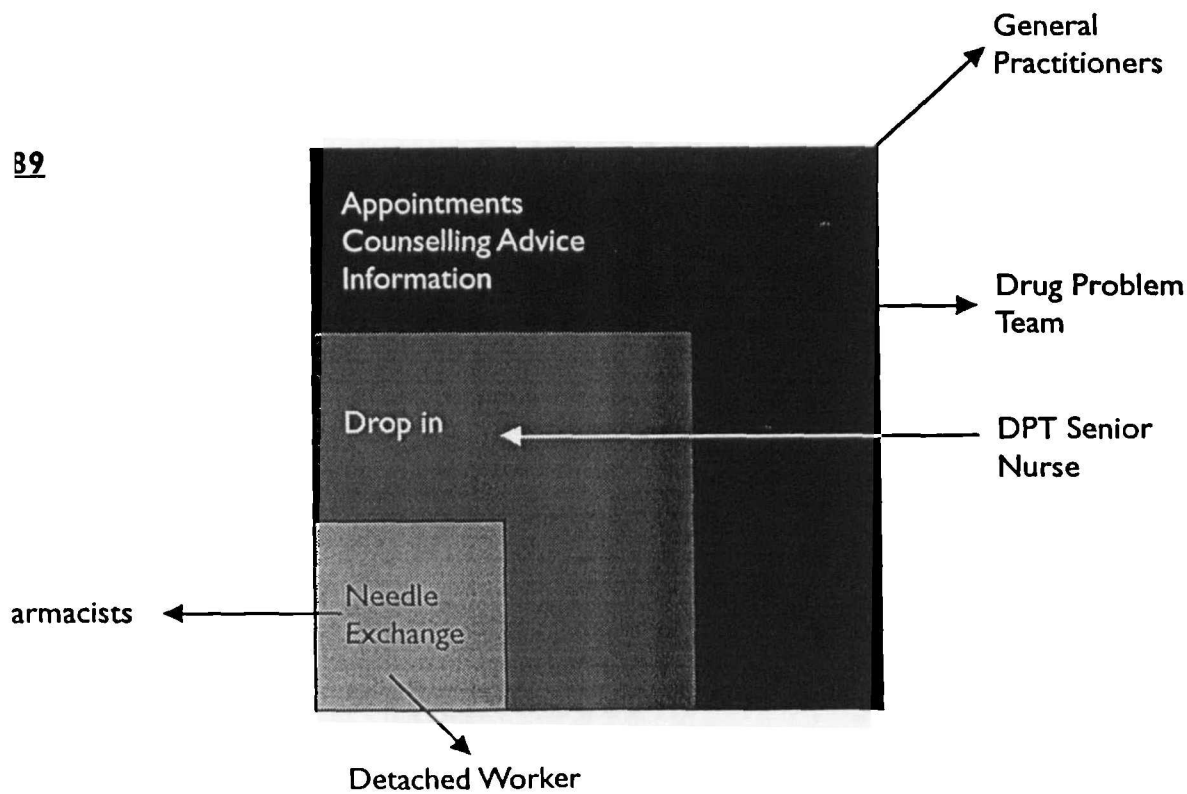
Project B: openness and diffusion

At project A, a more complex account of the project's development was given (Fig 5.2).

Fig 5.2: Development of Project B



89



When the project opened, its brief was to provide services to everyone with any kind of drug problem:

The key thing about the project all the way through has been the desire to provide a very accessible service to anyone who might have any kind of issue about drugs. (JT)

Whether we are or not, I don't know, but we should be targeting a whole wide range of people; all age groups, people from all walks of life, all races, all colours, men, women, the whole bit really. And also all the different drugs as well. (CM)

Drawing the definition of problem drug use so wide meant that initially the project had done a lot of work with tranquilliser users; there had been no other service for this group, and a lot of demand, and so this had seemed like a natural development. Over time, self help groups had evolved out of the groups the project set up, and these eventually operated autonomously, with minimal support from the project itself.

The project was at first not synonymous with direct services provided within the building; much of the work before the syringe exchange opened was carried on elsewhere, or was developmental. For example, a service had been set up on one of the peripheral estates, at the request of a group of community workers there:

We did actually start a service there in a fairly small surgery, an afternoon or a morning a week, which was OK actually, it was quite good. But unfortunately they lost the premises and they lost their Community Programme workers and so on. They had no way of actually maintaining it and it was impossible for us to run a service without having some backup. It's not really a workable proposition unless you've got the local support. (PM)

Other slightly later initiatives had been about trying to make the project accessible to women, also by developing smaller, localised services, although this approach had not been successful:

My initial thinking when I came to the project was that there was no reason on earth why women should traipse into the centre of town with their kids on the bus with a pushchair. And so it seemed as though it

made more sense if I was to develop services in local communities, localised facilities so that people didn't have the transport problems ... [But] that proved to be really hard and didn't take off very well, which is why I am now focussing on setting up a women's service here. (LW)

Another area of work undertaken was within prisons: running groups and seeing individuals for counselling in two local prisons. This was undertaken by one of the original team, Sarah, who had worked with the Parole Release Scheme in London.

The project had also tried to make its service accessible to people from ethnic minorities. Within the city there are substantial Afro-Caribbean and Asian populations, and all of the original team were white. Pan, who was Asian, was appointed in an attempt to address this issue:

Well, I was taken on as a black worker, I mean that was the job description; the advertisement was for a black worker to join the [project and to] work with the black and ethnic community, to promote the services of the project, and I suppose to make people aware that this is not an all white project and [only for white] drug users, and, you know, it was geared for everybody, everybody that's using. And [my] being bilingual as well, the type of people who weren't familiar with the English language would be able to come and talk to somebody. (PS)

The original assumptions had been that Asian people in particular might be experiencing problems with tranquilliser use, and that the project needed to be more accessible to Afro-Caribbean people using illicit drugs. The work with tranquilliser users had resulted in the self help groups, but in terms of Afro-Caribbean people, the project had not yet been successful.

The ending of the prescribing service, shortly after the project opened, meant that there were no treatment services in the city. The project's option was to try to work with GPs:

[T]here weren't any GPs really prescribing, so a key development for us was to contact the major health centres, to tell them about us first, also to find out what kind of contact if any they had with drug users and to look at ways of perhaps encouraging them to do some short term detox. We developed a kind of contract as a basis for that, whereby someone would receive a prescription on condition they came to see us. We particularly

developed that with one of the inner city practices, but also on an occasional basis with other GPs. (JT)

This particular development had not been easy because of the prevailing medical attitude within the city:

That was quite hard work because there had always been a kind of anti-prescribing tradition in this area and the CFI funded research and treatment programme ... [had had problems] about overspill of methadone onto the street, you know – all the things GPs like to latch onto as a good way of not prescribing. So it did not have a particularly good reputation. So that was hard work, and a good development for us. (JT)

The opening of the syringe exchange marked the beginning of major changes in the way the project ran. Whereas before, the project had held one drop-in afternoon a week, and the rest of the time worked with individuals or else on developmental work away from the building, once the exchange opened, the project was pulled back into the building and its work became much more focussed:

[W]e've changed so much since we started really, our complete practice has changed ... when we first started we sat down to plan how to run a service, people never thought of needle exchange schemes in those days, how they would become so central to what you do. (PM)

When the issue of HIV transmission had first arisen, it was obvious to the project that provision of equipment would be an important measure. However, there was an initial resistance to the idea of the project becoming the site, or rather the only site, for this:

[While] no one felt it was morally wrong giving people syringes, what we did feel was that we oughtn't to be the only agency doing it really, and also a recognition that it was going to change our service quite dramatically. So we spent about four or five months as an agency looking at things about it, the pros and cons of doing it, talking to the District Drugs Advisory Committee and saying 'look, we might be interested but we believe pharmacists ought to be doing it as well, and what about health centres and so on', and they were basically saying 'why don't you just go off and do it'. (JT)

The syringe exchange 'naturally prioritised our work' (CM), focussing it on to injecting drug users:

It was a different group of people altogether that were coming into the project for the needle exchange than we had been seeing previously. So it was different people, it was also more people and therefore more work for the agency, and also more contact; obviously there were spin-offs from the people we were seeing, you know, they would want to make a counselling appointment or something. (CM)

So the arrival at a point where the project *was* the building, centred on a daily drop-in, was not planned, in contrast to the development of project A. Even in developing the syringe exchange, the project had not wanted this to be enclosed within their service, but for syringe exchange as a facility to be widely available, diffused through the city. This continued to be an aim; work was still going on with pharmacists to organise a scheme based in shops:

I would really like to have a proper exchange in pharmacists. It's a long shot but they do in Yorkshire, in Bradford. It's great really, people just go into the chemist locally and there's a little sign there and they can just get syringes. It's very, very accessible, very easy to get hold of. I think the more we can do that, and it's the long term we're talking about, the less we may need to have a service located here as the exchange scheme ... It's not difficult to give out syringes to drug users really and I think we need to encourage that ... I think that the more people know about things like safer drug use and safer sex, and actually have to deal with that, the better it is for everyone ... as many workers in as many areas as possible, the better. The wider front you have got, the better chance people have got of getting some information directly themselves. (PM)

The very recent appointment of the detached worker was part of this process, and the main way in which the exchange was being developed. The importance of the post being called 'detached' rather than 'outreach' was explained by the coordinator:

It's detached rather than outreach in that we – a youth worker explained the distinction to me – detached is about working with people where they are and outreach is just about bringing people in. (JT)

Whether this definition of outreach would be universally accepted is not relevant, what matters is that it was the understanding of the project that for the title to mean what they wanted, detached was the right term:

Basically it's to make sure that injectors who don't use our service at the moment have access to needles and syringes and have access to information, advice and counselling. The access to syringes could be achieved by bringing people into the project ... or it could be about trying to tie someone up with a local pharmacist. Or it could be about doing domicilliary exchanges, but that is kind of option three really, otherwise it is very easy just to spend your time going round giving them to people ... So some of it is about working with people where they are, and some of it is about trying to feed people back into services. (JT)

The project's relationship with other services was also marked by fluidity. I have described some of the developmental work they had engaged in, with a fairly broad spectrum of agencies. The major relationship, however, was that with the NHS Drug Problem Team. Jennie's description of the project's initial reaction to the setting up of this service was typical. They had thought:

Oh my God, we've actually been doing all this work with GPs, and now we've got a treatment service', and [the DPT] obviously wanting to come in and find their patch really, and we had been in many ways a very thinly spread service doing all sorts of things at some kind of level and now here was a treatment service who was going to come in and expand what we had but also take away quite a big bit of what we were doing. (JT)

A lot of the concern and 'ambiguous feelings' (CM) staff reported towards the DPT were, therefore, about the way that being an open and 'thinly spread' project left them potentially vulnerable. In particular there was a feeling that the new consultant might be able to determine the shape of services locally in a way that no individual had been able to before, and that this might result in the project being severely reduced, a not unjustified fear. The key difference between the project and the DPT was the practice of prescribing, a practice available to the DPT but not the project:

Looking at developing the Clinic, it feels positive now, it did not feel positive at the time. It was introduced to us, and to the rest of [the DPT],

by the consultant at one of our regular liaison meetings by kind of 'Oh I've been thinking about this, what do you think?'. Our immediate reaction was, you know, this is going to be very like what we do, only it is going to be prescribing as well. If you're the user, do you want to go to a drop-in counselling service, or do you want to go to a drop-in clinic? No contest. And it was a particularly bad time for us because there were still lots of uncertainties about our funding. (JT)

In contrast to project A's clearly defined boundaries and concentration of focus, the diffused nature of the way project B worked had, in the face of power exercised by an NHS consultant, meant that the boundary between the two services had become blurred, almost 'leaky', with staff moving across the divide. In reverse, the senior nurse of the DPT had been coming into the project once a week to provide advice on health issues. Both these developments caused staff concerns about the identity of the project. The decision that two people should share the clinic work had been taken because the project had no choice that the person hours should be provided, their funding meant that it was that or a redundancy, and no one in the team wanted to move completely out of the project team; 'I think it would have been preferable to have an identified person, because I think it's much messier, the way it has been done'. (JT)

There was concern that the difference between the two services would not be obvious:

We're very different. I think that the clients who come to the drop-in, who have been coming here on a regular basis are much clearer. And obviously if you're being referred to [the DPT] then it becomes much clearer what services are available and that we are referring you to them because they can provide this, this and this, and we don't do that but we have this facility, or the ability to refer you to them. But for people who haven't had any contact with either agency, and also professionals I've spoken to aren't clear either. (CM)

The presence of the senior nurse, Celia, in the drop-in once a week, was also seen as blurring the project's identity. As a member of the DPT, Celia was in the position of supervising users' prescriptions. There was obviously a potential problem about her being in the drop-in and able to see people going into the needle exchange. To start with this had been managed by being very clear that she would be there on Wednesdays and that clients should not come in then if they did not want to see her. However this had

broken down and decision had been made that Celia would stop coming to the project when the new clinic opened. I discussed earlier (Chapter Five) the question of the provision of health care within the projects, for the current discussion the significance of Celia's presence is the breaching of the boundary between the two services, and the way that this project did not draw the tight, closed boundaries around itself that project A did.

Project B's developmental orientation meant that boundaries were not, initially, such an issue; quite the reverse, breadth and fluidity were important characteristics. However, this meant that, with the development of another service, the lack of boundaries and the diffused identity of the project meant the potential for at least osmosis and possibly merger.

I described earlier the nature of the space that project B occupied. Unlike both other projects, there was no shortage of space. One effect of this was that it was very easy to try out new developments, like the syringe exchange. There had been a small room, unused and a suitable size, opening off a space that could serve as the drop-in. The drop-in was originally held elsewhere in the building, but had been moved in order to make use of this room for the exchange. Similarly, there was an 'extra' room, too big for an office, but used as a resources room, holding books and leaflets, that professionals from other agencies could use.

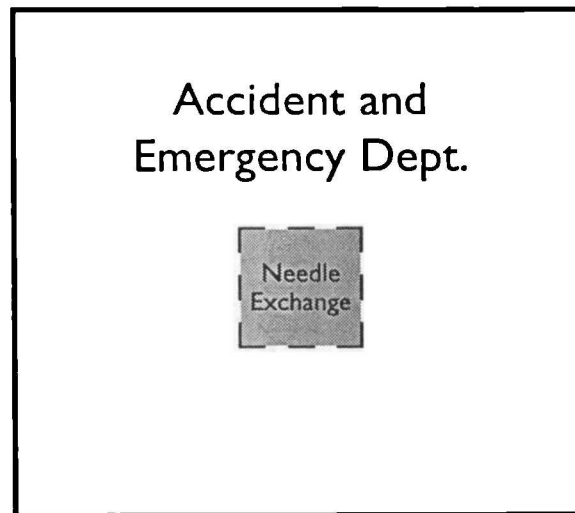
The way that the project shared the building with other services, and was scattered through three floors both enabled and was emblematic of the looseness and diffusion that characterised the project.

Project C: flexible closure

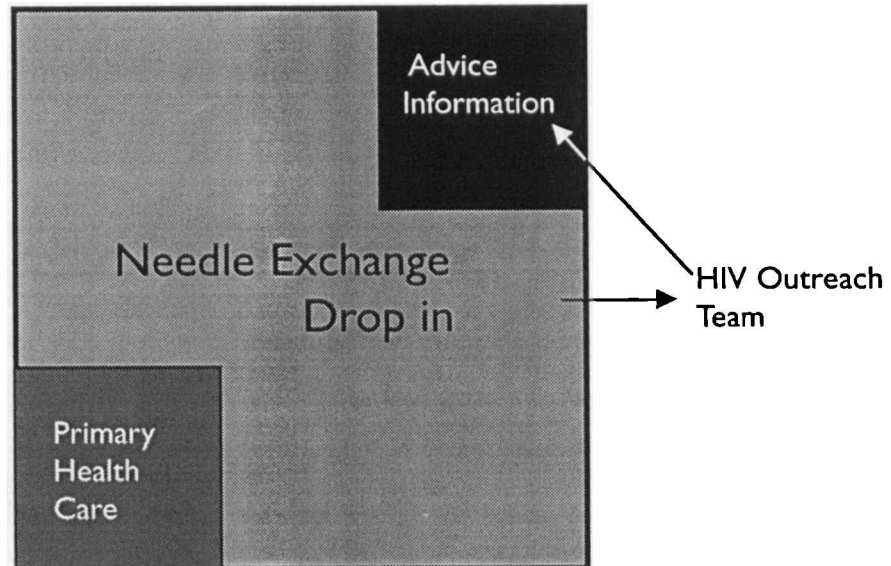
The development of this project was quite different to that of the other two (Fig 5.3). As described above, its early existence was as a function within the Accident and Emergency department; in fact it was literally a trolley, from which Clare had given out equipment. This had many difficulties, not least the question of people bringing dirty equipment back into the hospital, and the constant presence of police which is a feature of A&E departments. This tiny, open and overlooked space was replaced by its own building, described earlier. Clare, who had been operating the service along with her other duties, became full-time and was joined by a second worker, and then finally the team was expanded to four full-time staff, with Clare as coordinator. Until this last development, the team was in principle a collective, Clare had no formal superiority, although as the

Fig 5.3: Development of Project C

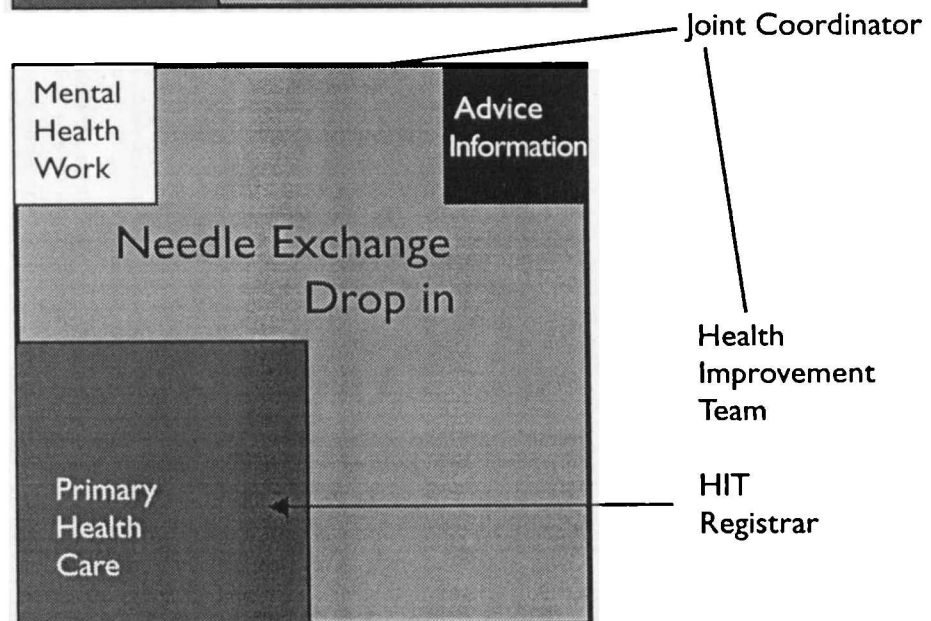
Early 1987



Late 1987



1989



initiator and 'product champion' (Cranfield et al 1992) of the project she naturally had enormous influence over its shape and activity. The diagram shows this gradual increase in size and complexity. What it also shows is that the project was relatively self contained. In the middle phase of development there had been a period of outreach work shared with a street based HIV prevention service, matched by a weekly session of HIV information work carried out by this team. However, this relationship had been hard to sustain during staffing difficulties; there was no spare staffing for outreach, and the project staff had not been able to support the incoming information work adequately. All the project's energies had been spent just keeping the core business going. In the later stages there was a formal relationship with the Health Improvement Team, but in practice, other than Clare's link as joint coordinator this was limited. The presence of the registrar from the HIT in the project once a week was really the only element of joint working.

A major reason for this self sufficiency, which has led me to define the project as being towards the 'closed' end of my range, was that the services with which the project was managerially linked, and with which it might have been expected to have the closest relationship, were the specialist drugs services within the mental health unit. The siting of the syringe exchange within the mental health services was a move Clare was not comfortable with, but which at the time she had not felt knowledgeable enough to oppose:

I suppose if I was honest, if I really had more cop about that sort of mechanism, because I had really only been working as a staff nurse and this whole business about setting up services and putting in bids and seeking premises was really new to me. Even management structures, or the system of units within the health authority was relatively unknown to me and if I had had a little bit more knowledge about it then, I probably would have said 'hang on a moment, is the mental health unit the right place for the project to be anyway, should we perhaps be going to the community unit'. But at that time those things were all above my head really. (CW)

The Drug Dependency Unit was perceived by the project staff as being abstinence oriented and philosophically at odds with the aims and objectives of the exchange in terms of offering drug specific services, and as irrelevant for most of the rest of the project's work: HIV prevention, harm minimisation and primary health care. The

exchange therefore developed as a completely separate service, establishing and maintaining very strong boundaries between itself and the rest of the mental health unit.

Although the project shared the building with other services, it had its own front door; the space of the project that users had access to was completely separate and enclosed. The project was very close to major drug dealing and using areas, and so was very much part of the street drugs scene. This means that there was a risk that clients would bring behaviour from the street into the project. Clients had to knock and wait to be let in by staff. This was seen as important :

Because we are on the street, and that's letting people know that as they come in, they are not on the street anymore. It needs to be a safe place for everybody. So that means that a lot of the street talk, a lot of the street dealings and goings on can't come in here. (PT)

The staff teams

Project A

At interview, Tom described project C as a hierarchy, with himself at the top. Certainly the shape and style of the project owed a lot to his very clear vision of how he wanted the place to be, and what he wanted of his staff. As with the clients who were expected to be 'responsible', clarity and responsibility were demanded of staff. What was expected of staff was not to get caught in time wasting and fruitless work with clients:

I think also, managementwise, if people are given a clear idea of what they're supposed to be doing and then they're told when they're not doing things as well as they could, they're told when they're doing things well and they're encouraged, and there's a general feeling that they're responsible, then people respond to that. (TT)

His role in this was to 'play devil's advocate': accepting that this level of direction and clarity was not often possible, but to keep pushing workers towards it in the face of clients' often muddled and contradictory views:

I don't actually believe, in many ways, that you can just say to people 'boom, boom, boom, one, two, three', but if we kind of aspire to that, we get somewhere close to it. (TT)

Again, as with the way staff talked to and about clients, emotions and feelings were ruled out of the discourse amongst staff. Although the project had regular meetings with an external facilitator, most staff were keen to stress that this was focussed on work and issues to do with the project. Jill described how they did not have individual supervision; she and Dave, her former colleague, had had 'bad experience' elsewhere with this, and said that here, in the sessions with the outside consultant:

We always try to keep things business like instead of anything personal (JP).

Collectively, taking the lead from Tom, the staff team defined themselves as business like and focused, not wasting time within the team on emotions or feelings. Tom had worked in the drugs field for over ten years, and all the others except Adam and Alison (the administrator who had no client contact) had three to five years' experience. Tom portrayed a hardened, 'seen it all before' attitude, both to drug users themselves and to the various ways in which policy and services changed over time and this was the dominant approach within team meetings.

Jill reflected that until quite recently the team had been 'me, Dave and Tom - we had to get along, and make things work, so we did.' They had, however, disagreed about the syringe exchange, which she and Dave had felt was important and so had argued with Tom over it. Tom's account was that they had engaged in a process of negotiation; he 'didn't want to block the whole thing' and so they had 'edged towards' a compromise. However, his reluctance was still there in the way he monitored the exchange so carefully, scrutinising the figures. This scrutiny was an exercise of supervisory surveillance over Adam; the figures made his work in the exchange visible and Tom would comment on them and therefore on Adam's work. This exercise of surveillance did work in making Adam conform to the project's norms. He agreed, for example, to talk to clients about bringing equipment back, although at interview he argued that he felt clients were very responsible, and that this was not a problem except that 'we need the figures'.

At interview he also expressed dissent about the team's approach to their own feelings, saying:

There are times ... when you are working so hard with people who are taking all your energies, and you start to feel that you're not actually doing the right thing, it's very hard to admit that. (AH)

While he commented that 'we don't want collective navel staring', he also said that he found it hard never to have the space to talk about his feelings about work:

Within the staff group we have talked about boundaries ... and there's been some very clear messages from people saying we don't want bleeding hearts. (AH)

Project B

In discussing project A, I quoted Tom's description of the structure as hierarchical, with himself at the top. Project B was a much more collective structure. Jennie was not director, but coordinator, 'which on bad days feels a bit like being the dog's body' (JT). In listening to talk among workers at project B, I was far more likely to hear varying views and opinions than at project A. A particular example of this was how to run the drop-in and what its functions were, which was a source of disagreement among the team. Similarly, at interview, they differed on details and used different phrases or constructions to describe their work, and referred quite easily to the differing opinions within the team. The structure then was much looser than that at project A, and allowed the expression of dissent.

Staff at project B also talked much more about their own feelings and personal lives, within the project. The barriers to this put up at project A were not there. The weekly staff meeting, at which administrative or policy issues were discussed started with an hour of 'support time' during which every member of the team was given time to talk about anything of concern to them, good or bad, to do with work or the rest of their lives. They also had three weekly meetings with an outside facilitator, in which they took it in turns to be the focus of attention and which they all valued.

All of the team except Sarah and Christine had been new to the drugs field. Jennie, Peter and Louisa had all had worked with homeless people, and Peter and Louisa had both also worked in voluntary sector alcohol projects, while Pan had been an engineer and then worked in youth training and community work. Christine had worked as a secretary in the probation service and then as an administrator in a drugs training unit, while Sarah had several years working in the voluntary sector drugs field in London. She in fact had a very similar career history to most of the staff at project A, which made the different backgrounds of the other staff here more obvious. Collectively they brought to the

project their experience in advice and information giving and counselling to a range of client groups but not, apart from Sarah, extensive experience of drug users.

Disagreement could be openly aired; indeed it was part of how the project operated that staff were called on by each other to express opinions, describe their vision of what the team should be doing, and construct their selves through debate. This was a very different exercise of power, one that was shared across the project. They all made their selves and their views visible to one another.

Project C

Until Clare's promotion, and the filling of the clinical nurse specialists' posts, project C had been a collective structure, with everyone on the same grade and rates of pay. However, with these changes, the project had become a hierarchy with the nurses on significantly better pay scales than the DHEWs. The move towards a more formal nursing approach was discussed earlier, but this was also causing friction as Polly, at this time the only DHEW in post, felt that her role and contribution was being downgraded. These tensions within the team were partly linked to the backgrounds of the staff; both Susan and John, obviously, came from a nursing background, although both had worked in drugs services before. Significantly, at interview it emerged that Polly was also qualified as a general nurse, but that she had rejected nursing and gone on to qualify as a social worker and counsellor. She was very clear about the difference between these background disciplines, and felt that she could see, in a way the others could not, what was being lost.

Rather like Tom at project A, Clare was a very strong character with a clear view as to how she thought the project should develop and in many ways, Susan and John shared her background and views. Polly on the other hand did not, and was prepared to express her open disagreement with the others. She was, however, also considering leaving the project.

The team had weekly group sessions with a psychologist. This was seen as an important chance to articulate feelings and anxieties and was something Clare had organised very early in the project's development and maintained since. All the staff stressed how important these sessions were, in two principal ways. The obvious importance was in order to address the differences that were beginning to arise within the team. The sessions were a space in which, like the staff of project B, the team could, through talk,

make their selves visible to each other through talk. This was 'allowed' by the project's internal practices, but it seemed as though it would not be enough to resolve the tensions

The other function that the group sessions fulfilled was to provide a sense of continuity and history. The staff team had changed rapidly throughout the life of the project, and except for Clare, none of the team had been in post for even a year. Susan summed this up:

[We] can actually get feedback on what staff have actually coped with in the past, because you think 'well other people have coped' ... you don't think you're the only person. (SS)

The identity of the project was thus being created and maintained by this continuity; staff felt they belonged to an entity that had existed prior to their arrival.

Use of time and language

I now describe the ways in which the projects' use of time and language was both reflective and productive of the identities I have outlined.

Time

One very clear way in which boundaries were kept at project A was time; the morning 'worker controlled time' defined limits on availability; clients were sometimes just ignored if they knocked on the door during this time without an appointment. More importantly, the daily staff 'handover' marked the end of the day. Tom saw this as an important meeting:

[E]verybody gets a picture of what's happened during the day, it's an unwinding from the day. Certainly I try and be conscious as it goes on of trying to lighten the mood. (TT)

Similarly, time was the boundary of the live caseload: anyone seen in the last two weeks. The filing system and clients' meeting described in Chapter Four, along with the daily meetings, meant this group was tightly defined, and visible to all staff. Once people had not been seen in the project for two weeks, they dropped from visibility. There was concern that even with these limits the size of this caseload was becoming too big, over a hundred people was too many people to encompass.

At project B, time was used in open, fluid ways. The project did not have a daily meeting, staff went about their business each day and met for longer meetings weekly. The callers' meeting, at which staff discussed clients, was a loosely structured meeting, with workers bringing up particular clients and discussing them at some length. Individual workers had their own caseloads, and shared information about clients in order to develop their own work with the client, rather than to make the client visible to other workers. Other than very basic information collected on everyone, what was recorded in a file was the worker's own choice. There was therefore, no defined caseload for the project as a whole; each worker held knowledge about the clients they were working with. There was no equivalent of the time limit at project A which made the caseload visible to everyone. In practice of course, they all talked to each other and knew a fair amount about most of the people who used the project, but there was no structure for purposefully ensuring that this happened.

Time was used to mark the boundaries of project C. Although this exchange was open for much longer hours every day than the other two, the drop-in was only open for three days out of five. This was to enable staff to drop the 'policing role' and offer more individualised services to people. So on these days the drop-in area became simply an exchange area – no chairs – while the treatment room and office (used for individual sessions) were open as normal.

However, in other ways, time was extremely fluid. There was no appointments system, and so staff never knew what was going to happen during the day. In this respect, the service was like an Accident and Emergency service, and while a basic queuing system operated, staff had to be constantly making decisions about priorities and the need for action.

The difference between this and the other projects in this use of time was reinforced for me when I tried to arrange times for interviews. At both other projects, workers would get out their diaries and make appointments – as they would for a client. Here staff would suggest a certain day and promise to try and be free. For both Clare and Susan this failed on the first attempt and I had to come back a second time.

Staff had decided to move the handover from the beginning to the end of the day. This meant closing the project half an hour earlier, but did mean there was a clear end to the day, rather than staff having to rush off as soon as the last client left.

Language

The final way in which identities were expressed and maintained was by the use of language. At project A, a particular kind of cynical humour was used, most particularly by Tom. This was usually in talking with staff, and was used to close discussions or indicate the limits of the project's responsibilities to clients:

In handover, if anyone starts being 'soft' on the clients (usually Jill), Tom has a cynical comment to harden attitudes up. For example, today a girl who is in ROMA had come in to ask about a clothing grant. Chris (relief worker) had rung the DSS and been told that she could get a community care grant under certain conditions, one of which was that all her clothes had been stolen. Tom said; 'Her clothes have all been stolen, she steals them from other people.' Everyone laughed and that was the end of the discussion. (Observation notes)

Another example involving the whole team occurred in the clients' meeting. The team were discussing a young man who was going into Phoenix House in Sheffield:

Normally he would need a detox first, as he is on a fairly large script, but he apparently sells rather than uses most of his script. Although arrangements were being made for him to go to City Roads first, because his admission date for Phoenix came up sooner, they agreed that he should be told to go straight there and 'suffer'. Jill said: 'Go directly to Phoenix, do not pass go, do not collect a detox'. (Observation notes)

The material my interviews elicited reflects many of the characteristics of the three projects. Here, other than Tom and Adam, staff were very brief and factual in what they said, tending to use phrases and constructions that echoed the public accounts of the project given in its own reports and publicity. Words like responsibility and clarity figured often. Alison, the administrator, said very little and saw her role as separate to that of those who had direct client contact. Fiona had only been there a few weeks and was still finding her feet. She expressed a feeling of being 'daunted' by the reputation of the project as a team. The identity of the project as somewhere practical health advice was available had attracted her to the post and she described the project in the terms other staff used to describe it, but in practice she saw much of the work in the needle exchange

as 'belonging' to Adam; he had told her when she first arrived that there was no problem about her doing simple dressings, but this had worried her.

Both Tom and Adam, on the other hand, gave long discursive interviews. Tom talked at length about the changes he had seen in drugs services over the year, and argued that harm minimisation was nothing new to the voluntary sector. Projects he had worked in in the 1970s had given advice about 'safe drug use'; not to mix barbiturates and alcohol, for example, or the importance of cleaning syringes and needles. This was the origin of the project's approach, a refusal to get carried away by recent changes. The need for focus and boundaries emerged from this, and was accepted by the other members of the team in terms of their work with and relationship to clients. In contrast, Adam talked at length about his disagreement with the way this attitude informed the team members' relationship with each other. He dissented from the idea of the limits to discussion, saying he needed a space in which to explore his feelings about his work and role.

At project B, there were no such limits drawn; staff discussed their own and clients reported feelings and ideas at length in meetings. A striking feature of the interviews with staff at this project was the extent to which they not only discussed their feelings, but couched their comments in terms empathetic with clients. In describing the drop-in and the problems that arose there, the women staff in particular were likely to phrase this in terms of how they would feel were they clients:

I wouldn't feel happy about just sitting down in that group. (CM)

I just sometimes think about how I would feel if I was walking into the drop-in, or if I wanted to come for needles and would I actually come here? (CM)

Or in describing how there was no point in drugs services 'haranguing' clients, because any reasonable person would then do the opposite:

They change and do things in the light of how they feel themselves, something for them, that's me one hundred per cent, I'm totally pigheaded, so I know, I expect other people to be the same. (PM)

The family support worker, Louisa, was probably the most extreme example of this; she identified with her clients as women, and in particular as mothers, throughout her

interview. Describing the way she had researched what women wanted for the Women's Mornings:

I am very aware that the examples I gave on the questionnaire are extremely attractive examples; would you like to have massage, would you like – I gave purposefully the most gentle, loving, pampering sounding ideas, because I believe that we deserve that. (LW)

Or defining her client load as being women and specifically, women with children:

[There are] quite a lot of women with children on the register, or they've been experiencing difficulty in being a mother, although I don't know anyone who doesn't actually. (LW)

During the interviews, staff gave differing, though not conflicting, accounts of the project's development. Each told their part of the story: Peter described the satellite projects; Louisa, the work with women; Sarah, the prison work and so on. This multiplicity of voices and perspectives is evident from the way I have reconstructed the material in this chapter. It reflects both the dispersal of the project's sites for work as well as the shared exercise of power. Unlike both Clare and Tom, Jennie did not exercise a hierarchical surveillance over the other members of the team and did not have any more influence over the style of its work. This was agreed through shared processes.

I have discussed the particular use of a 'code' in the language used with clients at project C, to reinforce the boundaries and protect the integrity of the project. Within the team language reflected the growing gap between Polly and the other members of the team. Her dissent, in contrast to that of Adam, was about the project's style of working with clients, although she was also unhappy about the move towards a formal hierarchy. This meant that the language the nurses employed was pushing out the one she used. This was suggested earlier, in the discussion of the very different way she and John constructed notions of mental health.

Summary

In this Chapter, I have developed my descriptive analysis of the three projects, beyond their approaches to harm minimisation and self management. Describing their development and their practices, I have argued that they are characterised by varying degrees of enclosure and openness, control and diffusion.

Project A I defined as enclosed, with tightly drawn boundaries around itself vis-à-vis other services, around its responsibilities towards and relationship with its clients, and around what was legitimate for staff to discuss. The drug user was required to attend the project frequently, and through this they were made visible and constantly present in the talk of staff. If they chose not to attend, they dropped from visibility.

The significance of the syringe exchange was played down, and its presence controlled by embedding it in the health and harm reduction work, and constructing it as a way into the rest of the project, rather than as a service in its own right. Far more emphasis was put on drawing used equipment into the project than on giving out clean equipment. The act of returning equipment was defined as responsible behaviour, rather than the prior act of taking clean equipment and using it. While people were using the exchange, the project attempted to exercise a fair degree of control over their behaviour away from the project, asking for frequent contact to keep them visible.

Within the team similar boundaries were kept between roles. The project had a clear, hierarchical structure, and the origins of the project's style of working lay in the experience and views of the director. This style was accepted in relation to work with clients by all the team, but was resisted, though not very effectively, by Adam, in terms of the way the team constructed its self.

Project B I defined as open, with very fluid boundaries between it and other services, most importantly the new NHS Drug Problem Team. The project staff were among the authorised speakers on drug use within the city, and this had enabled them to exercise power to make other professionals, for example some GPs, change their practice. However, when the issue of a syringe exchange arose, other speakers, on the District Drug Advisory Committee, had determined the model of practice the project adopted. The effect of this had been to make the project a less diffused, developmental entity, and more of a direct service provider, existing within and coterminous with its building. The emergence of another service provider, the DPT, institutionally located within the NHS and led by a consultant psychiatrist, was perceived by staff initially as a threat. Some of this threat arose from the consultant's right to the practice of prescribing.

Here the syringe exchange was constituted in the same fluid manner as the project itself, and there was not the concern for control evident at project A. Making equipment available, by whatever means, was seen as the key task. Using the exchange was seen as a sign of responsibility, and users were believed in their explanations of how they had

disposed of equipment; staff did not have to see that disposal for themselves. The significance of the act of syringe exchange was played down; workers saw it as a simple task, one which a much wider range of services or agencies could perform.

Power within the team was also dispersed, all members could and did speak and through discussion construct the style of the project's work. This process was both reflective and constitutive of the project's identity, its sense of self.

Project C I defined as towards the enclosed end of the range, but with less concern for control over the individual drug user. Very clear boundaries were drawn around the project to distinguish it from both other drug services in the Mental Health Unit, and from the street drug scene. Making the project physically and psychologically accessible put these latter boundaries at risk, and staff spent a lot of their time policing them; watching and listening, and enforcing rules when they were breached.

However, this closure was not matched by the same degree of control over clients' behaviour away from the project as at project A. Staff made rapid decisions, categorising people in terms of the likelihood of their returning equipment or disposing of it safely. Getting equipment back was important, but failure to return was not met with the outright refusal of more equipment. Similarly while staff expressed concern about people who used the exchange without asking for other help, no pressure was put on people who chose to use the service like this. Maintaining the boundaries and integrity of the project was important, but controlling the way in which clients chose to use the service was not.

Within the team, as at project A, there were clear structures, boundaries to responsibilities and a hierarchy. A particular style was coming to dominate the project's work, a style which had its origins in the professional backgrounds of the majority of staff. This was resisted by one member but promoted by others. Although the team recognised the importance of discussing their own lives and responses to work, and there was structured time for this, discussion was not resolving these tensions and different perspectives.

CHAPTER SEVEN: CONCLUSION

Introduction

In late 1986, a new service for people who inject illegal drugs was announced. This service, 'syringe exchange', was a response to the threat of HIV transmission among and from injecting drug users. Although the practice was started cautiously, on the part of government, with pilot schemes and evaluation, within two and a half years it had spread to become a normal part of the work of most drug agencies in England. With it there developed a discourse of 'harm minimisation', aimed at preventing, not just the spread of HIV but also the myriad of other harmful effects of drug injection.

This thesis started from the research question, 'what made it possible for syringe exchange, and with it harm minimisation, to be the response within English drugs policy to HIV?'. In Chapter One I stated that I would use a methodological approach drawn from Foucauldian genealogy, and outlined a theoretical framework employing themes from the work of Foucault and other writers, notably Armstrong, Rose and Turner.

In this final chapter I will draw together the themes of the thesis. Firstly, I will rehearse certain key theoretical assumptions, and what I mean by genealogy and the implications of this approach for the study. A key issue is the tension between the theoretical framework and the practice of empirical fieldwork, and here I will reflect on how I have managed this tension in the thesis. I will then take my argument through the following stages:

1. *The conditions of possibility of syringe exchange*
HIV, and the need to respond to its transmission among injecting drug users, did not force a change in the discourse of English drugs policy. The discontinuity had already occurred, and a new discursive space been created. A changed discourse was being constructed by a range of speakers from new sites of practice (Chapter Two). HIV provided the justification for a particular practice that both reflected the new discourse and further authorised its speakers and the sites from which they spoke (Chapter Three).

2. *The discourses of health*

There have been other, earlier discontinuities in the discourse and practice of twentieth century English drugs policy. These can be understood in terms of the discourses of health in the disciplinary society, and in the exercise of individualising and totalising power (Chapter Two).

3. *The self managing drug user*

The possibility and emergence of syringe exchange and harm minimisation can also be understood within this wider discourse, and the particular form of individualisation of the late twentieth century. They are means of self management by the drug user, towards whom the role of services is that of empowerment. They encompass both care of the body and knowledge of the self as techniques for self production (Chapter Five).

4. *Diverse and local sites*

The practice of syringe exchange and harm minimisation, and the discourse that practice both produces and reflects, are constantly reconstructed in diverse sites, in response to the local exercise of power and to local possibilities (Chapter Five and Chapter Six).

Key theoretical and methodological assumptions

The analysis of power employed in this thesis is as a force that is exercised, not a commodity that is possessed, and as intrinsic to all relationships. Power is not inherently repressive in its effects, but is positive as well. It is exercised through language and through other practices. Here I am looking at that productive notion of power; the creation at different times and through changing discourses and practice, of a different identity for the drug user. Using a similar approach, Nettleton (1992,1994) shows the production of different figures of the dental patient over time. The productive and potentially positive exercise of power needs stressing. In *Discipline and Punish* the exercise of this productive power can seem unrelentingly oppressive, in spite of Foucault's statement that it is also positive and creative.

The thesis also assumes that discourse and practice are interdependent, and are mutually reflective and productive. Authorised speakers produce their discourse from institutional sites that are both a source of authority and a location for practice. Practice produces knowledge that both verifies and produces anew the truths of a discourse. There is no

universal truth to be discovered or extracted by practice; for discourse to be accepted as truth, it must conform to the general regime of truth.

The genealogical approach also contains particular assumptions: firstly that we are interested in understanding the present by tracing its lineage into the past, rather than in reconstructing the past itself. That lineage will contain discontinuities and breaks, and it is these that are of interest.

Secondly, there are no essential truths or absolutes; all forms are transitory and provisional. In talking, for example, about the 'emergence' of syringe exchange, I am not implying some fixed, essential practice. As I argued in Chapter One, words, ideas and practices do not have intrinsic meanings or explanations, but are used tactically at any given time. The practice of substitute prescribing demonstrates this; it has been used in many different ways, including as a form of individual harm minimisation, as an explanation of the spread of addiction and as a means of undercutting the illicit market. Similarly, as we saw from the fieldwork and the survey, the practice of syringe exchange can vary and be used in different tactical ways.

Thirdly, in genealogy we are not looking for causes, but for conditions of possibility. There is no necessity for things to happen, because there are no underlying laws; instead every event or history is specific and dependent upon a specific constellation of conditions.

Implications for the thesis

The first implication of my approach I wish to draw out is that the approach involves standing back from the notion of a universal 'truth' about drug use, from that constructed within the discourse of harm minimisation as much as from that constructed within the psychiatric discourse of the 1960s and 1970s. I have therefore employed the terms 'addiction' and 'addict' when these were the objects of the discourse I was discussing. I have not intended this thesis as a contribution to what Strong has called the 'Piltown man' school of medical sociology (1979a), debunking, for example, the construction of addiction as a medical disease to show that a truer definition is possible. I hope that I have maintained a distance, not necessarily an ironical one, from the issue of what is or is not true about the practice of the use of illegal drugs, and instead provided an analysis of how that practice has been constructed at different times and the conditions of possibility and effects of those different constructions.

Secondly, the analysis of drugs policy from this perspective requires the analyst to look not at some central locus of power, but at the exercise of power at the periphery: in the surgeries and pharmacies where the prescribing and dispensing of drugs left traces visible to Home Office surveillance, in the Clinics where the practice of prescribing was scrutinised and adjusted in the light of the knowledge that scrutiny produced, and in the projects where syringe exchange was practised and developed. That is why the balance of this thesis (although not all of it) is located in the periphery, not the centre. Other accounts of policy, employing other approaches, have focussed on the centre, on events in central government and the role of the key civil servants and advisers, for example (Berridge 1991). The point I am making here is not about the difference between policy formulation and its implementation at the local level, to examine this would have been a different thesis; but about the nature of power. The model I am working with is not one in which syringe exchange was an idea that started in a central government office, and was then implemented by actors out in the field. It arose through the dispersal of power, ascending from the field as well as descending from the Department of Health.

However, this location in the periphery raises several issues about methodology, and particularly about the practice of fieldwork. Many Foucauldian studies are based on analysis of documents and the descriptions of practices contained within them, rather than on observation of practice on the ground. Here, as well as document analysis, I have attempted to 'do' fieldwork with a Foucauldian mind. In doing this, I have employed the traditional tools of fieldwork that arise from the interactionist and ethnomethodological schools: observation and interview, with some survey work. The question is whether these tools can really be adapted for a Foucauldian analysis. I am clear in my mind that the theoretical assumptions about power make it necessary to try. If power and surveillance are played out in different ways in local sites and under local conditions of possibility, then that is where we must look, at least as much as at the centre. Similarly, if discourse and practice are interdependent, and practice is productive of discourse as well as reflective, then we must examine practice, day by day, in those local sites, alongside the official discourse.

Foucault provides the substantive themes of the thesis; surveillance and the changing exercise of productive power, the relationship of discourse and practice, the significance of the sites of practice and the production of knowledge, the realms of the mind and the body. However, in spite of his notion of a history of the present, Foucault provides few tools with which to analyse the present, and in particular to analyse those practices which

are non-discursive. Document analysis alone will only provide access to the representation of practices within discourse, yet Foucault assumes the prior existence of non-discursive practices such as enclosure or confession.

The limitations of the tools account for two major difficulties in the application of Foucault's work; how to explore non-discursive practices and really reflect on the dynamic relationship between discourse and practice, and how to study resistance as well as the exercise of power.

To take the first of these; if non-discursive practices can only be accessed through discursive practices, ie through description contained within documents rather than as they are performed, then they will always be secondary to discourse in the production of knowledge. And yet central to the question of knowledge as power is the effect of practice; practice creates as well as reflects knowledge. Here I have taken the line that the practices of the present are available to us in other ways.

In analysing discourse with a 'Foucauldian' mind, we are using one of the basic tools of sociology's practice; reading. It is the form of analysis which is specific. To 'capture' practice, in order to analyse it, we can use other basic tools of sociology; observation and interview. The difference lies in the use of the material obtained through the tools, rather than in the tools themselves. I am aware that this is not a complete answer. Sociology, as one of the 'sciences of man' is itself constitutive of the objects it studies. The 'tools' I refer to are non-discursive practices of the exercise of our discipline; observation, for example, assumes some objective reality to the action it observes. Foucault himself, as Freundlieb (1994) argues, does this in even the *Archaeology of Knowledge*, constructing the entities he calls discursive formations and the rules that govern them. Perhaps it is ultimately impossible to step outside this paradox, and 'do' Foucauldian sociology, in which case my thesis represents a compromise.

In the first piece of fieldwork (Chapter Three), I dealt with this by abstracting the text of the interviews and treating them as a form of text, freed of any issue about the reality of practice. In the second piece of fieldwork (Chapters Five and Six), I cannot claim such a neat let out from my dilemma. I have to acknowledge that I do believe that the practices I observed and recorded had some kind of existence rooted in reality, and that what I have done through my practice as a sociologist is to inscribe them as text: my fieldnotes and interview material. Unlike the use of the interviews in Chapter Three, I have used this material as both text and as access to that prior 'reality'. Having acknowledged this

compromise, I would then say that my practice and analysis were both heavily influenced by the substantive theme I drew from Foucault's work. Without these, I would have 'seen' health promotion and health education going on in the projects, and described and analysed it as such. With Foucault, I saw a different process going on; the construction of the self managing drug user through those practices.

The emphasis on discourse and document analysis explains another weakness in Foucault; the failure to theorise adequately the notion of resistance and the 'absence of an analytical approach to resistance' (Bloor and McIntosh 1990:161). Without observation of practice, we have no idea how much resistance is invisible because it remains undocumented and undescribed. Here I have looked at the notion of resistance, though I acknowledge that my focus on the staff of the projects and not the clients means that I have probably not explored this as fully as I could have.

The approach that I have taken; to use the tools of observation and interview, but to analyse the data as I have will probably be frustrating for those coming from an interactionist perspective, to whom the picture I have painted may well seem impoverished, with details and illumination left out. Indeed if it does not appear in this light this may be because it has not been possible to sustain my approach and I have slipped into other forms of analysis.

To sum up; I have not taken a purist Foucauldian discourse analysis approach. If I had then clearly my methods would be inappropriate. Instead, informed by Foucault, and seeking to explore some of his substantive themes, I have attempted to do so, acknowledging the paradoxes and limits to this approach. Chapters Five and Six are an attempt to do this, and they perhaps bear the marks of the lack of 'fit' between the available tools of fieldwork and the theoretical frame. Their merit, I believe is, in taking up the issue of practice as productive of discourse as well as reflective. They show how a discursive object is constructed and re-constructed in the everyday practices of diverse sites.

Research as surveillance

Before moving on to my substantive arguments, there is a further aspect of my practice to reflect on. As I made clear at the start of the thesis, as a researcher within the Monitoring Research Group, I was part of the input of science into policy about HIV. The MRG's work was, as its name suggests, to 'monitor' and then evaluate the practice of

syringe exchange as a means of controlling the spread of HIV by changing individual drug users' behaviour. The majority of this exercise involved the surveillance of the users of syringe exchanges. The staff of all the pilot exchanges completed structured forms about each client who attended, and then recorded their pattern of use of the service in terms of dates of visits and amounts of equipment both taken out and returned. These forms were returned to the research team, and the data aggregated and analysed, producing the scientific truths about the effects of the practice of syringe exchange. These in turn were given to civil servants, who incorporated them into briefs to ministers, and disseminated them via policy documents back out to the field.

Within the research team I was not involved in this part of the work. The area for which I had responsibility was the examination of the operation, styles and management of the syringe exchanges themselves. In other words the objects of *my* surveillance were the staff rather than the users of the projects. The information I gathered was also processed and passed to civil servants. I am not unaware of the irony of this; that I am exploring issues of surveillance, power and the construction of objects of knowledge within settings over which I exercised a degree of surveillance. At one level this is the paradox of all sociology that I mentioned earlier, but I acknowledge that it need more discussion in this particular instance.

The question is, in what ways will this have influenced the research for the thesis, and how have I dealt with this? My view is that it had the most influence in the first round of fieldwork. At this stage, syringe exchange had not been 'proved' to work, it was experimental and its future not secure. By definition, most of the staff involved in running the pilot exchanges were intuitively committed to the idea. Indeed, for some of them the need to prove its worth in terms of preventing HIV ran alongside a commitment to it anyway as a means of improving drug users' general health. When I and my colleague interviewed them, we were engaging in an overt form of surveillance. They knew that we would report what they said, and they saw us as their opportunity to explain and advance the idea of syringe exchange. In using the interviews, I have used this situation quite deliberately, they were public accounts of the practice and the philosophy behind the practice. Having done this, I believe that I have dealt adequately with the tensions inherent in the situation.

By the time of the second round of fieldwork, the focussed study of three projects, syringe exchange had received its incorporation into policy; both the ACMD report (1988) and the result of the evaluation had been published (Stimson et al 1988b). The

Department of Health had issued guidelines for the operation of exchanges (DoH 1988), and some extra money had been made available to health authorities for services. The intense pressure of the pilot year was relaxed, and I believe that my presence was not experienced by the staff as surveillance, except in the normal way that social research is. All three projects were successful ones in terms of numbers of clients being seen, and staff were confident about their work and performance.

That the continued work of the MRG was experienced as an exercise of power elsewhere, I am aware through the national survey I carried out (Lart and Stimson 1990), and the contact this brought me into with services running exchanges on different lines from the ones monitored. A real issue was the question of the monitoring of clients. The form that staff were asked to complete with clients on first use or as soon as possible was fairly comprehensive and in a few agencies this was seen as too intrusive and not appropriate with drug users, and likely to scare them away from using the service. These schemes declined to participate in the further monitoring research for which the schemes identified by the survey had formed a sampling frame. This meant that, other than the returns they made to the national survey, these schemes were not visible. In other schemes, particular very small ones, the surveillance of the project was experienced as positive; it provided a sense of identity and confirmation.

The conditions of possibility of syringe exchange

The idea that the arrival of HIV did not of itself change English drugs policy is one that has been expressed elsewhere (Stimson and Lart 1991, Berridge 1991, Stimson 1990). If the threat of HIV transmission alone was enough to explain the response of syringe exchange and harm minimisation, then the policy of other countries, notably the USA and Sweden would have been very different. Instead, in neither of these two very different countries was syringe exchange possible in the way it was in England. In the USA, existing 'drug paraphernalia' laws have hindered the development of syringe exchange, although this varies between states, and in, for example Washington State, the state supreme court has upheld the legality of syringe exchange as an HIV prevention measure (Hagen et al 1992). The predominant response in the US has been outreach work to give information about HIV transmission, to teach drug users about cleaning equipment and, in some cases, to give out bleach. A major outcome of such work has been the encouragement of drug users into treatment programmes (Abdul-Quader et al 1992). In Sweden, in spite of an official report in 1988 based on the evaluation of two pilot schemes and recommending the adoption of syringe exchange, government has not

allowed the expansion of such schemes. The pre existing aim of a drugfree society defined syringe exchange and harm minimisation as signs of a capitulation to the drug epidemic (Gould 1993, 1994). It is important to remember how fast, and with what relative ease, syringe exchange was accepted in England.

In Chapter Two I outlined the specific set of conditions existing in 1986, when HIV first became an issue. Over the preceding five or six years there had been a shift in the discourse about drug use, and the creation of a range of new sites for practice. The shift in the discourse had appeared first at the centre, in the ACMD's 1982 and 1984 reports, and in the work of advisors and civil servants (Berridge 1991), but was spread to the periphery through this new network of sites. The surveillance offered by new techniques of estimating the prevalence of drug use (Hartnoll at al 1985) and the research that inscribed its social parameters (Pearson 1987, Parker at al 1988) mapped a new epidemic. Drug use came to be seen as almost endemic, embedded in the social body, rooted in the lifestyles of the young, increasingly surplus population. It was no longer a metaphorical contagion, with rapid and disastrous effects for the individual, (although crack-cocaine began to emerge in the discourse in this form in the mid-eighties). Instead, most drug use was conceptualised as a more insidious and long-term condition, of deterioration and gradual disability: the *Treatment and Rehabilitation* report's 'chronic handicaps and disorders of behaviour' (ACMD 1982:para 5.19).

This new discourse was not so much de-medicalised as de-psychiatrised, and opened up to include non-medical claims to knowledge. The 'chronic handicaps and disorders' had effects not just in the psyche of the individual, but on the body and the social being as well: 'social, psychological, physical or legal problems' (ACMD 1982:para 5.13). They were not, then, the proper concern of specialist psychiatrists, but of teams: of nurses, social workers, probation officers and others whose expertise was in the management of these complex needs arising from people's behaviour.

These teams were created throughout the network of the NHS, following the publication of the *Treatment and Rehabilitation* report, and as an effect of the exercise of a disciplinary power by the DHSS. The health authorities were subjected to a form of hierarchical observation and normalising judgement by the health circulars that asked for information, not just about drug use prevalence, but also service provision and development plans (DHSS 1984). The effect was not only an extension of surveillance of drug use, but a scrutiny of the authorities themselves. The publishing of the returns made visible the paucity of information and the lack of plans possessed by most health

authorities (DHSS 1985). The spread of the model of the community drug team, or drug problem team, that followed, aided by the Central Funding Initiative, created a whole new network of sites for the practical application of the new discourse. The personnel of these teams, many of whom were new to the drugs field, spoke the new discourse of 'problem drug use', and from these sites gained authority for their claim to articulate the truth about drug use and the drug user.

It was in this new discursive space that the specific practice of syringe exchange emerged. At the centre, the acceptance and promotion of the ideas of *Treatment and Rehabilitation* made it possible for the Secretary of State to state that government advice on HIV would include the injunction 'Do not inject drugs, but if you cannot stop, don't share equipment' (Hansard 1986a:col 804), and to announce the pilot syringe exchange schemes. The evaluation of these would ensure that the knowledge produced by the practice of syringe exchange conformed to the scientific regime of truth, and so could be articulated by government.

The role that HIV played was to provide a specific practice that was both reflective and constitutive of the new discourse. If syringe exchange was made possible by the new discourse, its practice further authorised and proved the truth of that discourse. It was a concrete expression of the discourse, something that had been lacking. The practice of substitute prescribing, particularly of heroin and other injectable drugs, was tightly controlled, by legal circumscription but also, and perhaps more significantly, by professional norms. Syringe exchange, on the other hand, was a practice that the staff of the new services could engage in, particularly those who were nurses. Syringes were part of their daily practice anyway, as was teaching people about their bodies and how to look after them, and meeting the basic first aid needs that drug users brought to the exchanges. The act of giving out equipment made it possible to talk about injecting and the harmful results of poor techniques. This made relationships between staff and drug users more 'honest'; drug users could disclose the reality of their drug use, and with it that of the rest of their lives. From these disclosures, and the practice of syringe exchange, the staff of the exchanges produced further truths: about their clients and about their work.

The discourse that accompanied this practice became known as harm minimisation. The task of preventing the spread of HIV was subsumed in the wider task of improving drug users' physical health. The ACMD report *AIDS and Drug Misuse Part 1* articulated this discourse from the institutional site of a ministerial advisory body, legitimating and authorising what staff in the exchanges were doing and saying. The report of the

evaluation, from the institutional site of a university, pronounced, albeit cautiously, that syringe exchange 'worked'; the knowledge produced through the monitoring research was that injectors who used exchanges reduced the extent to which they shared equipment with others. But even before this, syringe exchange as a practice, and the discourse of harm minimisation, had spread and were appearing in diverse and diffused sites throughout England.

The discourses of health

To understand this change in wider terms, we must locate the story of drugs policy in the wider discourse on health. Discontinuities in drugs policy can be understood in terms of changes in the discourses and practices of medicine, public health and psychiatry. These three disciplines are central to the exercise of bio-power and the workings of the disciplinary society. This focus is not to deny that drug use is also an object in other discourses, for example, that of crime, and that these discourses also produce practices the effects of which are constantly visible in drug users' lives. However, here I have examined the discourse of health and the exercise of power through that discourse.

Over the twentieth century, the gaze of medicine and psychiatry have moved from the individual bodies of those they enclosed within hospital and asylums, out into the unenclosed population. Here they articulated with the gaze of public health, and through the development of epidemiology as technique of surveillance constructed new objects for their discourses: the social body, and the interstices of that social body, in which could be discerned contagious diseases; the realm of the psyche as the site of the psychoses and the neuroses. These new objects were reachable from new sites of practice, outwith the walls of hospital and asylum, and once re-located there, practice made them ever more visible.

This process of exploring the social realm has gone on alongside the continued focus and development of clinical, hospital based medicine. The two are linked in the sense that it was the signs 'discovered' within clinical medicine that the new discipline sought in the general population.

This extended gaze began to dissolve the divide between the diseased and the healthy, the mad and the sane, both within populations and over time. From the blurring of the simple binary divide emerged a complex grid of 'risk' to be superimposed on the population. The development of medical knowledge, and the ability of technology to

handle more, and more detailed, data, creates ever greater categories of risk as minuter deviations from the norm are identified. The mesh of the grid is ever finer; potentially, with the knowledge of genetics, each individual could occupy a solitary cell in the grid of risk.

However, medical practice could not keep up with this individualisation. Instead, each individual must be his/her own supervisor; the production of the healthy self is the individual's responsibility. On offer is the guidance of experts medical and non-medical, dispersed through the media, the workplace, the leisure industry and myriad sites of practice, both statutory and non-statutory. Knowledge and advice is packaged and sold to the individual who, by constant monitoring of the body and the mind (the emotions, feelings and desires), and by the adoption of healthy behaviours, both somatic and psychic, takes care of the self.

The genealogy of drugs policy

Drug use has not escaped this extended gaze and redefinition. The Rolleston Report assigned addiction to the category of the neuroses, but at a time, the 1920s, when these were still, just, understood as arising from somatic disorders peculiar to some individuals, or categories of individuals. Those who spoke the truth on addiction were neurologists and general practitioners, and that truth included the practice of prescribing, for some addicts, to maintain their normal functioning. But this truth existed alongside the legal discourse whose object was not addiction, but the unauthorised possession of certain drugs. The Home Office, while leaving individual treatment alone, monitored the presence of those drugs in the social body by surveillance of the practices of prescribing and dispensing.

In the post-war period that surveillance mapped the growing presence of addiction and its changing epidemiology. The passing of the neuroses from the domain of neurology to that of psychiatry gave that discipline the authority to speak on addiction. When the surveillance began to reveal an 'epidemic' of addiction in the 1960s, the disease itself was re-located within the object of psychiatry, the mind, and a new aetiology was constructed: too easy access to drugs made available by non-specialist doctors. Both the disease and the cause had to be controlled, and the means of doing this, the Drug Dependency Clinics, combined the public health measures of specialist clinics and notification with the restriction of the practice of prescribing.

In describing the Clinics as comprising public health measures, I mean that conceptually they owed much of their early form and practice to the concepts of public health and social medicine, although they were staffed by hospital psychiatrists. In this sense they were part of the articulation of public health and hospital medicine, at least initially. This articulation was underpinned by the sense of urgency engendered by the 'epidemic'. Over the next decade this changed as the fear of the epidemic passed and the norms of hospital psychiatry dominated Clinic practice.

The Clinics controlled the prescribing which had been the perceived cause of the epidemic, and controlled and managed the population who had succumbed to it. Over the 1970s, the gaze of the psychiatrists left the wider field and focussed on the space within the Clinics and the minds of their individual patients. By the early 1980s, when the surveillance mechanisms began again to identify the signs of an epidemic of drug use, this individualised and narrowed gaze could not articulate with those of public health and the law.

This new epidemic, conceptualised as one of social behaviour that led to harm, was instead met with a response grounded in the diffused, individualised responsibility for health that characterised the public health of the 1980s. As I argued earlier, it was this grounding that made syringe exchange thinkable in England, and the network of new sites created for the exercise of this new discourse that provided a location for its practice and a medium for its diffusion.

The self managing drug user

The disciplinary society makes drug use subject to its individualising and totalising power no less than any other behaviour or aspect of life. Through the techniques of surveillance and the practices of the disciplines, bio-power has located drug use within the domain of health (alongside that of the law). There it has created identities and explanations for the drug user that have shifted over time, reflective of the wider shifts in the construction of the individual and his/her responsibility for the self. In the late twentieth century, the drug user is constructed as no less individualised and responsible for the production of the healthy self than anyone else.

The emergence of syringe exchange and harm minimisation can be understood within this particular form of individualisation. The drug user is, like all of us, the object of a discourse that, through the plethora of experts who will teach us the techniques of self-

care, individualises us in our responsibility, yet totalises us, in that through those techniques we will maintain the public health. Syringe exchange and harm minimisation are the particular exercise of that individualising and totalising power that takes the drug user as its object.

The pilot syringe exchanges constructed the 'responsible drug user', normalised and capable of rational, sensible choices. The role of services was not to control the drug user, or even his/her drug use, but to *enable* him/her to exercise that rationality in the care of the body. The diffusion of the practice of syringe exchange out of drug-specific settings, into high street pharmacies and other health settings, shown by the national survey, took as its object this normalised, autonomous drug user.

Where syringe exchange was located within existing drug agencies, or in the new specialist 'stand alone' exchanges, those services offered diverse forms of self management. The focussed study looked at the ways three projects practised syringe exchange and identified some of the themes of that diversity.

Project A and project C both took the drug user's body as their object, and sought to make their clients knowledgeable about that body and the effects on it of injecting. Detailed knowledge of anatomy and physiological functioning was inscribed on the body, and interwoven with technical matters of needle gauge and size of syringe. Both also took the healthy body as an object, giving advice and information on diet and exercise, the need to relax and give the body rest. At project C, this enabling approach was combined with more direct care; dressings were routinely done, and food supplements given out. Both these projects constructed the drug user as a body, upon which the effects of drug use could be discerned, but for the management of which the individual was responsible.

Project B took as its object the drug user's mind and social being, and sought to make their clients self aware and reflexive. The drug user was invited and enabled to talk, to practice self disclosure, to tell the truth about feelings, relationships and to produce anew his/her life. With the attention and guidance of counsellors, the client could choose to reconstitute the self, to lead a happier life. Here the actual practice of syringe exchange was closer to that of the pharmacy based schemes, a simple action, sensibly undertaken to maintain healthy behaviour. Indeed, the more appropriate site of the practice was seen as being in pharmacies and non-specialist settings. This project constructed the drug user as

a mind, but as a healthy mind, capable of self awareness and reflexivity, and, through self knowledge, the positive constitution of the self.

Project C also took the drug user's mind as its object, alongside the body. But this was increasingly a mind damaged by drug use, like the body damaged by drug use. As with direct care of the body, this mind was offered care.

For project A, the mind was a separate realm, and not one that was of concern. Emotions, feelings, desires were all secondary to the primary fact of drug use and its somatic effects. Drug users were not expected to reconstitute their minds, but to take care of their bodies. For project B, the body was a realm on which they could offer no guidance, but one that they could help the drug user make visible to other professionals, in generic services. The drug user as a social being was constructed as having the same rights to use health services as any other person, and it was the exercise of those rights that was the project's expertise.

Diverse and local sites

These diverse forms of syringe exchange reflected the localised sites in which they were practised. The pre-existing constructions of the drug user and drug use were carried over into, and shaped, syringe exchange and harm minimisation in projects A and B. In all three, the practice and discourse were constantly reconstructed in response to local possibilities and local exercises of power. In project A, power was exercised to draw boundaries around the project, to define its role and responsibilities and the responsibilities of clients. Enclosure and control were central to the exercise of power. The drug user was made highly visible and expected to present, frequently, his/her body for scrutiny. Injecting equipment became an extension of that body; its physical presence was also demanded.

At project B, power was exercised more diffusely. Like the drug user it took as its object, the project was located in the network of its social relations, in its contact with and influence on other services. In this network it was subject to the exercise of power by others, and could be changed by the effects of that exercise of power as much as it might change others. Similarly, the way power was exercised in the relationship with drug users was fluid and diffused; users were trusted with equipment, its use and disposal did not have to be made physically visible, but were reconstructed through talk.

At project C, closure and boundaries were used in the project's relationship with other services, and these were successfully maintained. Within the project, power was constantly exercised through surveillance, with the expectation that there would be resistance and this would have to be somehow met and overcome. This exercise of power, however, was to control what happened within the project, to manage behaviour and keep the space of the project separate from the space outside. Unlike at project A, power was not exercised to control and make physically visible the drug user. In this respect, project C was closer to project B in practice; the relationship with the individual drug user was more flexible and open, constructed as one of equals.

Summary

The response within English drugs policy to the issue of HIV transmission was the emergence of the practice of syringe exchange, and the discourse of harm minimisation. This response was both discursively and practically made possible by the developments in drugs policy and services during the early 1980s. The construction of the 'problem drug taker' and 'problem drug use', and the replacement of the 'addict' and 'addiction' in official discourse was central to this. The problem drug taker, and the focus on problem drug use and its effects, contained the discursive space which made harm minimisation possible. The new sites of practice established for the application of this changed discourse provided the space for syringe exchange, which in turn produced new truths about harm minimisation and its application. From the 'problem drug taker', there developed within the discourse of syringe exchange the 'responsible drug user', who could be empowered in that responsibility by services, and constructed as the self managing subject.

Syringe exchange appeared in diverse sites, and was practised in the context of local possibilities and local exercises of power. The forms of self management encouraged in those local sites varied according to those local possibilities, and the practice has changed and developed. The three sites examined here diverged in their emphasis, but have remained rooted in the individual responsibility of the drug user to manage his/her own health, whether physical or mental, through the practices of *care of the body*, and *knowledge of the self*.

The longer historical analysis demonstrates the exercise of disciplinary power in English drugs policy throughout the twentieth century. This exercise of power has reflected that

in wider health policy over the period, and has produced the autonomous, responsible, self managing drug user as the object of discourse.

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