# Producing the ‘problem’ of drugs: A critical analysis of the effects of drug policy since 2010 with a particular focus on people who inject drugs

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# Abstract

Over the past two decades, UK drug policy has shifted from being characterised by the public health imperatives of infection control and health maintenance, through various crime reduction initiatives, to a recovery orientated abstinence-based system of drug treatment underpinned by neoliberal notions of resilience, individual responsibility and self-regulating practices. Policy proposals and responses have been developed as solutions to self-evident drug problems with so-called evidence-based practices emerging as those that best address the particular problems of the day.

With drug related deaths at an all-time-high and blood borne viruses and other injecting related infections remaining a public health concern, this research asks the question, in what ways have particular problematisations of drugs and their effects since 2010 affected people who use them, with particular reference to people who inject drugs (PWID). This thesis refers to the sociological literature on poststructural policy analysis and the processes of subjectification to illuminate the real-world effects of discursive practices, and shows how the subject positions available within particular policy discourses serve to regulate and govern the conduct of PWID.

The research adopts a poststructural perspective drawing on Foucauldian influenced governmentality studies and is situated within an emerging body of literature and critical research that understands realities as being constituted through policy discourses and practices. Using Bacchi's (2009) approach to policy analysis, *What's the problem represented to be?* The research scrutinises policy and strategy documents over the past two decades and challenges the assumption that drug problems exist independently of societal or governmental forces (Bacchi and Goodwin 2016). Research objectives include exploring the operation of drug policy discourses as they are interpreted and negotiated by drug treatment professionals and drug treatment commissioners and how the effects of policy discourses impact on PWID.

Interviews were conducted with 28 individuals (6 commissioners of alcohol and other drug (AOD) treatment services, 12 AOD treatment professionals and 10 PWID) and analysed using Bacchi and Bonham's (2016) Poststructural Interview Analysis (PIA) approach. Purposive sampling was used to select participants and semi-structured interviews were conducted either face-to-face or using online/telephone communication platforms. Interviews typically lasted between 60 and 120 minutes. Interviews were transcribed verbatim and analysed alongside policy and theory as a means of plugging data into a poststructural analysis.

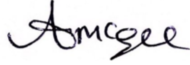
This research shows that contrary to claims from successive governments for a radical departure and unprecedented change, drug policies have been consistently characterised by the same problem representations that produce and reproduce discourses of criminality, pathology and compulsive behaviour. It shows how drug problems are constructed in power-knowledge relations (discourses) as 'truths' and reproduced through practices as technologies for governing and regulating the behaviour of people who use drugs (PWUD) and in particular, PWID. It highlights how taken for granted assumptions, that attribute notions of risk and harms as the inevitable outcome of using drugs, are constituted in socially constructed discourses as realities, while individually targeted interventions and the responsibilising practices of drug treatment contribute to harm producing policies and the reproduction of stigma experienced by PWID.

Key Words:

Bacchi; What's the problem represented to be?; poststructuralism; problematisation; problem representation; governmentality; drug policy; harm reduction; people who inject drugs; drug related deaths; social harm; social constructionism; Foucault; power; knowledge; discourse.

# Declaration

I declare that no portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.



Signed…………………………………………

August 2024

Date……………………………………………

# Acknowledgements

I owe a huge debt of gratitude to so many people who have influenced my thinking and supported me in the journey that brings me to completing this thesis. There are far too many people to mention in person and sadly some who are no longer with us.

I would like to thank in particular all of the people who gave up their time to be interviewed as part of this research and who shared with me their personal and intimate experiences of drug use and drug treatment. I also thank the many professionals who shared their experiences and views with me. A particular thank you to Olivia Wooding from Mersey Care NHS Foundation Trust and Nick Wilson from Exchange Supplies who helped to set up telephone, Team's and Zoom calls during Covid-19 'lockdowns' when it was not possible for me to carry out face-to-face interviews.

I am particularly grateful to my thesis supervisors, Viv Hope, Conan Leavey and Steve Wakeman for their patience, expert guidance and valuable insights. For keeping me focused and for providing constructive feedback and commentary on draft chapters.

I would also like to thank colleagues in Public Health, particularly Matthew Ashton for supporting a project that would eventually become the subject of this thesis, and to Charlotte Smith and Rebecca Kane for their infectious enthusiasm and encouragement throughout.

For the early parts of the journey, a big thanks to John Ellwood and Adrian Waites who introduced me to sociology when I gave up the hegemonically masculine world of mechanical engineering and enrolled in return to study classes as a mature student at the local art college. Adrian not only introduced me to Marxist Philosophy but was hugely helpful in encouraging me to apply to university as a full-time student.

To Joe Sim, Kathryn Chadwick and Phil Scraton, thank you so much for just the best possible grounding in critical analysis and for on-going friendship and support.

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Finally, to my family without whom this thesis might have been completed several years earlier but the journey would not have been so exciting and in no way as complete. Thank you.

**In memory of Gordon. September 1954 – July 2024.**

## List of Interviewees

**Interview Category – PWID**

| | Name | Age | Gender | First Injected |
|---|---|---|---|---|
| 01 | Mark | 55 Years | Male | 1985 |
| 02 | David | 52 Years | Male | 1982 |
| 03 | Miles | 54 Years | Male | 1990 |
| 04 | Julie | 48 Years | Female | 1994 |
| 05 | Sam | 64 Years | Female | 1978 |
| 06 | Keith | 31 Years | Male | 2013 |
| 07 | Des | 49 Years | Male | 1994 |
| 08 | Giles | 58 Years | Male | 1970 |
| 09 | Phil | 62 Years | Male | 1970 |
| 10 | Donna | 52 Years | Female | 1980 |

**Interview Category – AOD Treatment and Recovery Professional**

| | Name | Gender | Job Role | Service Type |
|---|---|---|---|---|
| 01 | Jamie | Female | Key Worker | AOD Treatment and Recovery Service |
| 02 | Simon | Male | Recovery Worker | AOD Treatment and Recovery Service |
| 03 | Natalie | Female | Key Worker | AOD Treatment and Recovery Service |
| 04 | Trevor | Male | Non-Medical Prescriber | AOD Treatment and Recovery Service |
| 05 | Jason | Male | Social Worker | AOD Treatment and Recovery Service |
| 06 | Jack | Male | Non-Medical Prescriber | AOD Treatment and Recovery Service |
| 07 | Aiden | Male | Consultant Psychiatrist | AOD Treatment and Recovery Service |

| | | | | |
|---|---|---|---|---|
| **08** | **Sue** | **Female** | **Recovery Worker** | **AOD Treatment and Recovery Service** |
| **09** | **Joe** | **Male** | **Non-Medical Prescriber** | **AOD Treatment and Recovery Service** |
| **10** | **Jody** | **Female** | **Public Health Registrar** | **Local Authority** |
| **11** | **Sarah** | **Female** | **Director of Public Health** | **Local Authority** |
| **12** | **Ethan** | **Male** | **Consultant Psychiatrist** | **AOD Treatment and Recovery Service** |

**Interview Category – AOD Treatment and Recovery Commissioners**

| | **Name** | **Gender** | **Job Role** | **Location** |
|---|---|---|---|---|
| **01** | **Amanda** | **Female** | **Lead Commissioner AOD Treatment Services** | **Cheshire and Mersey Local Authorities** |
| **02** | **Richard** | **Male** | **Lead Commissioner AOD Treatment Services** | **Cheshire and Mersey Local Authorities** |
| **03** | **Peter** | **Male** | **Lead Commissioner AOD Treatment Services** | **Cheshire and Mersey Local Authorities** |
| **04** | **Carol** | **Female** | **Lead Commissioner AOD Treatment Services** | **Cheshire and Mersey Local Authorities** |
| **05** | **Laura** | **Female** | **Lead Commissioner AOD Treatment Services** | **Cheshire and Mersey Local Authorities** |

| **06** | **George** | **Male** | **Lead Commissioner AOD Treatment Services** | **Cheshire and Mersey Local Authorities** |
|---|---|---|---|---|

While the gender identities of interviewees have been retained, names have been changed to protect anonymity. Organisational and agency identity have also been removed and local authority alcohol and drug treatment service commissioners are identified only by broader geographical region. Where quoted, individual interviewees are referred to in the text by their pseudonym and interview sample category.

## List of Abbreviations

**ADDER –** Addiction, Diversion, Disruption, Enforcement and Recovery

**ACMD –** Advisory Council on the Misuse of Drugs

**AIDS –** Acquired Immune Deficiency Syndrome

**AOD** – Alcohol and other drug

**BBV** – Blood borne virus

**BMA** – British Medical Journal

**CARATS –** Counselling, assessment, referral, advice and throughcare

**CJS** – Criminal Justice System

**DAT** – Drug Action Team

**DAAT** – Drug and Alcohol Action Team

**DCR** – Drug consumption room

**DDU** – Drug Dependency Unit

**DIP –** Drug Intervention Programme

**DRR** – Drug Rehabilitation Requirement

**DSM** – Diagnostic and Statistical Manual

**DTTO –** Drug Testing and Treatment Order

**EMCDDA** – European Monitoring Centre for Drugs and Drug Addiction

**HAT** – Heroin assisted treatment

**HBV** – Hepatitis B virus

**HCV** – Hepatitis C virus

**HIV** – Human immunodeficiency virus

**ICD** – International Classification of Diseases

**IDU** – Injecting drug use

**IOT** – Injectable opiate treatment

**JCDU** – Joint Combating Drugs Unit

**MDA –** Misuse of Drugs Act

**MERS –** Middle East respiratory syndrome

**MSM –** Men who have sex with men

**NDTMS –** National Drug Treatment Monitoring System

**NIDA –** National Institute on Drug Abuse

**NICE –** National Institute for Health and Care Excellence

**NSP** – Needle and syringe programme

**NTA** – National Treatment Agency

**OAT** – Opiate agonist treatment

**OHID** – Office for Health Improvement and Disparities

**ONS** – Office for National Statistics

**OST** – Opiate substitution treatment

**PHE** – Public Health England

**PIA –** Poststructural interview analysis

**PWID** – People who inject drugs

**PWUD –** People who use drugs

**RDMDB** – Regional Drug Misuse Data Base

**RT-PCR** – Reverse transcriptase polymerase chain reaction

**SARS –** Severe acute respiratory syndrome

**TOP** – Treatment Outcome Profile

**UKHSA** – UK Health Security Agency

**WHO** – World Health Organisation

**WPR –** What's the problem represented to be

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# Chapter One

# Introduction

## 1.1 Purpose

This research is a study of how illicit drugs and people who use them are represented in policy as 'problems'[1], how treatment services and other policy responses are organised around those representations of the 'problem' and how people who use drugs (PWUD) and in particular people who inject drugs (PWID) are governed and regulated as a consequence. The overarching research question asks, in what ways have particular problematisations of drugs and their effects since 2010 affected people who use them, with particular reference to PWID. The objectives of the study include exploring the operation of policy discourses relating to drugs and PWID as they are interpreted and navigated by commissioners of drug treatment systems and by professionals involved in the delivery of drug treatment services, illuminating how governing takes place and examining the discursive, subjectification and lived effects that policies produce. To help address this overarching question, the research has been guided by four additional questions:

1. In what ways have recovery narratives and discourses affected drug user identities?
2. To what extent do drug user identities play a role in treatment engagement?
3. To what extent have any considerations of benefits and pleasures associated with drug use been 'absented' from harm reduction and recovery discourses?
4. To what extent has recovery become narrowly defined around a 'recovering addict' identity alienating people who reject or resist that particular identity?

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[1] Throughout this thesis the use of scare quotes for terms like 'problem' highlights their contingencies (Bacchi and Goodwin 2016). This practice is commonly used in poststructural work that aims to challenge that which is taken-for-granted or self-evident, such as understanding drug use as a 'problem' in the conventional use of the term.

The research is situated within a poststructural theoretical tradition and a growing body of literature that challenges the assumption that drug 'problems' exist independently of society and government forces and are there waiting to be solved. Rather, it understands the 'realities' of addiction, drugs and people who use them, as constituted in and through policy and practices (Bacchi 2009; Fraser and Moore 2011, Keane 2002, Moore and Fraser 2013, Dennis 2019, Lancaster and Rhodes 2020). In a significant departure from traditional policy research, this study considers how governments are active in the creation or production of policy problems (Bacchi 2009) and directs critical questioning to what exactly is produced? How it is produced? And with what effects?

For Bacchi (2012) every policy or policy proposal is a prescriptive text, setting out a practice that relies on a particular problematisation or problematisations. Bacchi uses the term problem representations to refer to this form of problematisation. Using Bacchi's (2009) What's the problem represented to be (WPR) approach to critical policy analysis of contemporary drug policy and responses – namely harm reduction and recovery orientated drug treatment, this research disrupts the taken-for-granted assumptions around the problem-solving nature of policies and the construction of evidence-based practice.

The purpose of the research is to critically interrogate and make visible the politics involved in policy making including the constitution of problem representations and how governmental practices contribute to the production of 'subjects', 'objects' and 'places'. Following Bacchi's WPR approach, the research turns to Foucault's notion of the micro-physics of power 'to ensure recognition of the plural and diverse practices involved in the production of things' (Foucault 1979 cited in Bacchi and Goodwin 2016:14). Bacchi and Goodwin (2016:15) draw our attention to how 'assumptions about the *being* of things are replaced by reference to their becoming'. Importantly here, the physicality of objects is not questioned or denied, rather

‘objects’ are conceived of as in continuous development, as in formation rather than as fixed. In effect, practices and relations replace objects and subjects creating space for contestation and re-problematisation. Addiction and the addicted subject become categories that are made and can be unmade. Knowledge produced in research is no longer treated as ‘truth’ or as a set of ‘true’ statements about ‘reality’. Instead, knowledge operates as discourse and plays a critical role in governing practices and in the making of reality.

It is not the intention of this research to undermine harm reduction principles or the importance of harm reduction interventions as a response to health concerns, rather to highlight the effects of a neoliberal vision of harm reduction and the ways in which its knowledge (discourses) situate PWID at the centre of the policy gaze through particular representations of the ‘problem’ and through individually targeted interventions and responsibilising practices. It is the intention that, by drawing attention to the harm producing nature of drug policy, policy and treatment discourses, that public health and harm reduction practitioners will critically reflect and decolonise some of their own assumptions about the inevitability of harms and risks associated with using drugs.

In this sense, the hope is that this research and its findings could be used by commentators and analysts of drug policy as well as drug treatment and harm reduction practitioners, as a starting point for questioning and challenging the taken-for-granted assumptions about drugs, about the people that inject drugs and about the nature of risk that often characterises drug use. In short, to encourage practitioners to build critical reflection, a means of self-problematising their own assumptions and considerations of the effects of policy and policy responses.

While this research is not unique in either its approach or it’s aspirations, there is a distinctiveness in its methodological approach and in its epistemological and ontological assumptions. The research methodology combines a critical poststructural approach to policy

analysis, WPR, with a poststructural interview analysis (PIA) (Bacchi and Bonham 2016). The research contributes to a growing body of knowledge in the field of drug policy analysis by adding to the on-going debates between critical realist and poststructural theorists.

### 1.2 Background context

Drug policy in the UK has been characterised by prohibition – a globalised system of control written into the domestic laws of over 150 signatory countries through a series of treaties that mandate criminal sanctions for the production, supply, possession and use of a variety of psychoactive substances (Transform 2007). Criminalising restrictions in the UK came into effect with the introduction of the Misuse of Drugs Act 1971, a risk and harm-based classification system intended to determine the level of 'risk' and 'harm' caused by a particular drug and ascribing accordingly the appropriate level of criminal sanction. However, as Buxton (2021) reminds us in chapter five, while the 1961 United Nations Single Convention on Narcotic Drugs is recognised as the key treaty underpinning the contemporary drug control system, efforts to control drugs have a much longer history dating back over a century.

Published in December 2021, the UK latest Drug Strategy, *From harm to hope, a ten-year drugs plan to cut crime and save lives* sets out an ambition to reduce the number of drug related deaths and commits to implementing all of the recommendations set out in the 2-part review of drug treatment commissioned by the Government just 2-years earlier which characterised the drug treatment system as broken and wanting (Finch 2022). In spite of claims to 'do things differently' (HM Government 2021) and mark a radical departure from policies that had gone before it, the 2021 drug strategy, like its predecessors in 2017 and 2010, focuses on drug related crime and the financial costs to society. It is critical of what it sees as the passive drug prevention intentions of harm reduction policy and represents the 'problem' as one of

availability and supply – concerns that emerged as early as 1875 with 'new problematisations around the practice of self-intoxication' (Seddon 2016:400).

Two years into the ten-year plan *From harm to hope*, and with only eighteen months left of the £900 million funding to build a 'world-class' treatment system, the National Audit Office in its report 2023 *Reducing the harm from illegal drugs* stated on page 6, that it is 'too early to conclude whether the strategy will reduce the harm from illegal drugs'. The report goes on to state on page 37, that 'the Joint Combating Drugs Unit (JCDU) faces significant challenges in changing the culture of drug treatment and demonstrating progress against some of the strategy outcomes'. Strategy outcomes like, for example, its commitment to prevent one thousand drug related deaths by 2024. When in December 2023, ONS published data on drug poisoning for England and Wales, its report revealed that 4,907 deaths were registered in 2022, 1.0% higher than before *From harm to hope* was introduced in 2021 and the highest number of deaths registered since records began in 1993.

### 1.3 Outline of thesis

#### 1.3.1 Chapter two: Literature review

Chapter two outlines the emergence and development of a drug control system in the UK and establishes a genealogy of drug policy. The chapter goes on to highlight developments in monitoring and surveillance and reviews literature on public health and criminal legal interventions. Chapter two then reviews a body of literature from a poststructuralist perspective highlighting Foucault's conception of power, its productive capacity and the intimate relationship between power-knowledge and the production of 'truths'. The chapter moves on to consider literature from a harm reduction perspective and considers the importance of governmental studies to an understanding of a neoliberal vision of harm reduction. The discussion takes up the arguments of Keane (2003) and Roe (2005) who argues that while the

vagueness of harm reduction in its formative days provided an advantage in winning general support and acceptance it became a liability once mainstream support had been achieved. Keane (2003) has argued that medical rather than social arguments were advanced for harm reduction while public health practices with their reliance on epidemiological knowledge became an alienating and depersonalising perspective towards a highly individual problem. Chapter two concludes with a consideration of Foucault's notion of bio-power and the disciplining nature of drug treatment arguing that the logics of treatment pathologises drug use and subjugates any beneficial or pleasure experiences.

### 1.3.2 Chapter three: Theoretical framework

Chapter three follows the emergence of the anti-positivist critique in social science and outlines a theoretical framework for a critical poststructural analysis of policy. It goes on to review literature on the key poststructural themes of discourse, knowledge, power and truth. It reviews Foucault's assertion that discourses be seen as knowledge rather than language and Bacchi's (2000) conceptualisation of policy as discourse. Policy as discourse theory draws our attention to the mechanisms that 'make meaning' within policy (Bacchi 2000) and challenges the conventional view of policy as objective.

Chapter three builds on the theoretical arguments that knowledge practices (discourses) play a critical role in governing and disciplinary technologies. The chapter highlights the significance of contributions to governmentality literature from commentators such as Miller and Rose (1990), Dean (2010) and Lemke (2012) to our understanding of how governmental technologies and rationalities are those that are produced to justify a particular mode of rule (Gordon 1991).

Chapter three goes on to consider the role of responsibilisation as contributing to technologies of the self as a move towards self-regulating practices within a neoliberal vision of abstinence-

based recovery orientated drug treatment and concludes by introducing the notion of harm producing policies and the social production of harm.

### 1.3.3 Chapter four: Methodology

Chapter four introduces the methodological approach adopted in this research and outlines the key principles of a WPR approach and PIA framework for critically analysing interview text. This chapter outlines the ontological and epistemological assumptions underlying the methodology and considers Mol's (1999) assertion that lived realities are created by rather than reflected in social practices. Mol (1999) uses the term ontological politics to capture the position that research makes rather than reflects worlds.

Chapter four goes on to discuss the importance of critical reflection or self-problematisation as a way of ensuring that researchers are prompted to recognise that they are immersed in the conceptual logics of the time, that in part, who we are is shaped by the problem representations that we are to analyse. In this sense, self-problematisation is important because it helps to alert researchers to the extent to which their own world views shape their analysis (Bacchi 2021). Finally, chapter four describes sample selection procedures for conducting semi-structured interviews, including procedural and ethical considerations, interview analysis and transcribing audio recordings.

### 1.3.4 Chapter five: What's the problem with drug policy: Analysing problem representations

Chapter five uses a WPR approach to critically analyse documents and statement to reveal what the problem is represented to be in contemporary UK drug policy. It draws on Foucauldian theories of archaeology and genealogy to illuminate an historicised emphasis on representations of drug problems as particular kinds of problems and the subject positions available within them. WPR policy analysis scrutinises a range of official government policies,

including supplementary reports and supporting guidance, between 1998 and 2023. Chapter five reveals the problem representation within policies and considers the assumptions underlying particular problem representations and the harm producing effects of drug policy.

### 1.3.5 Chapter six: Producing the addicted subject

Chapter six considers the productive nature of discourse and argues that notions of addiction and addicted subjects are socially constructed. Through critical analysis of interview texts chapter six uses the concept of subjectification to consider how subject positions are made available within problem representations and how discursive practices rule in and rule out of the terms of reference any alternative knowledge or discourses. Chapter six examines how the knowledges claims that underpin notions of addiction and how the practices of drug treatment systems produce the addicted subject.

### 1.3.6 Chapter seven: Governing people who inject drugs through professional discourses

Chapter seven extends the discussion on governmentality using PIA to illuminate how PWID are governed and regulated through discourses and professional practices. Chapter seven draws on Peterson and Lupton's (1996) and Lupton's (2013) assertions that 'risk' has been constructed as a governmental and disciplinary technology. Chapter seven goes on to consider the contention that harm can be better understood, and therefore reduced, through the notion of a 'risk environment' (Rhodes 2002). Here the focus on risk shifts away from individual responsibilities to a consideration of the social determinants of risk and harm. Chapter seven concludes by arguing that 'harm reduction', once the domain of grass roots activism, has been subverted by professional practices and recast within the official discourse as part of a broader system of surveillance monitoring and corporate risk management.

### 1.3.7 Chapter eight: From hopeless to harmful: Responding to injecting drug use

Chapter eight pulls the overall analysis together focusing down on the specific position of PWID. This chapter draws attention to the pathologising and criminalising effects of problem representations and how PWID are situated not only as vulnerable people at risk, but as those who pose a 'risk' to the public health through irresponsible and unregulated behaviour. It argues that the logics of disciplinary and governmental practices impact on PWID in a way that increases risk, harm and stigma alienating them from treatment services and cutting them off from any harm reducing possibilities of support services.

Chapter eight concludes by arguing that drug policies are harm producing in their effect while socially constructed notions of risk are used to justify further authoritarian and repressive responses. Moreover, PWID experience the strongest forms of discrimination and the effects of hierarchies of oppression and stigma as policy representations cast them as both vulnerable and responsible.

### 1.3.8 Chapter nine: Covid-19 and the effect on people who inject drugs

Chapter nine critically reviews policy responses introduced during the Covid-19 pandemic, and draws attention to the similarities between them and the response to HIV in the 1980s, where official discourse appeared to adopt a less ridged approach characterised by a logic of care towards PWID. This more flexible approach, including a relaxation of the requirements for daily supervised consumption of controlled medications led some commentators to talk about opportunities for resistance and the construction of a counter hegemony to the coercive and punitive responses to PWID (Chang *et al.* 2020). Chapter nine concludes by noting that temporary relaxations were exactly that. The 2021 UK Government drug strategy, *From harm to hope*, represents the 'problem' of drugs and the 'problem' of PWID in the same ways as previous drug strategies in 2017 and in 2010. The harm producing problem representations of

the 2021 drug strategy reinforce a legal framework that effectively forecloses any discussion of alternative approaches. Once the perceived threat of Covid-19 had passed any short-term measures of flexibility were withdrawn as quickly as they were enacted.

### 1.3.9 Chapter ten: Critical reflections: Considering contributions to knowledge through self-problematisation

Chapter ten engages in a process of critical reflection by applying self-problematisation to critical thinking, to the problem representations and key themes that emerge within the research, in a way that might reveal any researcher assumptions and knowledge claims. It describes the active practice of critical self-problematisation, as developed in a WPR approach and why for Bacchi and Goodwin (2016) it is distinct from a process of reflexivity or calls for researchers to become more reflexive. Chapter ten, engages with a critical realist analysis of material events and offers a poststructuralist version of accounts in which particular realities and their meaning are constructed in policy and practices. It concludes with the observation that rather than attempts to reform the current drug treatment system through a series of policy amendments and updates, deconstruction and reconstruction through re-problematising the problematisations would allow different representations of 'problems' to be considered producing different effects and different outcomes. Poststructural policy analysis opens up the possibilities for 'things' to be problematised differently and through different problem representations, things can be otherwise.

### 1.3.10 Chapter eleven: Conclusion

Chapter eleven concludes the research, not by producing a list of recommendations or statements of how things should be, but by arguing for the possibilities of how things could be different. It argues that drug 'problems', represented in policy as particular types of 'problems', underpin a narrative of governmental discipline and regulation and are harmful to the health

and wellbeing of PWID. It answers the key questions posed by research from a poststructural perspective and encourages others to question their own assumptions and taken-for-granted 'truths' about drugs and the people who use them.

Finally, chapter eleven signals a way forward through the practice of critical reflection and self-problematisation, encouraging others to re-problematise their own problem representations and question the fixed nature of material conditions, challenging for example, what valentine and Seear (2020) have referred to as assumptions and taken-for-granted 'made in practice realities'. It sets the tone for re-problematising policy representations and the deconstruction of harm producing policies and practices.

# Chapter Two

# Literature Review

## 2.1 Introduction

This chapter aims to review a body of literature that underpins policy responses to drug use and people who use drugs (PWUD) considering the historical, social, political and economic conditions in which drug policy is produced and implemented. Policy and policy responses, particularly those orientated towards people who inject drugs (PWID), are critically reviewed along with the mechanisms and interventions involved in producing and reducing harms associated with the use of drugs, setting the context for the emergence of a poststructural response to the taken for granted assumptions surrounding drugs, drug use and contemporary drug policy. MacGregor (2017) reminds us that the notion of 'drugs' themselves needs to be viewed through a critical lens and outlines some of the complexities that can influence or obscure a clear line of sight:

> What counts as a drug is socially constructed – that is created in time and place – and thus can change. How do 'drugs' overlap with poisons, medicines, food and drink? Much depends on who administers the substance, for what reason, and in what quantity (MacGregor 2017:8).

Here, McGregor is opening up a number of important questions that are central to an analysis of drug policy, the labelling of certain substances as 'dangerous' and the contexts within which the use of substances is acceptable. In this sense, MacGregor is creating space for a poststructural analysis of drugs, drug use, drug policy and the social construction of ideas and taken-for-granted assumptions about PWUD.

Drug use and PWUD are described in the literature variously as a 'problem' that needs to be corrected or removed (Bacchi and Goodwin (2016); as an individual pathology (Institute of

Medicine 1996), or as the irrational behaviour of 'outsiders', rule breakers who pose a 'risk', a threat to the norms, values, stability and health and wellbeing of society (Becker 1963):

> Social rules define situations and the kinds of behaviour appropriate to them, specifying some actions as 'right' and forbidding others as 'wrong'. When a rule is enforced, the person who is supposed to have broken it may be seen as a special kind of person, one who cannot be trusted to live by the rules agreed on by the group. He is regarded as an *outsider* (Becker 1963:1).

Sociological research has attempted to understand the 'irrationality', ascribed to drug using behaviour within a context of social and cultural meaning, Becker (2015); Cohen (1972). Dennis (2019), for example, highlights sociologies tireless endeavours to find meaning where there seemingly is none. Drawing on important contributions from sociological literature, described by Netherland (2012) as offering a 'critical understanding to otherwise taken for granted phenomenon', Dennis reminds us, that some of the earliest sociological accounts of British drug taking (Young 1971) have attempted to understand for example, the 'social meaning of heroin use' within a context of what Marx had described as the alienating experience of capitalism and 'its false promise of joy from mass consumption' (Dennis 2019:3). Meaning and context where also a key consideration in Becker's 1953 study *Becoming a Marihuana User:*

> A person, then, cannot begin to use marihuana for pleasure, or continue its use for pleasure, unless he learns to define its effects as enjoyable, unless it becomes and remains an object which he conceives of as capable of producing pleasure (Becker 2015:52).

Becker is drawing our attention here to the importance of 'set' and 'setting' in the experience and effects of drug use, and what Zinberg (1984) referred to as the basis of 'controlled use'. For Zinberg (1984), if it were achieved, it could be a means of reducing any potential harm associated with the use of drugs. Questions over the degree to which one can control the use, quantity and frequency, of substances is in part the basis of a biological theory of addiction and

a topic that features strongly within the literature (see for example Institute of Medicine (1996), Leshner (1997), Leshner (2001), National Institute on Drug Abuse (NIDA) 2020). However, for Seddon (2010) the idea that drugs are inherently 'evil' is deeply embedded within prohibitionist ideology, an ideology that is apparent in much of the rhetoric surrounding drug policy and response today:

> Drugs are horrific. There is nothing recreational about them. I have never used them and will be incredibly tough on anyone who does (Rishi Sunak, Conservative Party Leadership Hustings, Darlington, August 2022).

Frisher and Beckett (2006) remind us that the vast majority of people who have ever used drugs do not go on to become drug dependent. 'Within the general population there is strong evidence for a high degree of natural desistance (Frisher and Beckett 2006:141). Moreover, the use of drugs is intimately linked to identity (Hammersley 2011; Beckett Wilson 2014; Best *et al* 2016) and can be moderated through identity change and fashioning new perspectives of the social world.

While a body of literature on drug use desistance is helpful in drawing attention to the possibilities for non-dependent use of drugs it treats the notion of problematic use uncritically and assumes a transition from recreational drug use to problematic use as being underpinned by neurological processes. Hammersley (2011) for example describes 'problematic drug use' as involving the use of drugs such as opiates, cocaine and amphetamines with intense delivery routes such as smoking or injecting being employed. Such accounts do not take into consideration the constructed nature of these problematisations of drugs or align with a poststructural analysis and the discursive effects of objects, subjects and practices. Beckett Wilson (2014) for example draws our attention to the need for a balanced approach to drug policy – one which considers both structure and agency as drivers for individual engagement with in drug use. For Beckett Wilson (2014) this distinction is not only important in a

consideration of desistance but critical in achieving the ‘right balance between sanctions and rehabilitation; enforcement and reintegration (Beckett Wilson 2014:62). However, regardless of the extent to which drug taking is within or outside of one’s control, this position assumes a policy as solution position rather than that of a poststructuralist analysis and this research which argues that drug problems are constituted and given meaning within policy.

Booth Davies (1997) has suggested that explaining one’s drug taking behaviour as being either within or outside of one’s control can have ’functional’ considerations for the individual and can have either positive or negative consequences depending on the moral and legal context in which the use of the drug takes place. For Booth Davies (1997) explaining drug use as outside of your control makes complete sense in a climate of moral or legal censure. Here, Booth Davies (1997) is suggesting a more nuanced and contextualised understanding of questions of control and addiction that partially aligns with poststructural accounts of drug policy, the processes of subjectification and the construction of a ‘drug using identity’.

In his seminal text *Folk Devils and Moral Panics* Cohen (1972) draws our attention to the significance of problem representations, the role of ‘amplification’ and relationship between belief systems and social control in the context of drug policy:

> If the addiction problem can be inflated to the proportion of a national menace, then, in terms of the doctrine of clear and present danger, one is justified in calling for ever-harsher punishments, the invocation of more restrictive measures and more restrictions on the rights of individuals (Cohen 1972:92).

For Cohen (1972) ratcheting up perceptions of ‘risk’ within the ‘doctrine of clear and present danger’ provides a context for escalating measures to ‘deal with the problem’ and underpins a logic of control evident in contemporary drug policy and punctuated by opinion statements and phases such as ‘tighten up’, ‘take strong action’ and ‘getting out of control’. However, as some commentators have noted, there has been only minimal attention and critical social research

focusing on the role of drug treatment and its practices within the mechanisms and discourses of drug control systems.

## 2.2 The emergence of drug control systems

In her discussion of the establishment of drug control systems in Britain, Berridge (1984) comments on how little attention the subject had received from a social policy point of view. Over two decades later, Fraser and valentine (2008) make a similar observation in relation to the broader discussion of pharmacotherapies in drug treatment and note the apparent acceptance of the description of methadone treatment as 'liquid handcuffs' by both health care workers and researchers alike. Their argument here is that 'treatment' can be experienced as a form of control – as a means of governing the conduct of PWUD and is sometimes described by clients as 'leaving an outlaw culture and entering a passively dependent one' (Fraser and valentine 2008:8). For Fraser and valentine (2008) the absence of critical sociological research on drug treatment risks missing the insights and intersections between prescribed drugs, illicit drugs and social identities.

Berridge (1984) notes how, in the early 1920s, the Home Office attempted to establish full-scale restrictions on opiate use by targeting criminal sanctions, not just against those individuals using them, but also against doctors prescribing them. Berridge (2013) notes that following the Pharmacy Act 1868, pharmacists were the main professional group controlling access to opiates. Seddon (2007a) has pointed out that in the compromise of a medico-legal alliance between pharmacists and the medical professions, the 1926 Rolleston Report of the Departmental Committee on Morphine and Heroin Addiction established an alternative framework for the regulation and control of heroin and morphine and brought about an apparent halt to the preferred option of the criminalisation of PWUD and the doctors who prescribe them (Berridge 1984). As Seddon (2007) notes Rolleston, Chair of the Departmental Committee, had

managed to defend doctors right to prescribe heroin as a medical intervention, all be it within the penal framework of the 1920 Dangerous Drug Act. The Committee outlined strict guidelines as to when it would be appropriate to prescribe morphine or heroin for the treatment of addiction laying the foundation for what became referred to as the 'British System' of drug treatment (MacGregor and Ettorre 1987):

> a) When undergoing treatment for the cure of addiction by the gradual withdrawal method;
> b) When, after every effort had been made to overcome addiction, the drug could not be withdrawn completely, either because withdrawal produced symptoms which could not be treated satisfactorily under the ordinary conditions of private practice (i.e., other than in a hospital); or because the patient , while capable of leading a useful and fairly normal life so long as he took a certain non-progressive quantity, usually small, of the drug of addiction, ceased to do so when the regular allowance is withdrawn (MacGregor and Ettorre 1987: 129).

In securing the legitimacy and professional right of doctors to prescribe controlled drugs as part of addiction treatment in the early twentieth century a disease model of addiction was established, with the habitual use of drugs like opium and its derivatives viewed as an individual pathology (Seddon 2007). Seddon notes how the Rolleston Report pronounced on this matter:

> In the most well-established cases the condition must be regarded as a manifestation of disease and not a mere form of vicious indulgence […] the drug is taken in order to relieve a morbid and overpowering craving (Ministry of Health, 1926:11, cited in Seddon 2007:150).

For MacGregor and Ettorre (1987) the medical profession had reasserted its disease model of addiction treatment while hegemonic medical discourses became  part of government policy making and have remained a powerful influence to the present day. However, they remind us that the 'British System' of maintenance prescribing, 'the management of an addiction by the prescription of maintenance doses, often over a fairly lengthy period' (McGregor and Ettorre 1987:130) was only part of the British drug control system rather than its core. This is a point echoed by Downes who has described the British System as 'little more than masterly inactivity

in the face of what was an almost non-existent addiction problem' (Downes 1997:89). For Downes (1997) the significance of the British System was its attempt to establish a system of treatment rather than one of punishment as a response to the 'problem of addiction'.

**2.3 Monitoring, surveillance and containment**

During the early 1960s, concerns were aroused among sectors of the medical profession over what appeared to be a significant rise in the availability and use of heroin, and for some signalled a failure of the British System (Spear 2002). Spear (2002) however has challenged the view that prescribing heroin as a legitimate medical practice was ever intended to reduce the prevalence of addiction or suppress emerging drug markets. The increase in use, especially among younger individuals, was seen as a disturbing challenge and brought significant pressure to bear on the government. The response came in 1965, as MacGregor and Ettorre (1987) point out, in the form of the second Brian Committee established to investigate and make recommendations on the growth of heroin use. The second Brain Committee recommended crucial changes in drug policy and concluded that the increase in heroin use was largely due to over prescribing by doctors in private practice. Stopping short of prohibiting the therapeutic use of heroin, Spear notes how, in January 1966, Brain told the Council of the British Medical Association (BMA) that:

> We of course considered this [abandoning the use of heroin altogether] but our enquiries convinced us, if we were not convinced already, that in certain circumstances, there is no satisfactory substitute for heroin, and we thought it quite wrong that doctors and patients should be deprived of an essential drug because it is abused by drug addicts and the few doctors who prescribe them (Spear 2002:195).

Rather than abandoning the use of heroin altogether in addiction treatment, the second Brain Report considered that controlled supplies needed to be severely curtailed and called for the 'provision of suitable units for the treatment of drug addiction' (MacGregor and Ettorre

1987:130). Despite there being little evidence to support the allegations of excessive prescribing by doctors, many of Brain's proposals and recommendations were accepted by the government and formed the basis of the 1967 *Dangerous Drugs Act.*

In 1968, tighter controls on heroin prescribing were implemented under the 1967 Act, significantly reducing, as Seddon (2007b) notes, the availability of prescribed pharmaceutical heroin. Seddon (2007b) notes how only Home Office approved and licenced doctors working in the newly established drug dependency clinics would be allowed to prescribe to 'addicts'. In addition, all users of a variety of opiates were required to be notified as 'addicts' to the Home Office confirming Smart's assertion that PWUD are:

> In the unique although unenviable, position of occupying the locus of attention of several different modes of regulation; legal, moral and medical (Smart 1984:31).

A position of simultaneous surveillance and regulation that has been increasingly associated with a reluctance on behalf of PWUD to engage in the treatment system.

For Seddon (2007b, 2010) the restrictions and tighter controls over the supply of legitimate heroin brought about by the 1967 *Dangerous Drugs Act* saw the tripartite struggle between medical and pharmacy professionals and the Home Office for regulatory power over the supply and use of heroin clearly swing back towards the Home Office. The Brain report, as Seddon notes, describes addiction as 'a socially infectious disease' and made recommendations for the monitoring, surveillance and containment of the problem (Seddon 2011:417).

However, in what might be described as the policy equivalent of a spectacular own goal, the space created by restrictions in legitimate and therapeutic supplies was quickly filled and occupied by illegal imported heroin. These unregulated markets became the principle source of supply for PWUD and have remained so to the present day (Seddon 2007b). Attempts to disrupt those illegal markets and supply chains only result, as Carroll *et al.* (2020) remind us, in

increasing harm for those already at risk as PWUD seek out supplies from unknown and untrusted sources. Ray *et al.* (2023) make similar assertions in their analysis of the effect of law enforcement drug market disruptions on drugs overdose deaths suggesting that 'supply side interdiction might produce more public harm than public good' (Ray *et al.* 2023:757) casting doubt on the core assumption that public health and public safety is protected through such policies and policy responses – a cautionary note that public health leaders might be mindful of in their alliance with 2021 UK drug strategies mandated Combating Drugs Partnerships.

### 2.4 Public health and criminal justice responses – two sides of the same coin

Throughout the 1980s and 1990s, a growing body of literature reflected a public health orientated interest in drug use and particularly in PWID, as research turned its gaze to the emergence of harm reduction and policy responses focused on the growing health and societal concerns around HIV/AIDS. However, even the apparent liberal intentions of harm reduction policy and interventions were still, as Stimson (1987) notes, underpinned a by state response of criminalisation. Representations of drugs and crime became more dominant within research and literature throughout the 1990s and 2000s. The 1998 Crime and Disorder Act and subsequent Drugs Act 2005, mark a significant development in the 'technologies' (interventions) for governing and regulating the conduct of PWUD while ratcheting up public anxiety around a spiralling drug-crime nexus. The 1998 Act introduced Drug Treatment and Testing Orders (DTTO) giving courts the power to sentence offenders to a period of drug treatment as an alternative to custody. The integration of criminal justice interventions and drug treatment was drawn into sharper focus with the arrival of the Drug Intervention Programme (DIP) including court instructed Drug Rehabilitation Requirements (DRR) under the Drugs Act 2005. For Seddon the Drugs Act 2005 represents a 'new phase in the imagination and governance of the drug problem' (Seddon 2010:77). Seddon (2010) notes how DIP introduces the concept of the

'problem drug user', potentially threatening those who use heroin and crack cocaine who commit crime to fund their drug use and cause most damage to society. The basic premise of DIP is that the criminal justice system is a good place to find and engage problem drug users' and move them into appropriate treatment and support. As Seddon (2010) has noted, the evidence behind these assumptions is questionable, but the risk-based logic is impeccable within the constructed notions and taken for granted assumptions about drug use crime and criminality. Criminalising restrictions had already come into force with the Misuse of Drugs Act 1971, a risk and harm-based classification system which supposedly ranked substances according to the level of risk and harm that they reeked on individuals and determined the levels of criminal sanction accordingly, while the 1998 and subsequent 2005 Acts consolidated the power of the police and courts in the 'treatment' of substance use. However, as Downes noted in 1977 restrictions hardly act as a deterrent to drug use and people will obtain them from illicit sources if legal sources are unavailable. Downes raises a crucial question in relation to the assumptions around drug use, treatment and control:

> The question is why, not how they [PWUD] begin to entertain the idea of themselves as addicts and progress from there to the state of addiction (Downes 1977:91).

Drawing on poststructural critical theory, an emerging body of literature has become influential in contesting and deconstructing some of the taken-for-granted assumptions about drug use and the people that use them. Poststructural analysis of public health-based approaches for example have problematised the 'logic of governmentality' within harm reduction interventions, while historical and contingent notions of discourse attach a particular meaning to the effects and material realities of risks associated with injecting drugs to deaths associated with its use. A growing area of interest in poststructural research is that of policy analysis and this is discussed in more detail in subsequent chapters. Poststructural policy analysis has been instrumental in

contesting the problem-solving assumptions of policy and in drawing our attention to processes by which problems are constituted and given meaning within policy (Bacchi 2009, Bacchi and Goodwin 2016).

### 2.5 Policy matters

Policy plays a pivotal role in defining social problems and in determining subsequent economic and political action. The processes by which social problems become public concerns is a complex and contested area, with some commentators suggesting that levels of economic and political intervention are often not proportionate to the amount of people directly affected by the issues. Isaacs (2021) for example dismisses the idea that social problems become public and political concerns only because of the scale of the problem or the numbers of people affected. Isaacs (2021) argues that if that were the case, we would not be concerned with people who use drugs, rough sleepers or other relatively small groups of people. Following C. Wright Mills, Isaacs (2021) makes a distinction between 'personal troubles' and 'public interest' when defining a social problem. In this sense, his argument is, that for an issue to become a social problem it must first move from the private sphere of concern to the public sphere of concern. For Isaacs (2012) when concerns are discussed in the public sphere, they becomes located in the broader territory of social problems. These problems might emerge as 'moral panics' that capture the public imagination for short periods of time or as problems that persist over longer time-scales and are associated with the values and belief systems in existing social structures.

> No problem can be adequately formulated unless the values involved and the apparent threat to them are stated. These values and their imperilment constitute the terms of the problem itself (Mills 1959:129).

As Nicholls and Berridge (2020) remind us, the history of attitudes towards substance use, and its regulation, is never just about the substances themselves and is characterised by an

assemblage of social attitudes, anxieties and beliefs around the context of their use. For Nicholls and Berridge 'these concerns tend to be articulated with an emphasis on where substances are consumed and what these spaces signify in terms of gender, race and class, as much as their specific psychoactive effects' (Nichols and Berridge 2020:25). From nineteenth century notions of the 'dangerous classes' to 'high risk groups' associated with communicable diseases, moral and public health representations of 'risk' have produced and reproduced concerns around the effects of drugs and people who use them on broader society:

> Substance use by women, for instance, is framed repeatedly as creating risks to wider society through the impact on unborn children; the consumption of substances in public spaces is associated with both sexual risk and a threat to sexual propriety; substance use in private however, is similarly condemned as furtive, pointing towards dependence and moral weakness (Nicholls and Berridge 2020:25).

Millio (2001) notes how the emergence of 'healthy public policy', with its emphasis on lifestyles, child care, personal and community social and health services and information exchange, promotes the notion of improved conditions; safe, secure and sustainable livelihoods, measured by its impact on population health.

Public health science then has a particular role in justifying an anxiety and long-term concerns around drug use, initially through risk factor epidemiology and more recently through the emergence of health economics. Lupton (2013) asserts that through the science of 'risk factor' epidemiology, the lives of PWUD, particularly those people who inject drugs (PWIDs), have been characterised in public health discourse by the risk associated with HIV infection or viral hepatitis. For Nicholls and Berridge (2020) the gaze of moral and public health concerns surrounding the effects of drug use invariably fall more heavily on the poor with the proposed solutions often impacting most heavily on the most disadvantaged individuals and communities. Bacchi (2018) notes for example how these concerns are often heavily and

negatively value laden, indicated by their close association with social problems, producing and further reinforcing drug using stereotypes, social stigma and a discredited identity. Bacchi (2009) and Bacchi and Goodwin (2016) speak of drug user identity in terms of the subject positions available and the subjectification effects of drug policy and discourse, one of the central questions of a poststructural policy analysis and a theme explored throughout this thesis.

**2.6 Poststructural policy analysis: Power, knowledge and truth**

For Ball (1990) policy is a matter of the 'authoritative allocation of values'. Ball describes policies as the operational statements of values, 'statements of prescriptive intent' (Ball 1990:3). However, values are not free-floating, independent of social, economic influence and political context. Ball (1990) draws our attention to the centrality of power and control in policy asking the question who's values are validated in policy and who's are not? Post-structuralist analysis of social policy, particularly those influenced by Foucault, emphasise how power is intimately connected to and intertwined with knowledge. Commentators such as Mills (2003) have noted how Foucault was particularly interested in establishing in his writings an interconnectedness between power and knowledge and power and truth:

> Knowledge does not simply emerge through scholarly study but is produced and maintained in circulation in societies through the work of a number of different institutions and practices. Thus, he moves us away from seeing knowledge as objective and dispassionate towards a view which sees knowledge always working in the interest of particular groups (Mills 2003:79).

As Watson (2000) reminds us, for Foucault, we cannot think of knowledge without thinking of power. Watson points out that following Foucault 'all fields of knowledge are constituted within power relations and all power relations constitute a field of power' (Watson 2000:68). Foucault's analysis of power focuses on the productive forces of power and is concerned with questions of how it is exercised and by what means:

> We must cease once and for all to describe the effects of power in negative terms: it 'excludes', it 'represses', it 'censors', it 'abstracts', it 'conceals'. In fact, power produces; it produces reality; it produces domains of objects and rituals of truth. The individual and the knowledge that may be gained of him belong to this production (Foucault 1977:194).

Watson (2000) notes that the productive forces of power and power/knowledge nexus are relevant to an understanding of Foucault's notion of bio-power and an analysis of the power of social, medical and legal professions and the knowledge claims on which their power is often based. Foucault's notion of bio-power and biopolitics are discussed in subsequent chapters where techniques of treatment and control are considered in relation to governing the conduct of PWUD. Firstly however, it is necessary to review a body of literature on drug policy and how policy influences and shapes various models of drug treatment. If, as Ball (1990) argues, 'policy matters' and is an articulation of the dominant values and social structures, then the poststructural critical analysis of drug policy and policy responses described by Bacchi (2009) and Bacchi and Goodwin (2016) is useful in revealing problematisations within policy representations and the effects of those representations on PWUD. As Ritter *et al.* (2018:6) remind us 'PWUD die from preventable overdoses or are killed by police and military acting on behalf of their governments while stigma and marginalisation associated with drug policy and policy responses continues to affect the lives of many more'. A poststructural analysis of contemporary and historically situated drug policy starts to unravel the problematised notions of the 'drug problem' and of the problem of the people who use them revealing the contested nature of risk, dangerousness and harm as socially and politically constructed within the discursive struggles of power, knowledge and truth.

### 2.7 Harm Reduction, governmentality and the regulated self

From the mid-1980s and into the 1990s, UK drug policy was characterised by a pragmatic and flexible approach to reducing harms associated with drug use and drug using practices. In its

1988 report, the ACMD urged treatment services to make and maintain contact with PWID in the belief that engagement with services offered the best opportunity for responding to and reducing the harms associated with drug use, ‘above all the risk associated with injecting drugs and the acquisition and transmission of HIV infection’ (ACMD 1988:17). Although the ACMD did not use the term harm reduction directly, Ashton and Seymore (2010) note that the 1988 report endorsed harm reduction principles and signalled a new direction in managing public health risks associated with drug use and drug users and set out a blueprint for the wide scale development of harm reduction services and interventions. A response that, Strang (1993) and Stimson (2007) have noted, prioritised a reduction in the harm associated with drug use over a reduction in drug use itself. Harm reduction interventions included Needle and Syringe Programmes (NSP), condom provision and flexible methadone prescribing services and were a pragmatic response to the serious and real concerns that HIV infection among PWID could threaten the public health through sexual transmission (Robertson *et al.* 1986, McKeganey 2011).

While some critics of harm reduction describe a narrative that reflects a moral ambivalence to drug use (McKeganey 2011), Stimson has referred to the period from the mid-1980s as the ‘health phase’ of UK drug policy, where drug related problems equated to issues pertaining to individual and public health. This phase continued as the dominant discourse until the 1995 Drug Strategy reversed this trend and ushered in what Stimson (2000) terms the ‘crime phase’ of drug policy. Here drug harms are no longer viewed as a public health problem but are intrinsically linked to criminality as ‘drug-related crime came to be viewed as the primary scourge for families and communities’ (Hunt and Stevens, cited in Monaghan 2012).

MacGregor (2010:11) notes how Newcombe, one of the original architects of harm reduction in the UK, comments that:

> There is no overarching theory of harm reduction and various models can be *observed*. The main point is to distinguish between drug *use* itself, its causes and effects – which is the main question for the abstentionists – and discussion of the risks of drug use (Newcombe 2008 cited in MacGregor 2010:11).

For Newcombe (1992) harm reduction in the UK has its origins in scientific public health with roots in humanitarianism and libertarianism. It is hierarchical in its aims and draws a clear distinction between its key principles, which he sees as reducing the negative effects of drug use, and those of abstention policies which prioritise decreasing the prevalence and incidence of drug use and which 'are rooted in punitive law enforcement and medical paternalism' (Newcombe 1992:1). Describing a 'middle road alternative' to prohibition and the medical disease model of addiction, Marlatt notes that:

> Based on public-health principles and founded by 'grassroots' advocacy among drug users themselves, harm reduction offers a pragmatic yet compassionate set of principles and procedures designed to reduce the harmful consequences of addictive behaviour for both consumers and for the society in which they live (Marlatt 1996:779).

Significantly for Marlatt, harm reduction does not preclude an abstinence position. Following the 1988 ACMD report *Aids and Drug Misuse* Marlatt supports abstinence as an 'ideal end-point along a continuum ranging from excessively harmful to less harmful consequences (Marlatt 1996:786). Not only is harm reduction without any overarching theory, its various models are potentially confused and contradictory. For many activists, harm reduction is fundamentally pragmatic, not theory driven. The Harm Reduction Coalition 2010 note for example that:

> It is recognised that traditional ideological or theoretical explanations of the aetiology of high-risk behaviours and associated interventions are not always generalisable and may impede development and application of effective, tailored harm reduction interventions. Thus, harm reduction adherents tend to deemphasise general theory and ideology and seek out acceptable, feasible and effective solutions that are applicable to specific situations. A pragmatic, tailored approach to developing harm reduction solutions is a cornerstone of this framework (Collins *et al.* 2012:21).

Much of the literature on harm reduction presents a pragmatic, humane and public health orientated scientific approach to the problems related to substance use. As Andersen and Järvinen (2007:236) note ‘harm reduction is presented as the self-evidently correct approach to the problems associated with substance use while critical reflection has been very rare’.

De-emphasising theory in harm reduction can leave the principles on which its interventions are based, potentially blind to the ideological forces of governance and technologies of risk management while the lines between the aims of those principles, (harm reduction) and those of abstention, become somewhat blurred within its approach. In a critical review of harm reduction, Miller (2001) deconstructs some of its assumptions surrounding harm reduction pointing out, that from a sociological point of view, there are a number of shortcomings with the approach including a failure to engage with the dominant discourse practices of social institutions (Miller 2001:168). Discourse plays a central role in society and Miller is critical of the potential mechanisms of social control within the framework of harm reduction. Nadelmann, an advocate of harm reduction must have been aware of the role of discourse in drug policy when he wrote:

> The advantage of harm reduction as a slogan or policy label is obvious. Who, in their right mind, could oppose the notion of reducing harm? It is easily embraced by government officials and others who favour less emphasis on criminal justice policies and more emphasis on public health approaches, and not readily disavowed even by those who prefer more punitive drug control methods. It is sufficiently vague that people with very different ideas about drug policy feel comfortable embracing it as their label. And it conveys a sense of British or Dutch ‘sensibility’ that can prove irresistible to those who view the ideological excesses of the drug war rhetoric with a sceptical eye. (Nadelmann 1993:37).

For Roe (2005) the vagueness of harm reduction in its formative days proved an advantage in winning general support, acceptance and overcoming criticism, but became a liability once mainstream support was gained. As Keane (2003) has pointed out, within the domain of policy and funding processes medical professionals were acknowledged as the experts, advancing

medical rather that social arguments for harm reduction, while public health practices with their reliance on epidemiological knowledge, become a depersonalising and alienating perspective towards what is a highly individual problem. For Keane this ‘takes attention away from issues such as poverty and inequality, and increases the power medical expertise’ (Keane 2003:231).

In the decades before harm reduction became a recognised ‘brand’, marginal social and political groups were loosely organised around opposition to drug prohibition. For Roe (2005) through forming a coalition with public health, the newly mainstreamed harm reduction movement identified with HIV prevention initiatives and the medical management of social problems and became reluctant to overtly engage in political criticism, moving away from direct challenge of existing policy and laws. Roe (2005) has noted within the ‘new harm reduction movement’ there remained a historical tension between those who see harm reduction primarily as a means of promoting health and mitigating harms associated with substance use and a more activist group who see it as a platform for broader and more structural social change.

Following a Foucauldian inspired notion of governmentality, Roe (2005) calls for a political critique of the social and legal systems that create harm and points to a body of research that critically exams how harm reduction approaches, while aiming to prevent harm in the short-term, props up and reproduce the social structures of harm in the longer-term. Roe (2005) reminds us however, that Foucauldian critiques of harm reduction and public health (Mugford 1993, Miller 2001) do not say that it is problematic in itself to base the drug treatment policy on the principles of public health, rather that those principles are not necessarily as empowering and free from moral judgement as advocates of harm reduction claim. As Miller and Rose (2008) remind us, public health-based policies represent part of the:

> self-regulating capacities of subjects, shaped and normalised in part through the powers of expertise, have become key resources for modern forms of government

> and have established some crucial conditions for governing in a liberal democratic way (Miler and Rose 2008:26).

## 2.8 Harm reduction and neoliberal responsibilisation

Harm reduction typically divides harm into those faced by the individual, harm to the community and harm to society. However, as Keane (2003) notes, a focus on the reduction of harm to the wider community does not necessarily translate into a reduction of harm for the individual. The complex and sometimes contradictory relationship between these harms is for Keane (2003), rarely discussed within harm reduction discourse. Moreover, harm and risk are discursive and defined through technologies and techniques of governance associated with public health practices and risk assessments (Lupton 2013). As O'Malley (1999) has noted, a spectrum of labels and categories can follow such assessment practices ranging from 'dependent' and 'harmful' through 'excessive' and 'inappropriate' to 'informed', 'controlled' and even 'responsible' drug use, transforming the governmentality associated with drugs and people who use drugs, through the governing tendencies of harm reduction practices.

Seddon (2010) has also suggested that the rise of harm reduction cannot be explained simply in terms of a response to the threat of HIV. For Seddon, this development can be better understood by 'looking more closely at the ways in which harm reduction was aligned with a particular vision of the drug user' (Seddon 2010:87). Public health discourses have defined the way in which drug problems were represented and informed the development of new 'technologies' for managing and regulating those problems (Seddon 2010, 2011), and that developments in new regulatory and governing practices can be best understood by locating them within the wider context of the unravelling of welfarist politics and the rise of neoliberalism. Moore and Fraser (2006:3036) remind us that 'whereas classical liberal welfarist rationality emphasised state and expert responsibility for the care of individual citizens' neoliberalism has:

> created another rationality for government in the name of freedom, and inventing or utilising a range of techniques that enable the state to divest itself of many of its obligations, devolving those to quasi-autonomous entities that would be governed at a distance by means of budgets, audits, standards, benchmarks and other technologies that were both autonomising and responsibilising (Rose, O'Malley and Vaverde 2009:13).

For Foucault, expert knowledge is central to the techniques and practices of subjectification or the formation of certain types of subjects (Lupton 2013). Central to the new public health was the science of risk epidemiology and the notion of long-term risk and high-risk groups (MacGregor and Thom 2020). For Lupton (2013) through the application of risk epidemiology, 'risk is problematised, rendered calculable and governable'. Through these technologies, 'particular social groups or populations are identified as at risk or high risk, requiring particular forms of knowledges and interventions' (Lupton 2013:117). Peterson (1997) points out that by focusing on risk factors and statistical correlations, rather than the individual, the possibilities for preventative interventions are increased at a population governmental level. These new regimes of governmentalism are based on what Dean (2010) describes as 'new prudentialism'. For Dean (2010) new prudentialism refers to the increased reliance on scientific calculation. The 'deployment of technologies of agencies and technologies of performance' (Dean 2010:194) in the calculation of risk based on large data sets, and on the minimisation of these risks through the multiple 'responsibilisation' of individuals, families, households and communities. Through self-regulation, those affected by risks, now become responsible for them (Castel 1991, Roe 2005). Public health-based harm reduction is illustrative of a technology of agency through which populations that manifest high risk or are composed of individuals deemed 'at risk' become the target of programmes to transform their status (Roe 2005) rendering them active citizens capable, as individuals and communities to monitor and manage their own risk (Dean 2010). In her sociological analysis of injecting drug use, Vitellone (2012) describes for example, the distinctiveness of harm reduction as transforming PWID from

pathological deviants into public health citizens who care for themselves and others, while Walmsley (2012) in his analysis of governing injecting drug use points to transformations in discourse from the pathology of needle fixation to the normative practice of risk management and knowledge production. The language of self-harm is replaced with harm reduction.

### 2.9 The New Abstentionists: Recovery and the re-making of harm reduction

When in December 2010 the UK Coalition Government published its new drug strategy it set out 'a fundamentally different approach to tackling drugs and an entirely new ambition to reduce drug use and dependence' (HM Government 2010:3). Moreover, the Strategy, *Reducing Demand, Restricting Supply, Building Recovery: Supporting People to live a Drug Free Life,* confirmed the government's position to make clear that individuals are accountable for their actions. 'We will increase the responsibility of individuals to work with those who are there to support them to tackle and overcome their dependence' (HM Government 2010:3).

The Strategy marked a departure from the previous government's tough on crime – tough on the causes of crime narrative and a drug treatment system focused on the reduction of drug-related crime and regulating the behaviour of problem drug users (Duke 2013). The 2010 strategy was unequivocal in its aims and harm reduction, the dominant discourse in UK drug policy since the mid-1980s was not mentioned once in the entire strategy (McKeganey 2014). The following year the Coalition Government published *Putting Full Recovery First* (2011) which provided a clear indication of what the government considered to be key failures of the drug treatment system and its growing disillusionment with the effectiveness of methadone maintenance treatment. Ashton (2008) noted that there was a renewed faith in abstinence-based treatment programmes with the rise of what he termed the 'new abstentionists' (Duke 2013). In a *Druglink* Special Insert, Ashton wrote:

> Around Bonfire Night 2007 a rocket shook the peaks of England's drug treatment structure – someone asked how many patients ended up drug-free. Clothless as the fabled emperor, 3% came the reply. The new abstentionists were on the march and the statistics seemed to be with them (Ashton 2008:1).

As McKeganey (2011) notes, the view that 'drug treatment works' had been virtually unshakeable in the UK until around 2007 when the confidence in that belief evaporated virtually overnight and a sense of crisis descended upon the treatment system. Treatment engagement and claims of crime reduction outcomes were dismissed as irrelevant and no justification for investment in drug treatment that should be about getting people off drugs. *Reducing Demand, Restricting Supply, Building Recovery: Supporting People to live a Drug Free life* (2010) wrote abstinence into policy as the primary goal of drug treatment while *Putting Full Recovery First* (2011) provided the means by which an abstinence agenda would be operationalised and how an official discourse of abstinence would become popularised and dominant throughout the treatment system:

> Through changes to local commissioning structures, we will re-orientate local treatment provision towards full recovery by offering people more abstinence-based support and giving them genuine choice about their responsibilities and futures, Department of Health (2011:4).

In 2017, the Conservative Government published yet another UK Drug Strategy, the fifth in under two decades. Hopes of a new direction in drug policy and an effective response to increasing numbers of drug related deaths quickly evaporated as the new strategy spilt out the same rhetoric of reducing demand, restricting supply and building recovery. 'Our overall aims remain to reduce all illicit and other harmful drug use and increase the rate of individuals recovering from their dependence' (HM Government 2017:6).

Recovery had brought about a renewed optimism in drug treatment and the promise of a fresh outlook for those described by a growing anti-harm reduction lobby as being 'parked on methadone' and 'abandoned to treatment' (Ashton 2008). Fuelled by recovery capital and social

resilience and liberated from the tyranny and burden of drug treatment, a new identity was emerging among a section of the drug treatment community – people in recovery were looking to 12-step fellowships and mutual aid for their support and the treatment system responded accordingly.

Best *et al* (2017) refer to membership of 12-step fellowships as offering a strong social identity, important in their view for sustaining recovery and/or desistance. Recovery can be characterised by its prescriptive focus on identity transformation via 'normal' (non-alcohol and other drug using) social relationships, practices and responsibilities (Fomiatti *et al* 2017). For Best *et al* (2017) understanding recovery/desistance through the lens of a social identity model emphases the role of social groups – important because of their shared values and access to social capital. For Best *et al* (2017) membership of drug using and/or offending groups challenges attempts at recovery/desistance adds to social exclusion and increases stigmatisation.

> The importance of a social identity model of recovery/or desistance is the transition from membership of groups that support or tolerate negative behaviour and the impact this has on access to resources as well as on self-image and the feeling of exclusion, to groups who not only provide a positive sense of value and worth, but also access to social and other forms of community capital (Best *et al* 2017:7).

The above underlines Moore *et al's* (2017) assertion that emphasising the 'non-addicted' and 'normal' reproduces a series of binary opposites between addiction and free-will, independence, self-control, responsibility, productivity and autonomy. Recovery focused treatment relies on a 'recovering addict identity' within which exists both the possibility to promote the 'normal' and the potential to reproduce the stigmatising and pathologising ideas about people who continue to use drugs (Fomiatti *et al* (2017). In adopting the 'recovering addict' identity individuals must first accept the subject position 'addict' and all the negativity associated with it. Abstinence-based recover orientated treatment ideology with its limited outcome options

reproduces and reinforces the pathology and stigma assembled around the socially, politically and economically constructed representations of risk, harm and identity of addiction.

As Moore and Fraser (2013) point out, episode-based treatment collapsed multiple and complex problems into easy to calculate successful treatment episode outcomes – treatment complete, drug free, while the cause of economic, social, emotional and psychological problems would increasingly be located and rooted in alcohol and other drug use. Positive change in a struggling economy and a treatment system decimated through unprecedented budget cuts imposed via the politics of austerity (Edwards 2017), became the responsibility of the health seeking neoliberal citizen and recovery was the vehicle for realising it Fraser and Moore (2011).

In its 2017 report *Commissioning impact on drug treatment* the ACMD warned that:

> A loss of funding could lead to decreased treatment penetration and increased levels of blood-borne viruses, drug-related deaths and drug driven crime in communities. Moving drug and alcohol misuse treatment into local authority public health structures appears to have been detrimental to treatment in the context of the financial challenges faced by local authorities (ACMD 2017:4)

Against a backdrop of unprecedented public sector cuts, a pandemic and record numbers of drug related deaths, the Government in 2021 published *From harm to hope: A 10-year drugs plan to cut crime and save lives* (HM Government 2021). The effects of the strategy and the impact of the Covid-19 pandemic on PWID is picked up in subsequent chapters, for now, it is useful to note that the strategy acknowledged that 'the capacity of the treatment system was insufficient to meet the need for support and that half of the people with an 'addiction' to the most 'harmful drugs – opiate and crack cocaine' are not engaged in treatment (HM Government 2021:12).

In spite of the strategies insistence on heroin and crack cocaine being the most harmful 'drugs of addiction', it fails to mention the possible benefits of heroin assisted treatment, cocaine

assisted treatment or the availability of overdose prevention centres. Instead, the strategy makes repeated reference to the Government's treatment 'flagship' Project ADDER re-affirming its commitment to law enforcement and abstinence-based recover orientated treatment. In a footnote on page ten the strategy describes Project ADDER (Addiction, Diversion, Disruption, Enforcement and Recovery) as:

> a comprehensive approach to tackling drug 'misuse' and offending, bringing together local agencies, police, councils and health services in some of the areas most affected by drug 'misuse'. This programme tackles drug 'misuse' through coordinated action combining targeted and tougher policing with enhanced treatment and recovery services (HM Government 2021:10).

The 2021 strategy appears to offer an all too familiar fatalist perspective on drug use with interventions focused around the criminal justice system and a treatment system limited in treatment options and characterised by governing practices. Its stated aim to breakdown the stigma associated with the use of drugs is exposed as rhetorical virtue signalling on behalf of government commentators as the strategy makes repeated references to 'substance misuse' and 'substance misusers' while importantly failing to meaningfully address law reform, confirming the Governments unwillingness to accept that current drug laws 'compound social disadvantage, erect barriers to people seeking help and worsen health outcomes' (Winstock *et al.* 2021:1).

**2.10 Pharmacotherapy, biopower and regulatory practices**

Following Foucault, the association between opioid pharmacotherapy and the regulation and social control of people who use drugs is already established within the literature on biopower. Bourgois (2000) for example reminds us that Foucault's concept of biopower 'refers to the ways historically entrenched institutionalised forms of social control discipline bodies'. The bio-politics of substance use include a 'wide range of laws, medical interventions, social institutions, ideologies, and even structures of feeling' (Bourgois 2000:167). For Bourgois, the

definition of methadone maintenance as drug treatment is a concrete example of biopower at work:

> The state and medical authorities have created distinctions between methadone and heroin that revolve primarily around moral categories concerned with controlling pleasure and productivity: legal versus illegal; medicine versus drug. The contrast between methadone and heroin illustrates how the medical and criminal justice systems discipline the use of pleasure, declaring some psychoactive drugs to be legal medicine and others to be illegal poisons. Ultimately, it can be argued that the most important pharmacological difference between the two drugs that might explain their diametrically opposed legal and medical statuses is that one (heroin) is more pleasurable than the other (methadone) (Bourgois 2000:167).

Bennett (2011) also notes how methadone treatment, a central pillar of the public-health based harm reduction approach, has been promoted as a 'humane and effective alternative to imprisonment and justified on the grounds of providing better life chances for opioid users':

> What is often presented as a treatment for the benefit of opioid dependent persons, a treatment developed to rescue opioid users from a life of misery, disease, financial hardship, destitution, and so on, is also – perhaps primarily – a bio-political technology strategically deployed to contain and control drug users, illicit drug use, drug-related crime, and the spread of infectious diseases for the benefit of the general population (Bennett 2011:150).

For Bennett (2011) methadone programmes have even extended into rendering PWUD 'safe enough' to be released from prisons. In this sense public health and medical authorities serve as agents of the state in rendering PWUD less dangerous:

> Without treatment and the disciplining practices that underpin it, this extension of liberty would be politically more difficult given prohibition and community fears and anxieties over drug use. In methadone, then, we find the coexistence of freedom and subjugation, or perhaps more accurately, a limited freedom made possible by the micro-system of regulation and surveillance (Bennett 2011:150).

Bennett's observations can be seen played out in the targeted crime reduction strategy Project ADDER outlined above and in the Government's 2021 strategies aspirations to increase drug treatment places for everyone leaving prison with an addiction problem. The new infrastructure

of institutionalisation and supervision extends the control over PWUD through categorising and defining those unwilling or unable to engage as treatment resistant. Through treatment engagement initiatives including criminal justice interventions and public health programmes of 'unmet need' harm reduction provides a refined set of 'interventionist technologies which make it possible to guide and assign individuals without having to assume their custody could prove to be a decisive resource' (Castel 1991:295). In this sense, Seddon (2010) suggests that through the lens of Foucauldian governmentality, at a strategic level at least, harm reduction and criminal justice interventions are two sides of the same coin both sharing a focus on managing and controlling the risks posed to individuals and communities by 'problem drug users' and both concerned with engaging PWUD with the regulatory and governing practices of drug treatment.

### 2.11 Conclusion

The history of drug control describes the consolidation of professional restrictions as reaching a particular significance with the 1868 Pharmacy Act and subsequent 1884 Patient Medicine Bill, which together saw the sales of opiate-based medicines restricted to registered pharmacists (Berridge and Edwards (1987). From the mid-nineteenth century onward, professional discourses have shaped, influenced and constructed notions of 'problem' drug use and people who use them, pathologising or criminalising the non-medical use of controlled substances and drawing up policies for their regulation, containment and control. Contested notions of addiction and treatment have contrasted with the more overtly disciplinary intentions of the criminal legal system and its punitive responses to PWUD while advocates of harm reduction and abstinence recovery approaches struggle to identify distinct policy outcomes. Harm reduction, as noted by Hathaway (2001) encourages 'safer drug using practices' as opposed to the elimination of drug use but fails to address, as Miller (2001) notes, the social and structural

determinants that can lead to drug use in the first place and are often the cause of harms associated with their use.

A body of literature reminds us how any consideration of the benefits and pleasures associated with the use of drugs have been ‘absented’ from harm reduction discourse (O’Malley and Valverde 2004; Moore 2008; Duncan *et al.* 2017; Dennis 2017; Keane 2017), while Bacchi (2018) argues that ‘drug problems’ operate in policy as taken-for-granted descriptions of conditions that need to be rectified or eliminated through the disciplinary techniques of drug treatment and other interventions. In a departure from a traditional analysis of ‘drug problems’, which view policies as ‘problem solving’ projects, Bacchi (2009) develops a Foucauldian inspired poststructural approach, arguing that drug problems are constituted, brought into existence and given meaning as particular types of problems within drug policies . Fraser and valentine (2008) draw our attention to the lack of critical social research into drug treatment noting that while the ‘clinical effectiveness’ and patient compliance of methadone treatment have been analysed in the pages of public health and medical journals, the broader social meaning and potential disciplinary tendencies of substitute therapies have been subject to little sustained social research.

# Chapter Three

# Theoretical Framework:

## 3.1 Introduction

This chapter introduces the theoretical framework that informs this research and the study of drug policy effects on PWID. The study is situated within a poststructural theoretical tradition and a growing body of literature (Bacchi 2009; Fraser and Moore 2011, Keane 2002, Moore and Fraser 2013, Dennis 2019, Lancaster and Rhodes 2020) on drug policy that challenges the assumption that drug problems exist independently of society and government forces and are there waiting to be solved. Drawing on the work of Foucault and governmentality scholars the study follows a WPR approach to policy analysis arguing that the realities of drug use and people who use drugs are constituted in and through policy and practice. The study considers how 'drug problems' are given meaning and represented in professional discourses and are related to technologies for managing and regulating the behaviours of people who use drugs. In this sense, the study draws on social constructionist perspectives offering a critical analysis of drug policy that focuses on the 'constructed effects' of drug policy rather than an assessment of whether it meets its objectives of 'solution-based outcomes'.

## 3.2 Poststructuralism and the anti-positivist critique

Poststructural critiques emerged over half a century ago to challenge the reductive nature of structuralist theory and the excesses of positivist methodologies in the social sciences (St. Pierre 2011). In his seminal text, the *Sociological Imagination* C. Wright Mills mounted a scathing attack on mainstream social science research, much of which he referred to as 'mediocracy' and 'pretentious' in its effort and which was characterised by:

> A set of bureaucratic techniques which inhibit social enquiry by 'methodological' pretentions, which congest such work by obscurantist conceptions, or which trivialise it by concern with minor problems unconnected with publicly relevant issues. These inhibitions, obscurities, and trivialities have created a crisis in the social studies today without suggesting, in the least, a way out of that crisis (Mills 1958:20).

The crisis that Mills was referring to centred on a drift in social science disciplines towards increasingly serving the interests and needs of giant corporations while decontextualising the 'lives and experiences of ordinary people, their communities and the neighbourhoods in which they lived' (Scraton 2007:5). The way out of the crisis, came in part, with the emergence of critical theory and the anti-positivist critique and the eventual development of poststructural theories.

The origins of critical theory date back to 1923 and can be located within the Marxist influenced Institute for Social Research at Goethe University in Frankfurt Germany (the Frankfurt School) and the work of Max Horkheimer, Theodor Adorno and Herbert Marcuse. Second generation Marxist scholars such as Jürgen Habermas have been credited with producing work at the pinnacle of critical theory (Held 1980) driving forward a critique of positivism that 'emphasised a critical approach to social analysis that would promote social transformation' (Poutanen and Kovalainen 2012:4). Habermas has also been credited with opening up and engaging in methodological debate with postmodern and poststructural theorists. Like poststructuralism, critical theory rejected positivist social sciences and the value-free assumptions and methods rooted in the natural sciences by emphasising the role and positions of norms, values and meanings in the constitution of knowledge.

While poststructuralism is often seen as antagonistic towards structural Marxist theory and its privileging of the economic as the strongest driving force for social change, it does not reject the significance of the economic within its analysis of politics and power (Peters 2001).

Poststructuralist opposition to Marxism and Grand Theory for example emphasises the possibility for a multiplicity of theoretical standpoints, some of which take account of the political economy and are sympathetic to the material conditions of class, race and gender (Peters 2001). As Peters (2001) suggests, in the same way that Althusser produced a structuralist account of Marx and Marxism, a poststructuralist reading Marx is equally possible and has a relevance to this research in terms of the assumed or taken-for-granted neutrality of politics in the construction of policy:

> Nietzsche provides poststructuralists with the resources to understand Marx's 'power' differently – to view it, in Foucauldian terms, as operating at the microphysics of everyday life (Peters 2001:13).

Newman (2005) has argued, that in this sense, poststructuralist theory can be seen as working within the paradigm of radical and anti-authoritarian politics. For Newman (2005) this is not only because many poststructuralist commentators have emerged from a Marxist and Althusserian theoretical tradition but that a poststructuralist approach is aimed at undermining or problematising the claims to legitimacy and normality of dominant political and social institutions. Following Foucault, Newman questions the legitimacy of discourses and practices that are typically regarded as taken-for-granted, normal and natural.

> There is nothing inevitable or natural about the way we do and think about politics: what we perceive to be our political reality today is a contingent historical formation that has emerged through the suppression of alternative realities. Therefore, we might say that poststructuralism has an anti-authoritarian *ethos* – an implicit commitment to question the truth claims of any form of political, social and even textual authority (Newman 2005:3).

It is these claims to legitimacy and normality (the taken for granted assumptions) produced and reproduced in discourse and discursive practices that this research addresses.

### 3.3 Discourse

Bacchi and Goodwin (2016) note that the term discourse has become prolific within social theory literature and that even among contemporary poststructuralist policy analysts, a diversity of meaning is fairly common place. Poststructuralism is often associated with the 'linguistic turn' (Fairclough 2013, Fischer 2017), and the 'proposition that it is through language that knowledge and, indeed, reality are constructed' (Bacchi and Goodwin 2016:35). Bacchi and Bonham note that:

> This development is associated with a primary focus on language as central to the nature of lived experience. The focus has generated a reaction among those who argue that the 'linguistic turn' undercuts political analysis by making language a determining influence and by refusing to engage with 'material reality' (Bacchi and Bonham 2014:174)

Bacchi and Bonham (2016) remind us that in *The Archaeology of Knowledge* Foucault distances himself from studies that focus on linguistics and communication stating that:

> Discourse, at least as analysed by archaeology, that is, at the level of its positivity, is not a consciousness that embodies its project in the external form of language (langage), plus a subject to speak it. It is a practice that has its own forms of sequence and succession. (Foucault 1972, cited in Bacchi and Goodwin 2016:35).

However, as Bacchi and Bonham (2016) have noted, in spite of this conceptual distance, his association with the term discourse has resulted on occasion in the misplaced characterisation of Foucault as being only concerned with language and linked to linguistic determinism.

In their defence of Foucault's position, Bacchi and Bonham (2014) attempt to clear up the confusion by way of reference to the concept of the 'statement'. The confusion for them arises from the simplistic view that statements are elements of speech. For Foucault, discourse is understood not as language but as knowledge. Discourse is a 'regulated' practice

in the sense that it is both regular and 'rule like' through its routinisation (Bacchi and Bonhan 2014:183).

> Foucault introduces the concept of the 'statement' to refer to exactly *those things said* – *what* people say or write – not as language, but as 'monuments' or 'events'. Foucault describes his approach to knowledge as *an archaeology*. Statements, therefore are to be analysed as material artefacts, *at the level of their existence*. The focus is on how they have come to be, rather than on what they might mean". (Bacchi and Bonham 2014:183 – 184 emphases in original).

Foucault's notion of archaeology helps us to make visible knowledges that embedded in discursive practices and is developed further in chapter five as a way of drawing attention to the ways in which power/knowledge relations underpin contemporary practices in drug treatment.

Following Foucault, Mills (2003) supports the view that discourse is not the equivalent of language and reminds us that there is not a simple relation between discourse and reality. For Foucault (1972:49) discourses are practices that systematically form the objects of which they speak. They are 'understood as socially produced forms of knowledge that set limits upon what it is possible to think, write or speak about a given social object or practice' (Bacchi and Goodwin 2016:35). Jäger and Maier (2016) use the Foucauldian term 'dispositif', the mechanisms and knowledge structures which enhance and maintain the exercise of power, to describe a 'constantly evolving synthesis of knowledge that is built into the linguistically performed practices (thinking, speaking, writing), non-linguistically performed practices (doing things), and materialisations (natural and produced things)' (Jäger and Maier 2016:111).

It is in this sense that Hall (2001) refers to discourse, not as language, but as a system of representation. A system that includes rules and practices that produce meaningful statements and the mechanisms that regulate discourse in different historical periods. For Foucault, discourse meant:

> A group of statements which provide a language for talking about – a way of representing the knowledge about – a particular topic at a particular historical moment. Discourse is about the production of knowledge through language. But…since all social practices entail *meaning*, and meanings shape and influence what we do – our conduct – all practices have a discursive aspect ( Hall 2001:72).

For Hall (2001) Foucault's analysis of discourse is, at least in part, an attempt to overcome the traditional distinction between what one says (language) and what one does (practice).

### 3.4 Discourse: knowledge, power and 'truth'

Hall (2013) reminds us that Foucault does not speak of truth in any absolute sense. For Foucault, 'truths' are multiple, contingent upon a discursive formation that constitutes and sustains it in any given setting, context, or historical moment.

> It may or may not be true that single parenting inevitably leads to delinquency and crime. But if everyone believes it to be so, and punishes single parents accordingly, this will have real consequences for both parents and children and will become 'true' in terms of its real effects, even if in some absolute sense it has never been conclusively proven (Hall 2013:34).

Hall's example here could just as easily be applied to drug use and the constructed 'truths' relating to risk, harms and crime associated with PWID. The argument here is, that 'truth' 'does not sit outside of the productive relations of power – knowledge (Foucault 1980).

> Truth is a thing of this world: it is produced only by virtue of multiple forms of constraint. And it induces regular effects of power. 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 1980:131).

For Foucault, 'the term discourse refers to knowledge, what is within the true', what is accepted as truth, and understood to be a cultural product, 'rather than to language' (Bacchi and Bonham 2014 p.174).

> Following Foucault, discourses are understood as socially produced forms of knowledge that set limits upon what is possible to think, write or speak about a given social object or practice (Bacchi and Goodwin 2016:35).

Foucault uses the term discursive practice to describes those practices of knowledge formation by focusing on how specific knowledges (discourses) operate and the work they do (Bacchi and Bonham 2014:174).

For Foucault (1980), the 'political economy' of truth in neoliberal capitalist societies centres on the form of scientific discourse and the institutions that produce it:

> Truth is to be understood as a system of ordered procedures for the production, regulation, distribution, circulation and operation of statements. Truth is linked in a circular relation with systems of power which produce and sustain it, and to effects of power which it includes and which extend it. A 'regime' of truth. (Foucault 1980:133)

Foucault's reference here to the production, regulation, circulation and operation of statements is as Mills (2003) points out, central to his interest in the relationship between discourse, knowledge and power. Foucault's use of the term discursive formations describes how groups of statements connected with the same topic, and which appear to produce similar effects, are grouped together on the basis of an association with particular institutions or sites of power. For Foucault, statements are not simply elements of speech they are representations. 'They lead to the reproduction of other statements which are compatible with their underlying presuppositions' (Mills 2003:64).

### 3.5 Policy as discourse

As discussed in chapter two, Ball (1990:3) describes policies as the 'operational statements of values'. For Ball (1990) the allocation of values, who's values are validated in policy and who's are not, draws our attention to power – knowledge relations in formation of policy and how, following Foucault, power is intimately connected to knowledge (discourse). For Bacchi policy

as discourse theory defines ‘discourse in ways that accomplish particular goals’ and at ‘some level contain an agenda for change’ (Bacchi 2000:46). Policy as discourse theory draws attention to the mechanisms that ‘make meaning’ within policy and legal debates uses the concept discourse as a partial explanation about why progressive change is difficult to achieve.

> The goal is to illustrate that change is difficult, not only because reform efforts are opposed, but because the ways in which issues get represented have a number of effects that limit the impact of reform gestures. The argument is that issues get represented in ways that mystify power relations and often create individuals responsible for their own ‘failures’, drawing attention away from the structures that create unequal outcomes (Bacchi 2000:46).

Bacchi is alluding here to the processes of responsibilisation and governing styles associated with advanced neoliberal political economies described by Rose (1999) whereby individuals are targeted as being responsible for their own futures through exercising choices. Moreover, individuals are encouraged to think of themselves as responsible for everything that goes wrong in their lives through ‘bad choices’. Mol (2008) for example, introduces the notion of a ‘logic of care’ arguing that good care has very little to do with patient choice and therefore creating more opportunities for patient choice, a ‘logic of choice’ will not improve health care.

Policy as discourse theory challenges the conventional view that public policy is an objective and rational exercise intended to address and resolve problems that simply exist. Policy as discourse theory attempts to illustrate how policy problems or social problems are created within discourse. For Bacchi (2000; 2009), problems are produced as particular kinds of problems within policy proposals. How they are produced has important political implications for people, the effects of which, can be revealed by shifting the emphasis from problems to problematisations.

As noted earlier, this research engages with Bacchi’s analysis and the policy as discourse position outlined above as a way of understanding the techniques for governing the lives of

PWID. Following Bacchi's (2009) Foucault inspired poststructural policy analysis, 'What's the problem represented to be' (WPR), the concept problematisation is used in this research to connect with and interrogate policy as a means of unmasking how 'drug problems' are constituted within a neoliberal political economy and given meaning within drug policy. Following Bacchi's WPR approach, by replacing problems with problematisations, this research highlights concerns with the way in which the concepts 'problem' and 'problems' operate in the alcohol and other drug field historically and contemporaneously. As Bacchi (2018:4) cites several researchers who have already applied a WPR approach in the alcohol and other drug field of research (Farrugia, Seear, and Fraser 2017; Farrugia 2016; Fraser and Moore 2011; Lancaster, Seear and Treloar 2015; Lancaster, Seear, Treloar and Ritter 2017; Lancaster, Treloar and Ritter 2017; Mansson and Ekendahi 2015; Manton and Moore 2016; Moore and Fraser 2013; Seear and Fraser 2014); and these now make up a substantial body of literature referred to in chapter two. The next chapter outlines the WPR approach in more detail and discusses where it connects this research theoretically and methodologically.

In his discussion of multidisciplinary research within the alcohol and other drug field, Moore notes that:

> The production of knowledge about drugs is constituted through a network of positions occupied by individuals (e.g. researchers, policy-makers, practitioners, community members) and institutions (e.g. research centres; federal, state and local government; drug services). These positions are related through relations of domination, subordination or equivalence, and through struggles over the distribution of power that enables and reproduces access to scarce resources (e.g. research funding, 'impact' on policy and practice). Subjugated knowledges such as qualitative accounts of drug use, struggle for equal legitimacy with the dominant discourses of biomedicine and epidemiology. The need to produce knowledge that is 'policy relevant' and 'accessible' also tends to stifle innovation and critical research (Moore 2011:74).

Bacchi (2016) refers to the emergence of critical realism as an example of a research paradigm, located somewhere between positivism and interpretivism, with a particular appeal and leaning

towards performative studies and programme evaluation. Critical realism assumes the existence of a reality independently of social actors ‘while accepting that the interpretations of those actors can influence that reality’ (Bacchi 2016 p. 5) Bacchi (2016) suggests that ‘critical realism alters the positivist evidence-based question ‘what works?’ asking instead ‘what works for whom in what circumstances and in what respects, and how’? For Bacchi, this question has appeal amongst health policy researchers as it recognises the need to examine the contexts within which policy interventions operate. However, as Bacchi also notes, it becomes necessary to reflect on how that formulation, ‘what works for whom in what circumstances?’, conceptualises contexts, subjects and problems. Moreover, Bacchi (2016) argues that the space for critical analysis in realist evaluation is constrained because problems tend to be prescribed by those commissioning the evaluation.

> In Foucault-influenced poststructuralism, realities emerge in practices. Hence, a single reality, assumed in critical realism, is deemed to be a political creation rather than an ontological given (Bacchi 2016:8).

Stevens (2020) characterises this poststructural position as ‘radical constructionism’ in which he objects to the assertion that the realities of alcohol and other drug use are constituted in practice. For Stevens, ‘in order to see the value of this knowledge, we need a conceptual framework which allows for the possibility that there is a reality that is external to it’ (Stevens 2020:2). Stevens’ argument here is that not only are constructionist views going too far in emphasising the role of discourse in the production of reality (Fraser and Moore 2011) but that ‘naming things as practices is denying the material reality of those things, or the basic anterior material on which to ground these practices (valentine and Seear 2020:2). For valentine and Seear (2020) this is just not the case and Stevens’ claim that constructionists believe that nothing exists outside of discourse does not withstand a close reading of poststructuralist texts.

They cite for example Fraser and Moore's comments on fatal heroin overdose:

> Who would want to dismiss, for example, a fatal heroin overdose as merely a discursive construction, as if a change in ways of talking and thinking about it would alter it or instantly prevent it from happening (cited in valentine and Seear 2020:2).

The assertions of Fraser and Moore's (2011) and valentine and Seear (2020) here are entirely consistent with Foucault's notion of discourse and of practices. As Hall (2013) reminds us in chapter six, Foucault's emphasis on discourse as knowledge and meaning does not deny that things can have a material existence in the world.

As previously noted, critical poststructural social research rejects the assumptions and methods of the natural sciences by emphasising the role of history, power, discursive practices and meanings in the construction of knowledge. Unlike the natural sciences that view material reality as an 'objective given', discourse and dispositif analysis examine how reality is brought into being by human beings assigning meaning. As is discussed further in chapter six, Hall reminds us that 'Foucault does not deny that things can have a real, material existence in the world. What he does argue is that nothing has any meaning outside of discourse' (Hall 2013:29). Moreover, as valentine and Seear (2020) remind us, policy making, among other things, is always political:

> From a Foucault-influenced poststructural perspective, policy work, like all knowledge work, is political work; policy research, like all research, is understood as a form of ontological politics (Mol 1999) that makes worlds (Bacchi and Goodwin 2016:9).

In line with the view that knowledge production through research is understood as a political practice, A WPR approach Bacchi (2009); Bacchi and Goodwin (2016) is sympathetic to the term ontological politics as capturing the position that research makes rather than reflects worlds. Bacchi and Goodwin (2016) draw our attention to the use of information and

communication technologies in shaping what it is possible to think, plan, organise and implement in the way of governing techniques. They offer as an example of ontological politics at work in the field of addiction treatment, the use of 'diagnostic instruments and practices that construct their objects rather that describing a pre-existing reality' (Bacchi and Goodwin 2016:89). In this sense, as discussed in chapter six, governmental technologies form a part of ontological politics that enable some realities while disabling others.

A number of contemporary commentators on theory, research and practice in the alcohol and other drug field are now drawing on the concept of ontological politics as a way of understanding the relationship between socially constructed knowledge and contested versions of reality. Recent works include Dennis's (2019) account of 'Doing drugs research in more than human worlds', Bacchi's 2018 account of drug problematisation and politics and Fomiatti *et al.* (2021) analysis of addiction recovery.

### 3.6 Governmentality

In his introductory text on governmental rationality, Gordon (1991) notes that in a lecture titled *Security, territory and population* given in 1978, Foucault introduced a new domain of research and thought into governmental rationality which he called governmentality. While in contemporary discussion people take government to be something purely political, Foucault wanted to show that well into the eighteenth century, the problem of government was situated in a more general context (Lemke 2012). Government was a term not only associated with political discussion but with philosophical, religious, medical and pedagogic texts:

> In addition to management by the state or administration, government also addressed problems of self-control, guidance for the family and for children, management of the household, directing the soul, and other questions (Lemke 2012:13).

Following Foucault, Dean (2010) describes the development of governmentality since the eighteenth century as a system that constitutes and exercises a complex form of power, what Foucault refers to as biopower – the power over life itself. Miller and Rose (1990) for example refer to governmentality as a 'way of thinking or mentality that allows the exercise of power by social authorities to manage populations in modern politics' (cited in Bacchi and Goodwin 2016:8). For Miller and Rose governmentality has a discursive character. They suggest that to analyse the conceptualisations, explanations and calculations that inhabit the governmental field requires an attention to language. Like Jäger and Maier, Miller and Rose see discourse as a 'technology of thought', requiring attention to the particular technical devices of writing, listening, numbering and computing that makes possible in discourse a knowable, calculable and administrable object. 'Knowing' an object in such a way that it can be governed is more than a purely speculative activity:

> It requires the invention of procedures of notation, ways of collecting and presenting statistics and the transportation of these to centres where calculations and judgements can be made and so forth. It is through such procedures of inscription that the diverse domains of governmentality are made up, that objects such as the economy, the enterprise, the social field and the family are produced in a particular form and made amenable to intervention and regulation (Miller and Rose 1990:5).

Following Foucault and Miller and Rose (1990), Dean (2010) and Bacchi and Goodwin (2016) support this view arguing that the term governmentality is used to describe a particular form of government with historical origins realised in contemporary Western democracies, in which the security, reproduction, productivity and stability of the population are concerns of the state. An assemblage of institutions and practices that formed a system of population management and which for Foucault were essential to the development of a capitalist economy. Following Foucault, they describe this form of government (governmentality) as 'a triangle of power'; sovereignty, discipline and governmental management (Bacchi and Goodwin 2016:41) and

which constitutes a system of 'bio-politics' with the population as its target, political economy as its major form of knowledge and the apparatus of security as its essential technical instrument (Dean 2010:30).

For Bacchi and Goodwin (2016) the study of governmentality draws our attention to the 'rationalities' and 'technologies' that exist in both conventional political institutions and the multiple agencies and groups of professional and experts to contribute to the administration of societal affairs. For Gordon (1991) governmental technologies and rationalities are those that are produced to justify a particular mode of rule:

> A rationality of government will thus mean a way or system of thinking about the nature of the practice of government (who can govern; what governing is; what or who is governed), capable of making some form of that activity thinkable and practicable both to its practitioners and to those upon whom it is practiced (Gordon 1991:3).

For Lupton (1995) governmentality incorporates both coercive techniques and practices of the state and non-coercive techniques and practices through which the state and other institutions encourage individuals to engage in strategies for the sake of their own interests and wellbeing. Lupton (1995) suggests that the analysis of governmental techniques and practices of the self – self-government – provides a means of understanding the social and political role of public health and other health promotional discourses and practices. Chapter seven develops further an analysis of the regulatory capabilities of governmental techniques and discourses on PWID. Public health generally, and drug treatment systems specifically, incorporate governmental techniques and practices that promote self-governing or technologies of the self:

> Despite the radical user-friendly intentions of harm reduction activists, their movement could not escape what Foucauldian critics refer to as the 'logic of governmentality'. Harm reduction operates within the limits of a middle-class public health discourse committed to educating 'rational clients…..free to choose health'. In pursuit of knowledge and progress, medicalised discourses promote disciplined subjectivities that self-impose responsible behaviour (Bourgois and Schonberg 2009:106).

As Moore (2011) has argued, when viewed from this perspective, harm reduction interventions that promote self-imposed responsible behaviour – technologies of the self, become new forms of neoliberal governmentality.

### 3.7 Technologies of the self

Foucault introduced the term technologies of the self as a way of describing a theoretical shift in his analysis of power, away from a pre-occupation with techniques and technologies of domination towards questions of power in relation to the self and the constitution of subjects. Lemke (2012) notes that for many commentators this theoretical shift signalled a departure for Foucault in the analytics of power and politics, an observation that for Lemke and others is misplaced. Lemke (2012) asserts that Foucault's turn to a focus on subjectification processes, rather than signalling an abandonment of political analysis, was motivated purely by political interest. As Moss (1998) has noted, Foucault's interest in questions concerning the constitution of the self, followed observations of a new field of conflict emerging. Struggles and resistance against the government of individualisation and against forms of subjectivity. For Moss, the turn to a focus on processes of subjectification offers a much-needed clarification of the rather ambiguous previous notion of power:

> This clarification is significant because it introduces the notion of a 'free' subject - individual or collective subjects who are faced with a field of possibilities in which several ways of behaving, several reactions and diverse comportments may be realised – over whom power is exercised (Moss 1998:81).

Lemke (2012) notes that the shift in focus represents a re-problematising and correcting of previous works and reminds us that for Foucault, government refers to a continuum of power relations that extend from political government through to forms of self-guidance, self-regulation – technologies of the self. Rather than a departure from an analytics of power and

politics, any theoretical shift or turn 'takes place inside the analytics of power rather than between the genealogy of power and a theory of the subject' (Lemke 2012:21).

Foucauldian theories of the self have a particular relevance to this study and the subject positions available to PWUD and PWID as discussed in later chapters of this thesis. For example, the ways in which PWID are encouraged to become responsible for themselves and others through the responsibilising interventions of harm reduction practices (Walmsley 2012). Following Rose's (1999) description of governing techniques associated with advanced neoliberal political economies, Lemke notes how:

> Neoliberal government encourages individuals to give their lives a specific entrepreneurial form. It responds to a stronger 'demand' for individual scope for self-determination and autonomy by 'supplying' individuals and collectives with the possibility of actively participating in the solution of specific matters and problems that had hitherto been the domain of distinct state agencies specifically empowered to undertake such tasks (Lemke 2012:85).

Lupton (1995) usefully draws our attention to ways in which technologies of the self-operate in and through the governmental discourses of public health. Lupton (1995) notes that:

> Like many other contemporary institutions and agencies, public health and health promotional discourse and practices privilege a certain type of subject, a subject who is self-regulated, 'health'-conscious, middle class, rational, civilised. They also privilege a body that is contained, under the control of the will. Governmental strategies emerging from public health and health promotion, sponsored by the state and other agencies, are directed at fostering such subjects and bodies. If people do not find themselves interpellated by governmental discourses, if they do not recognise themselves therein or have no investment in these discourses, they will not respond accordingly (Lupton 1995:131).

The argument here is that technologies of the self – the processes of subjectification that result in self-regulation and self-governing are an effect of discourse and representation of problems as particular kinds of problems. As Lemke (2012) points out above, on becoming part of the solution to the 'problem' through active participation one is also becoming part of the problem as constituted and given meaning in policy. Moreover, participation in this neoliberal context

comes at a cost. Individuals themselves have to assume responsibility for actions and activities and their possible failure. As this research asserts, the neoliberal governing practices of drug treatment and harm reduction shift the responsibility for health and wellbeing onto the individual and away from any collective or societal failings. When PWID suffer injury, illness or loss, neoliberal responsibilisation translates the misfortune into the result of self-inflicted actions.

### 3.8 Responsibilisation

Responsibility, or more often lack of it, has become a central theme within problem representations and discourses of drug use and people who use them. The practices of responsibilisation associated with neoliberal discourses are key to an understanding of new forms of governmentality and technologies for governing the conduct of conduct that cut across all political parties Juhila, Raitakari and Löfstrand (2017). For Rose (1999) notions of self-governing and the 'actively responsible subject' are closely linked to autonomy and choice. Juhila, Raitakari and Löfstrand (2017) note that responsible subjects in neoliberal societies are expected to make choices that 'maximise their well-being, health, safety and quality of life. However, as Miller and Rose (2008) have noted, a problem for neoliberal governmentalism is how (and by what means) to govern individuals towards making responsible choices where they continually make life choices to the contrary. For Miller and Rose (2008) the aim of neoliberal governmentality is to create governance techniques that are directed to the 'management of freedom' and which link subjects to their subject positions.

For Juhila, Raitakari and Löfstrand (2017) the resposibilisation of individuals within neoliberal systems of health and social care can be described as 'governing at a distance' and a transition in public services that can be characterised by a shift from a provision-based paradigm to a framework-based paradigm and a state that instead of steering and rowing, only steers.

Governing in neoliberal societies, as noted by Juhila, Raitakari and Löfstrand (2017), entails new constellations of partnerships between public and private. A premise that they argue resonates with the idea of 'Big Society' and an emphasis on strong civil society and private enterprise rather than a strong interventionist state of government. This research offers examples of those neoliberal governmental technologies; processes of subjectification, responsibilisation, self-guidance and self-regulation (technologies of the self) at work within the discourses of drug treatment, abstinence-based recovery and harm reduction through viewing problems as problematisations (Bacchi 2009; Bacchi and Goodwin 2016).

**3.9 Problematisation**

At one level the term problematise has been associated with a desire to question something or raise doubts about a particular position. How for example someone engages in problematising an issue and the form of problematisation they produce. How problems are shaped and understood, 'problems that at some level, are taken to exist as real states or conditions' (Bacchi and Goodwin 2016:39).

> Foucault used the term problematisation in two ways: first, to describe his method of analysis and second, to refer to a historical process of producing objects for thought. The second meaning captures a two-stage process including 'how and why certain things (behaviour, phenomenon, processes) become a problem. (Bacchi 2012:1)

For Bacchi (2012) the study of problematisations raises the possibility to illuminate how things which appear self-evident and taken for granted are in fact fragile, often attributable to historical conjuncture that have nothing definite about them. For Bacchi raising questions (problematising) the 'certainty of fixed objects' and 'rendering them fragile' is particularly important because 'they shape our experience of who we are and what we know' (Bacchi 2012:2). To understand how problematisations provide an entry point for reflecting on this

process requires an examination of the relationship between problematisations and practice. In her consideration of problematisation, Bacchi refers to Foucault's' description of practices as 'places where what is said and what is done, rules imposed and reasons given, the planned and taken for granted interconnect' (Bacchi 2012:2). For Bacchi (2018) the study of problematisations provides critical insights into how practices (what is said and what is done) constitute subjects and objects. Bacchi reminds us that Foucault was interested in 'specific kinds of practices, those that establish and apply norms, controls, and the exclusions that make true/false discourse possible. In short, he directed his attention to governing practices and how they worked' (Bacchi 2018:8). For Bacchi (2018) the purpose of studying problematisations is to establish a critical distance from the taken for granted, self-evident given notion of 'objects' (addiction and drugs) and people who use and inject drugs as 'subjects' shifting the presumed 'reality' of 'objects' and 'subjects' to the relations of discourse (power/knowledge) and mechanisms (governmental technologies) in there becoming. Bacchi's argument here is that drug policies characterise and constitute drug 'problems' that are enacted as 'within the true' and 'real'. The application of the WPR approach illustrates the role of problematisations as 'important mediating factors in the production of the real' (Bacchi 2018:10) while the 'implications of these problematisations can be unpicked through three different kinds of effects; discursive effects, subjectification effects and lived effects' (Brown and Wincup 2020:3).

The following chapter sets out in more detail Bacchi's WPR approach as applied to this research. The theoretical insights of poststructuralism help to guide the analysis through further chapters linking research, theory and practice. Considering how, for example, the work of Foucault has advanced critical theory and merged an analysis of power with contemporary critical analysis and contemporary governmental studies. How the work of Mol (1999, 2002) and Law and Mol (2002) on ontological politics has contested the notion of a fixed reality and

disrupted the distinction between epistemology and ontology (St. Pierre (2011). How the radical intentions of harm reduction interventions have been subsumed and subverted by a neoliberal politics of responsibilisation and how the emergence of a social harm perspective has highlighted how criminalisation masks the social production of harm (Hillyard *et al.* 2004; Canning and Tombs 2021).

### 3.10 Harm producing policy and the production of harm

Following Bacchi's (2009) WPR poststructuralist approach to policy analysis, this research makes the case that drug policy, like other policies, constitute and produce problems as particular kinds of problems and rejects claims for any solution-based strategic framework. Moreover, following Bacchi's proposition to replace problems with problematisations as a means of revealing the discursive, subjectification and lived effects of policy, and drawing on social harm theory, this research focuses attention on the 'harm producing' capacity of drug policy. The notion of harm producing policies draws on the theoretical concepts of harmful societies proposed by Pemberton (2016), social harm perspectives Hillyard, Pantazis, Tombs and Gordon (2004), Canning and Tombs (2021) and zemiology of politics, Davis and White (2022) and is developed further in chapter five.

As with the shift to resposibilisation within new modes of governmentality, the notion of harmful societies and the social production of harm is intimately connected to the politics of neoliberalism and formations of discursive practices (Hillyard and Tombs 2004). Following Foucault, Canning and Tombs note that:

> Discourses define the reality of the social world through regimes of truth and none more so than what he described as the scurrilous discourses of criminology. Power and knowledge are not independent but intimately linked. Ideas which function as true are perpetuated by institutions and their discourses. Hence the need for a counter-discourse on social harm (Canning and Tombs 2021:44).

While Hillyard and Tombs (2004) project was to highlight the extent of social harm that was excluded from a definition of crime, handled outside of the formal processes of criminal law or just simply ignored, the concept has a relevance to the problematisation of drug related harms and the lived effects for PWUD and PWID. Following Bacchi (2009) and Bacchi and Goodwin (2016), this research is concerned with the effects of drug policy and drug policy responses on PWID. While problem representations constituted within drug policy strongly associate PWUD and PWID with crime and criminality they do not acknowledge the effects of those problem representation as producing harm. A social harm perspective associates the production of harm not only with the individual actor but with those responsible for creating the policy. For Hillyard and Tombs (2004) adopting a social harm approach triggers a different set of responses to the issue of harm. Rather than situating the responsibility for and consequences of harm with the individual actor or 'handing it over to unelected, largely unaccountable and certainly non-representative' agencies and organisations, those different policy responses would require politicisation of the issues (Hillyard and Tombs 2004:22). In this sense the ambitions of a social harm perspective are entirely consistent with those of poststructuralist re-problematising policy representations.

### 3.11 Conclusion

By design, critical research challenges the epistemological, ontological and axiological assumptions of natural science. The displacement of the structural-functionalist theory in the 1960s, by critical theory created a space for the development of contemporary critical analysis and emergence of poststructural theory with its focus on constructionism, a rejection of taken for granted 'truths' and a contextualised analysis of relations of discourse, power and knowledge. This theoretical framework underpinning this research is informed by a Foucauldian influenced poststructural policy analysis WPR alongside poststructural interview

analysis. Both approaches share the same epistemological and ontological assumptions and are outlined in more detail in the following chapter. An underlying goal of WPR is to make the productive activity of policy (the discursive practices) of policy visible (Bacchi and Goodwin 2016) and is aligned to Foucauldian theory of power. As noted earlier, WPR makes the case that policies do not address problems that exist, 'rather they produce 'problems' as particular kinds of problems' (Bacchi and Goodwin 2016). For Bacchi and Goodwin (2016) the manner in which problems are constituted shapes the lives of people and the identities that they take on. By analysing how problems are produced and represented, through following Bacchi's proposal to replace problems with problematisation, it is possible to unmask and critique the discursive practices that underpin the politics of governmentality and the conduct of conduct (Bacchi 2000). Further to governmental studies and a consideration of the influences of neoliberal responsibilisation, the research introduces notions of harm producing policies as a means of situating responsibility for harm and the lived effects of drug policy including; criminalisation, structural and symbolic stigma and violence, discrimination, injecting related infections and the on-going crisis of drug related deaths to those with the authority for constructing policy and the harmful policy representation therein.

# Chapter Four

# Methodology

## 4.1 Introduction

Chapter three introduced the theoretical context of this research by situating the research within a poststructural understanding of government and governing practices. Such an understanding involves a critical consideration of the productive nature of discourse, the numerous institutions and practices that produce representations of reality and knowledge that interrelate in particular ways to shape and form the social rules for the conduct of the self and others. Following Foucault, critical analysis rejects the premise that knowledge is value-free or value neutral, arguing that reality is constituted historically and contemporaneously through socially produced forms of discourse.

This chapter now moves on to outline the methodological approach adopted in this research. The central question addressed in this thesis is:

**In what ways have particular problematisations of drugs and their effects since 2010 affected people who use them, with particular reference to people who inject drugs?**

To help address this overarching question, the research has been guided by four additional specific questions:

1. In what ways have recovery narratives and discourses affected drug user identities?
2. To what extent do drug user identities play a role in treatment engagement?
3. To what extent have any considerations of benefits and pleasures associated with drug use been 'absented' from harm reduction and recovery discourses?

4. To what extent has recovery become narrowly defined around a 'recovering addict identity' alienating people who reject or resist that particular identity?

Addressing these questions requires an approach that engages critical enquiry and a consideration of the interrelations between research, theory and practice in the analysis of government, policy and policy responses, professional and public discourse and the material conditions of social structures. The methodology used in this thesis combines critical social theory with poststructural policy analysis in a framework of critical enquiry that challenges both the conventual view of government policy as a problem-solving force with an analysis of the power relations within the production/reproduction and legitimacy of knowledge and truth. Engaging with Carol Bacchis' (2009) poststructural policy analysis, 'What's the problem represented to be?' (WRP) offers an analytic strategy to facilitate poststructural policy analysis (Bacchi 2009; Bacchi and Goodwin 2016) and a way of thinking differently about taken for granted and commonly accepted categories of governing practices. For Bacchi (1999) and Bacchi and Goodwin (2016) by analysing how problems are produced and represented through the study of problematisation, it is possible to unmask, to gain access to, and to critique the discursive practices (the knowledge practices) that play a central role in the politics of governmentality and how we are governed. The implications of problematisations (problem representations) can, as Brown and Wincup (2020) have noted, be unpicked through a consideration of what Bacchi and Goodwin (2016) refer to as three types of effects; discursive effects, subjectification effects and lived effects. The point here for Bacchi and Goodwin (2016) is to contest the supposed independence and innocence of problems.

### 4.2 Epistemological and ontological assumptions

In adopting a poststructural approach, this research makes certain epistemological and ontological claims about knowledge, truth and reality. As outlined in the last chapter, the

concept of knowledge, the production, reproduction and effects of knowledge, are central to this research. Foucault's assertion is that knowledge is experienced in and through discourse, discourse as knowledges. For Foucault, knowledges are made up of both general background knowledges, assemblages of knowledge that might be apparent in epistemological and ontological assumptions, as well as relatively bounded forms of social knowledges such as those associated with specialities and professional disciplines. Bacchi and Goodwin (2016) remind us that the use of knowledges in the plural signals a scepticism that poststructural enquiry holds towards:

> The premises and proposals associated with disciplines, including political science, psychology, epidemiology, social work, anthropology, and so on, are seen as contingent historical creations, human constructions, that need to be interrogated rather than enshrined as 'truth' (Bacchi and Goodwin 2016:5).

Bacchi and Goodwin (2016) note that for Foucault knowledges are understood as things that are 'in the true', in other words, things that can be said as kinds of accepted and agreed forms of truth, rather than as 'truth'.

Following a Foucault influenced poststructural policy analysis reveals a fundamental assumption over the intrinsic relationship between discourse, knowledge and power.

> Discourse, Foucault argues, constructs the topic. It defines and produces the objects of our knowledge. It governs the way that a topic can be meaningfully talked about and reasoned about. It influences how ideas are put into practice and used to regulate the conduct of others (Hall 1997:29).

Importantly here, as Mills (2004) points out, Foucault is not denying the existence of a reality beyond discourse. His assertion is that 'what we perceive to be significant and how we interpret objects and events and set them within systems of meaning is dependent on discursive structures' (Mills 2004:46). Burr (2015) refers to this as a narrowing of one's field of vision in which alternative ways of knowing become excluded from consideration, worthy of attention

or even being real. In other words, how alternative knowledge is subjugated or ruled out of any accepted discursive practices:

> If discourses regulate our knowledge of the world, our common understanding of things and events, and if these shared understandings inform our social practices then it becomes clear that there is an intimate relationship between discourse, knowledge and power ( Burr 2015:79).

Foucauldian discourse analysis distinguishes between discourse analysis, which tends to focus on an analysis of language and a poststructural discourse analysis which is an analysis of discourse – an analysis of socially produced knowledges. Mills (2003) reminds us that discourse is not equivalent to language.

> Discourse does not simply translate reality into language; rather discourse should be seen as a system which structures the way that we perceive reality (Mills 2003:55).

The meeting ground between knowledges and languages is that knowledges depend upon categories and concepts that find their expression in language. Foucault uses the term discursive formations to describe how ‘statements which deal with the same topic and which appear to produce similar effects’ coalesce through a common association with particular institutions or sites of power (Mills 2003).

Mol (1999) introduces the concept of ontological politics to emphasise that lived realities are created by rather than reflected in, social practices including policy and research practices. For Mol (1999:86) ‘ontological politics suggests a link between the real, the conditions of possibility we live with, and the political’.

> If the term ‘ontology’ is combined with that of ‘politics’ then this suggests that the conditions of possibility are not given. That reality does not precede the mundane practices in which we interact with it, but is rather shaped within these practices (Mol 1999:75).

Mols' notion of ontological politics sets WPR as a poststructuralist approach to policy analysis apart from realist accounts of knowledge and policy analysis, for example Stevens (2020c:8) who cites Bhaskar (2008) in arguing that 'ontological realism is logically necessary for people who seek to use better expiations of reality':

> In order to render intelligible scientific change and to reconcile it with the idea of scientific progress we must have the concept of an ontological realm, of objects apart from our descriptions of them (Bhaskar 2008:240 cited in Stevens 2020c:8)

Stevens (2020c:8) goes on to assert that 'if we want to create a sound understanding of drugs and drug use to inform changes to policies, then we have to accept ontological realism'.

Bacchi and Goodwin (2016:15) draw our attention to the poststructuralist proposition that 'knowledge, such as that produced in research' is not treated as 'truth' or as a 'set of true statements about reality', rather as playing a 'critical role in governing practices' and in the 'making of reality'. Bacchi and Goodwin (2016) suggest that in line with the view that the production of knowledge through research is understood as a political practice, the term ontological politics captures the position that research makes rather than reflects worlds.
Following this position, the location of the researcher within historically and culturally constituted and entrenched forms of knowledge takes on a particular significance. Foucault influenced poststructural policy analysis makes a commitment to self-problematisation as a way of subjecting one's own thinking to critical scrutiny.

**4.3 Reflexivity and self-problematisation**

Burr (2015) notes that the debate over researcher reflexivity has gained prominence in the social sciences and the term reflexivity is one typically associated with constructionist theory and writing. The term draws our attention to the possibility of the social construction of one's own account as a researcher and how that researcher influence might undermine any claims to

validity and opens up questions about the 'power' of the researcher. In short, the concept assumes that the researcher cannot separate the 'self' from the research (Devaney 2017). Adkins (2002) notes that this has led to a 'crisis of representation and legitimation' in aspects of social research associated with postmodernist and poststructuralist methodologies. Questions of 'validity, reliability and objectivity, which had been settled in earlier phases' were once more problematic (Denzin and Lincoln 1994:10) For Adkins (2002) one of the ways that poststructuralists have legitimised and validated research is through a turn to reflective practice – 'an antidote to the problems of both realism and relativism' (Adkins 2002:333).

Reflexivity is essentially an attempt to demonstrate a level of self-awareness integral to the researcher situating her/himself in the research process – an exercise in self-critique engaged in by the researcher to examine how their own experiences and prior knowledges might or might not have influenced the researcher in a process that subjects their role to the same critical analysis as the research itself (Patnaik 2013). For Bacchi (2009) this process of self-analysis or reflexivity is necessary because as researchers:

> We are immersed in the conceptual logics of our era and who we are is at least in part shaped through the very problem representations we are trying to analyse (Bacchi 2009:19).

The Foucault influenced WPR analytic strategy used in this research builds reflexivity into the analysis through an undertaking referred to as self-problematisation (Bacchi and Goodwin 2016). Bacchi and Goodwin (2016) note that reflexivity takes on a special significance in Foucauldian analysis as they remind us of Foucault's commitment to 'problematise even what we are ourselves' (Bacchi and Goodwin 2016:24). For Bacchi and Goodwin (2016) a WPR approach moves beyond a 'declaration to become reflexive' to 'endorsing a precise and demanding activity' where one's own problematisations and the problem representations they contain are subjected to the six questions of a WPR analysis (Bacchi 2009).

Self-problematisation was maintained throughout this research in a number of ways. Firstly, in line with a poststructural approach, a sceptical approach was maintained towards taken for granted truths and how 'problems' were represented in policy. This scepticism was extended into professional discourses and 'practices'. Analysis avoided making value judgements of problem representations based on good/bad binary opposites, rather analysis focused on the policy effects of representations of problems. Secondly, an awareness of 'self' was maintained throughout the research through the adoption of critical thinking. Moreover, incorporating the notion of 'thinking with theory' (Jackson and Mazzei 2012) provided a critical framework for contrasting interview texts with theoretical positions reducing the possibilities for personal interpretations. Finally, following a Foucault influenced WPR approach, analysis tends to distance itself from recommendations on 'the way forward' or declarations of 'this, then, is what needs to be done' (Bacchi and Goodwin 2016:24).

The purpose of analysis is to make visible the politics involved in constituting policy including the making of problem representation, illuminating how governmental practices contribute to the production of subjects, objects and places and to highlight the possibilities for different problematisations and therefore different representations of the 'problems'. In this sense, analysis questions the inevitability of 'things' suggesting that they can be otherwise.

This research was conducted in two stages, an analysis of drug policy followed by semi-structured interviews which were analysed using a combination of Bacchi and Bonham's (2016) poststructural interview analysis and Deleuze and Guattari's (2013) notion of 'plugging-in'. Where the research produced opportunities for alternative problematisations, the presuppositions, assumptions and possible effects of new problem representations where subjected to the six questions integral to a WPR approach.

### 4.4 Stage One: Policy Analysis

Analysis commenced with the selection of policy documents or texts. Given that the initial focus of this research was the effects of drug policy on PWID since 2010, a careful reading of UK government drug strategies since 2010 provided an entry point for analysis. However, as the research developed conceptually and an analytic strategy (WPR approach) was decided upon, it became apparent that a broader critical reading on UK drug policy was required. To this end, the inclusion of UK strategy documents, including supporting and implementation guidance, extended back as far as 1998. The purpose of this broader critical reading was, in keeping with the analytic approach, to produce a genealogy of drug policy while drawing on that genealogical perspective to challenge some of the claims of contemporary strategy and policies. The following documents were problematised using a WPR critical policy analysis approach:

UK Drug Strategy *Tackling Drugs to Build a Better Britain* (1998)

UK Drug Strategy *Tackling Drugs to Build a Better Britain: An Update* (2002)

UK Drug Strategy *Drug: Protecting families and Communities* (2008)

UK Drug Strategy *Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life* (2010)

*Putting Full Recovery First* (2012)

*UK Drug Strategy* (2017)

*From harm to hope: A 10-year drugs plan to cut crime and save lives* (2021)

*Guidelines for local delivery partners, From Harm to Hope: A 10-year drugs plan to cut crime and save lives* (2022)

*Guidelines for local delivery partners, From Harm to Hope: A 10-year drugs plan to cut crime and save lives. Appendix 2 – National Combating Drugs Outcomes Framework* (2022)

Government White Paper, *Swift, Certain, Tough: New consequences for drug possession* (2022)

*From harm to hope: A 10-year drugs plan to cut crime and save lives. First Annual Report* 2022 – 23 (2023)

### 4.5 What's the problem represented to be? (WPR)

In her 2018 paper, *Drug Problematisations and Politics: Deploying a Poststructural Analytic Strategy*, Bacchi reminds us that the term 'problem' is prolific in drug research and policy. She argues that drug problems operate as taken for granted descriptions of conditions that need to be 'rectified and/or eliminated' and argues that the terms such as 'drug problem' are stigmatising, 'value laden' statements 'indicated by their association with social problems' (Bacchi 2018:4). Citing Tanesini, Bacchi (2018:4) notes that concepts have no fixed meaning: 'They are proposals about how we ought to proceed from here'. For Bacchi (2018) it follows therefore that 'problem' and 'problems', as constructed concepts, have to be considered within the projects to which they are attached and constituted in. 'They are never exogenous (outside of) social and political practices' (Bacchi 2018:4).

WPR offers a different lens with which to view and think about policy and brings into question the common view that the role of government is to solve problems that sit outside, are independent of them and waiting to be addressed. Rather than reacting to problems, 'governments are active in the creation or production of policy problems' (Bacchi 2009:1). Drug policies give shape to drug problems they do not address them (Atkinson *et al.* 2019:64). The study of problematisations produces insights into modes of governing and the enactment of subjects and objects. For Bacchi (2018) problem representations become part of how governing takes place. 'They are enacted as part of the real' (Bacchi 2018:6). Following Foucault, Bacchi (2018) draws our attention to how through problematising 'what takes place' in and through governing practices, reveals access to how 'the real' is constituted and how subjects constitute themselves. In chapters six and seven, this research considers how addiction

is constituted as an 'object' of knowledge and how PWUD and PWID are produced as particular kinds of 'subjects' through governing practices.

### 4.6 Six questions and one step in the WPR approach

The WPR approach to policy analysis has been developed and refined over two decades and comprises of the following six questions and one step shifting the emphasis from 'problem solving' to 'problem questioning' (Brown and Wincup 2020:3).

Box 1: What's the problem represented to be? (WPR) approach to policy analysis [2]

Question 1: What is the problem (in this project, drug use and people who use drugs) represented to be in a specific policy or policies?

Question 2: What deep-seated presuppositions or assumptions (conceptual logics) underlie this representation of the 'problem' (problem representations)?

Question 3: How has this representation of the 'problem' come about?

Question 4: What is left unproblematic in this problem representation ? Where are the silences? Can the 'problem' be conceptualised differently?

Question 5: What effects (discursive, subjectification, lived) are produced by this representation of the 'problem'?

Question 6: How and where has this representation of the 'problem' been produced, disseminated and defended? How has it been and/or how can it be disrupted and replaced?

Step 7: Apply this list of questions to you own problem representations

[2] Box 1: Analysing Policy: What's the Problem Represented to be? Adapted from Bacchi, C. (2009), Cited in Bacchi and Goodwin (2016:20).

#### 4.6.1 Question One – What's the problem represented to be in a specific drug policy or policies?

Bacchi and Goodwin (2016:20) refer to question one as a starting point for analysis. It allows an entry point for considering governing practices and a way of opening up questioning of taken for granted assumptions behind particular ways of thinking. The premise of a WPR approach is that 'all policies are problematising activities and therefore contain implicit problem representations' (Bacchi 2009: 2).

Question one build on this premise and provides a starting point for a critical analysis of 'problem representations' which starts with a policy or policy proposal, examines the recommended interventions, and works backwards to see what the problem is represented to be. For Bacchi (2009) and Bacchi and Goodwin (2016) considering what we propose to do about something reveals what we think needs to change and hence what we think the problem is. Importantly here, Bacchi and Goodwin remind us that in a WPR approach, the researcher is not imposing an interpretation or assessing the 'distance between promised changes and failure to deliver those changes (Bacchi and Goodwin 2016:21). They are determining the problem representation from the proposal that is implicit within the proposal or proposed solution. For example, a 'problem' produced within the 2010 UK Drugs Strategy as Duke (2013) points out, was harm reduction and a methadone maintenance treatment programme with too many users stuck in the 'methadone parking lot' while the strategies policy solution was an abstinence-based recovery orientated drug treatment system.

Bacchi (2009) reminds us however, that on occasion there are multiple problems representations that are embedded or concealed within one another and refers to this as 'nesting'. Effective interrogation of problem representations can sometimes involve subjecting problematisations to repeated application of the WPR integrated questions in order to tease out

‘nested’ multiple problem representations. This was conducted within this research by critically reading and re-reading documents to consider the multiple effects of the problematisations and the problem representations within them.

### 4.6.2 Question two – What presuppositions or assumptions underlie this representation of the ‘problem’?

Bacchi (2009:5) has described question two as ‘working at the level of fundamental worldviews’, an exercise in Foucauldian archaeology to uncover the (assumed) thought that lies behind specific problem representations’. This background, taken-for-granted, knowledge include assumptions (presuppositions) at an epistemological as well as an ontological level. The goal of question two is to identify and analyse the conceptual logics that underpin specific problem representations. Bacchi (2009) uses Foucault’s term ‘conceptual logic’ here to refer to the meanings that must be in place for a particular problem representation to make sense. Question two enables the interrogation of commonly accepted authoritative knowledge (discourses) that determines what is within the true and what is considered to be true. This required an analysis of the networks of relations and practices ‘discursive practices’ in which knowledge is produced and escalated to the status of ‘truth’.

### 4.6.3 Question three – How has the representation of the problem come about?

This question encourages the analyst to produce a Foucauldian genealogy (a history of the present) that focuses on the discursive practices that privilege certain knowledges in the processes that lead to a particular policy representation or representations becoming pervasive and dominant. The goal of genealogy in question three is to disrupt any assumptions about ‘natural’ evolution by identifying specific points where key decisions were made. For example, producing a genealogy of drug policy in this research was useful in questioning the claims that each new strategy provided a fresh outlook while genealogical analysis suggested that all of

the UK drug strategies dating back to 1995 have been underpinned by dominant assumptions about prohibition and drug control.

For Bacchi and Goodwin (2016) the point of genealogy in question three is to illustrate how power is involved in the social production of knowledge and provides an opportunity to consider the effects of subjugated knowledges. Subjugated knowledges consist of historical knowledges that have been buried or masked by functional arrangements or systematic organisations (Bacchi and Goodwin 2016:47).

### 4.6.4 Question four – What is left unproblematic in this problem representation? Where are the silences? Can the problem be thought about differently?

Question four considers the limitations of certain problem representations and opens up the opportunity to think differently about issues raised in a particular problem representation. For example, the opportunity for the analyst to reconceptualise and re-problematise issues in a way that allows particular representations not to be seen as problems. The objective of question four is to consider the issues and perspectives that have been closed off, silenced, or left unproblematised and to reveal subjugated knowledges that might challenge identified problem representation (Bacchi 2009:13). For example, in this research, a re-problematisation of the problem representations that locate harm as a reality and inevitability of drug use reveals how a consideration of the possible benefits and pleasures associated with drug use have been 'absented' from drug policy discourse (O'Malley and Valverde 2004; Moore 2008; Duncan *et al.* 2017; Dennis 2017; Keane 2017).

### 4.6.5 Question five – What effects are produced by this representation of the problem?

Question five enables critical analysis of policy representations and the effects that they produce. Problem representations can negatively impact on groups and individuals disproportionately producing a greater degree of harm for some social groups than others. This

question speaks to the central question that this research endeavours to address. Bacchi (2009) identifies three inter-relating effects to be considered at this stage of the analysis; discursive, subjectification and lived effects. For example, when considering the discursive effects of problem representations in this research, presenting drug use as a crime 'problem' or a 'problem' of addiction both limits and structures the nature of drug treatment. The analysis of the subjectification effects in this research reveals the possible subject positions open to PWUD and both the stigmatised and stigmatising potential of those subjectivities. While the material consequences, the lived effects of problem representations, can be seen in this research through an analysis of the review of drug treatment that has formed the basis of the 2021 UK drug strategy. Here, a focus on the drugs/crime nexus and the burden of cost has resulted in significant investment in drug treatment and the expansion of treatment places to engage increased numbers of 'problematic' drug users with the controlling apparatus of drug treatment. Bacchi (2009) suggests a consideration of the following sub-questions as part of the integrated analytic process engaged in at question five

Box 2: sub-questions to support integrated analysis at question five [3].

- What is likely to change with this representation of the 'problem'?
- What is likely to stay the same?
- Who is likely to benefit from this representation of the 'problem'?
- Who is likely to be harmed by this representation of the 'problem'?
- How does the attribution of responsibility for the 'problem' affect those so targeted and the perceptions of the rest of the community about who is to 'blame'?

### 4.6.6 Question six – How/where is this representation of the 'problem' reproduced, disseminated and defended? How could it be questioned, disrupted and replaced?

For Bacchi (2009) this question builds on question three which directs attention to the practices and processes that allow certain problem representations to become pervasive and dominate.

[3] The overall goal of question five is to be able to say which aspects of a problem representation have deleterious effects for which groups, and hence may need to be rethought (Bacchi 2009:18).

The objective of question six is to 'emphasise the possibility for contestation and to destabilise 'truths' (Bacchi and Goodwin 2016:23). This research highlights the relational effect between policy representations, drug treatment commissioners and drug treatment professionals in reproducing taken for granted 'truths' and solution proposals.

### 4.7 Stage Two: Poststructural Interview Analysis: Shifting the focus to '*what* is said'

As Bonham and Bacchi (2017) have noted, interviews are often used as a source of 'truth' about an event or an individual's experience that the researcher wants to gain access to. A perspective, which for Bonham and Bacchi (2017:689) relies on a notion of 'fixed human essence' characterised as a 'coherent, stable, autonomous, meaning-making individual' (Bonham and Bacchi 2017:688). Bonham and Bacchi (2017) remind us that for Foucault, the individual 'subject' is an accomplishment, one of power's effects. The contingent nature of the interview 'subject' presents a major theoretical challenge for analyses that assume an ability to draw on interviewees' accounts and testimony as a form of 'truth'.

> Since poststructuralism puts in question 'subjects' as sources of 'true' information based on 'direct' experience, it is necessary to approach interviews differently from forms of analysis that rest on these premises. (Bacchi and Goodwin 2016:110).

### 4.8 Analysing interviews differently

To overcome the theoretical challenges confronting the use of interview material in poststructural analysis Bacchi and Bonham (2016) have developed a methodology solidly grounded in Foucauldian theory and concepts (including genealogy and discursive practices) that locates interview accounts and comments within the practices that generate them. This methodology, Poststructural Interview Analysis (PIA) proceeds from the initial premise that 'interviews, like all knowledge practices, including conventional policy studies, are inherently political'(Bacchi and Bonham 2016:114). For Bonham and Bacchi (2017) the research task

becomes one of shifting the focus away from the ‘people’ who speak to *‘what is said’*. By taking ‘things said’ as a starting point, the researcher is able to interrogate the mechanisms, procedures and processes (the discursive practices) involved in their production:

> The knowledge that enable them, rather than the language used in their expression, makes apparent how it has become possible for interviewees to speak of themselves as particular kinds of subjects Bonham and Bacchi 2017:690).

For Bonhan and Bacchi (2017) interviews are sites within discursive practices. It is through the ‘ongoing enactment of relations’ within a discursive practice that ‘things said’ come to be possible and how ‘objects’ and ‘subjects’ are in formation (the kind of subject that one can become). Bonham and Bacchi (2017) note that poststructural scholars propose a ‘subject’ that is multiple, relational and in continual process. ‘In this poststructuralist account the *individual* is theorised as an *effect* of contemporary processes of individuation’ (Bonham and Bacchi 2017:688). For Bacchi and Bonham (2016 this particular approach to ‘subjects’ as ‘in process’ makes it possible to treat interviews, or more precisely interview transcripts, as texts. They note that the procedure for dealing with these texts involves a process of ‘depersonalisation’ that some analysts might see undermining the individual integrity of interviewees’. However, as Bacchi and Bonham point out, the objective of PIA is to

> highlight the contingency and politics involved in shaping the kind of person it is possible to become – to *politicise* ‘personhood’ – and hence to increase opportunities for contestation (Bacchi and Bonham 2016:120).

**4.9 Poststructural Interview Analysis (PIA) Politicising Personhood**

PIA has been designed to align with WPR and provides a totally interconnected poststructural methodology. As noted above, the analytic strategy commences with an examination of interview transcripts for ‘*what* is said’ and proceeds to scrutinise how it is possible for such things to be said (Bonhan and Bacchi 2017). ‘The analytic strategy involves applying the

following processes of interrogation (adapted from Bacchi and Bonham 2016) to the interview transcripts' (Bonham and Bacchi 2017:693).

Box 3: Poststructural interview analysis processes [4]

- Noting '*what* is said'
- Producing genealogies of '*what* is said'
- Highlighting key discursive practices
- Analysing '*what* is said'
- Interrogating the production of 'subjects' and 'objects'
- Exploring transformative potential
- Questions the politics of distribution

### 4.10 Interview analysis – plugging into the data

While a substantial body of literature exists relating to the application of a WPR approach, fewer examples of PIA are available for review. On one hand, the lack published studies illustrating how other researchers had applied a PIA model could be seen as a limiting factor in terms of possibilities to learn and follow. However, Bonham and Bacchi do not intend PIA to be a prescriptive model of analysis and the lack of 'established techniques' lends itself to using the PIA model in a more flexible and innovative way.

Poststructural analysis sits at some distance from the analytic assumptions of thematic coding (Braun and Clarke 2006). St.Pierre and Jackson (2014:716) suggest that coding can be seen more in terms of a positivist technique and far from guaranteeing rigor and validity, encourage the detontextualisation and fragmentation of interview discourse into codable elements of text.

[4] Adapted from Bacchi and Bonham (2016) cited in Bonham and Bacchi (2017:693).

Guided by the research questions, analysis comprised of a number of key tasks; understanding 'what is said' about drug use and PWID, determining if 'what is said' reproduces or challenges taken-for-granted discourses on drug use and PWID, identifying the dominant discourses (discursive practices) that make it possible for 'things' to be said, 'objects' and 'subjects' to be produced and the effects that those discursive practices have in terms of governing practices and the conduct of conduct. Following Jackson and Mazzei (2012) this research uses Deleuze and Guaattari's concept of plugging in as an alternative to the positivist tendencies of thematic analysis. Plugging in offers (as outlined in chapter three) a methodological technique for dealing with multiple data sources that moves beyond the reductionist nature of thematic coding while remaining faithful to the productive sensibilities of a poststructuralist analysis. Through its focus on shifting the focus from 'concept' to 'process' the application of plugging in throughout the analysis works in a way that complements PIA in the exploration of effects of problematisations and the problem representations that they contain.  For further discussion of PIA and interview analysis see appendix A.

**4.11 Selection and recruitment of interviewees**

This section of the chapter describes data collection; how interviewees were selected, recruited and how interviews were conducted. Moreover, it describes how it became necessary to amend the research protocol as a result of 'lockdown' measures introduced as part of the Covid-19 pandemic restrictions between 2020 and 2021. A purposive sampling approach was taken to select three distinct but related sample groups; drug treatment commissioners, drug treatment service providers and people who inject drugs (PWID). Distinct because of the unique position occupied by each group in relation to the commissioning, delivery and extent of engagement with drug treatment and support services, yet related through the experience of each in the process from interpreting and acting on policy to delivering and receiving (or not) a public

health related service. Semi-structured interviews were selected as best suited to this qualitative research and to ensure the ability, through 'probing', to explore any 'subjective meaning that respondents ascribe to concepts or events' (Gray 2018:381). Interviewees were initially recruited from within the Merseyside Region. PWID were initially recruited from drug treatment and recovery services and from needle and syringe programmes (NSP) and included PWID engaged with structured treatment programmes and those who were not, using professional networks, personal contacts, word-of-mouth and 'snowballing' techniques, within the Merseyside area. Drug treatment professionals were recruited via NHS Trust and Voluntary, Community and Faith organisational and agency agreements with service 'gatekeeper' roles established to identity those staff willing to take part in the research. Drug treatment commissioners were approached and recruited directly by the researcher through professional contacts and networks. For example, Cheshire and Merseyside Alcohol and Drug Treatment Commissioners Group network meetings.

While policy documents and drug strategies selected for analysis related to all of England, interviewee recruitment was initially limited to the Merseyside area for practical reasons and as the initial intention of the research proposal was to conduct all of the interviews on a face-to-face basis.

Recruitment inclusion criteria for commissioners and drug treatment services staff included for commissioners; being responsible for the commissioning, procurement and contract performance management of drug treatment and recovery services, and for treatment staff and service providers, being responsible for (directly or indirectly) the management and delivery/provision of drug treatment and recovery services, including opiate substitution treatment (OST) and/or the provision and delivery of needle and syringe programmes (NSP). Inclusion criteria for PWID included people accessing NSP (including those not engaged in

any structured treatment programme) and who have injected psychoactive substances (primarily heroin and/or cocaine) for a period of time more than six months (either currently or in the past).

In spite of efforts to positively engage service gatekeepers and NSP staff, providing assurance through face-to-face information briefings and Q&A sessions, recruitment of PWID was slow with only a small number of PWID making contact directly through personal contacts. Further problems compounded PWID recruitment when the main NSP service, chosen for its central location and usually high levels of activity (confirmed by the local Integrated NSP Monitoring System (IMS)) embarked on substantial organisational restructuring and experienced the disruption of a move to new premises. Five days dedicated to opportunistically recruiting PWID in the agencies usually busy City Centre NSP resulted in no engagement and no interviews while staff reported that those who had previously used the NSP had turned to pharmacy-based programmes in order to avoid the disruption.

In an attempt to improve PWID recruitment, service gatekeepers reviewed client lists and caseloads making a note of any clients in treatment (structured or otherwise) who were known PWID. Lists were sent to each key worker with a request to introduce and describe the purpose of the study during consultations and/or key worker sessions or NSP engagement, and enquire into their willingness to participate by taking part in an anonymous and confidential interview. Recruitment of service commissioners and drug treatment professional was less problematic and proceeded within the planned timeframe.

In March 2020, Covid-19 ‘lockdown’ measures brought about restrictions on research and researchers engaging in qualitative interview-based projects. Recruitment of PWID through NSP services had by now ground to an almost stand still while face-to-face consultations and interviews with drug treatment and recovery services had been suspended. Amendments to the

research protocol and ethics agreement enabled a transition from face-to-face interviews to interviews carried out via virtual media platforms, Skype, Zoom or MS Teams, as well as by telephone. NSP-Direct, a NSP postal service recently established by Exchange Supplies in response to Covid-19 'lockdowns' opened up new opportunities to engage with PWID while amended protocols allowed for the inclusion of PWID recruited from areas outside of the Merseyside Region. Recruitment was back on track. Exchange Supplies are one of the few, if not only, drug related agency in the UK to employ people who are actively and openly engaged with drug use including PWID. Personal acquittance and friendships with staff and owners of Exchange Supplies have been established over decades and helped in overcoming some of barriers to recruiting interview participants. Communications promptly led to introductions with a number of Exchange Supplies employees who were both willing to take part in research interviews and introduce other PWID to the researcher/author. Closer to home, 'snowballing' techniques and word-of-mouth communications had also resulted in further recruitment of PWID including a number of long-term PWID who were known to the researcher/author previous roles in drug treatment and harm reduction services.

The sample included a total of 28 Interviewees:

- 6 Commissioners of drug treatment services
- 12 Drug treatment professional
- 10 PWID

Interviews were completed between July 2019 and June 2021. While recruitment of commissioners and providers of drug treatment services was managed from within the Merseyside Region, PWID where now recruited from the South West and North West geographies of England, representing a broader range of service-related experiences than those that the researcher/author had been familiar and involved with.

PWID recruited into the study were generally longer-term users of substances (aged between 31-years and 64-years at the time of interview) and had a diverse range of life history and service experience, including an assemblage of personally acquired techniques and strategies for navigating, in some cases avoiding drug treatment services and some of the challenges they can throw up. The sample comprised of three individuals identifying as female and seven identifying as male. Most had starting injecting in their late teens/early twenties and had a diverse range of educational and employment backgrounds. Three were University graduates; Donna, Phil and Giles, and one, Phil, had previously worked as an academic researcher on drugs and harm reduction projects.

### 4.12 Semi-structured interview schedules and interview procedures

Semi-structured interview schedules were designed for each sample group reflecting the central research question as well as the four additional guiding questions. Topic guide questions where informed by an initial review of literature and preliminary readings of policy documents. Topic guide questions differed to reflect the different positions occupied by interviewees but all followed the same format covering five main topic areas; context, values and beliefs, treatment, risk and harm reduction, homelessness, health and drug related harm, drug policy and policy responses, and crime, harm and the law. Interviews took place in workplace offices or virtually via online platforms; Skype, Zoom, MS Teams or conducted over telephone. Prior to interviews, interviewees were provided with written information sheets describing the research and its purpose, given the opportunity to ask questions and asked to sign an informed consent form. Permission was requested for interviews to be recorded which all interviewees agreed to. Interviews lasted between 60 and 120 minutes.

### 4.13 Transcribing, organising and analysing interviews

Each interview was digitally recorded, transcribed verbatim and text stored securely in line with the study ethics agreement. Interviews were transcribed by the researcher/author as soon as feasibly possible after the interview was concluded. Once transcribed the digital recording was deleted from the recorder. Interviews were transcribed verbatim in order to reduce the possibility for researcher selection of 'the important data'. Interview transcripts, or texts, included laughs, coughs, pauses and hesitations and speech intonation. While PIA, as noted earlier, is not an analysis of linguistics, the punctuation around 'what' is said provides some additional insights the subjects connection to those things said. As Bacchi and Goodwin have noted:

> By analysing exactly what interviewees say it becomes possible to reflect on the criteria and processes by which they differentiate themselves as particular kinds of subjects, how they come to occupy specific subject positions and how they open spaces to disrupt those positions (Bacchi and Goodwin 2016:119).

### 4.14 Procedural and ethical considerations

Participant information sheets were produced in plain English for each of the three sample groups that explained how interviews would be conducted, how issues of individual safety and welfare would be managed, how information would be protected and how individuals would have the right to terminate the interview without explanation at any point in the proceedings. Recruitment of PWID and drug treatment and recovery service staff was initially manged through service gatekeepers and similar plain English information sheets were produced for these individuals. The study received University ethical approval in February 2019 (19/PHI/004) and recruitment of interviewees started, with support from nominated gatekeepers, in May 2019. Because one of the sample groups, providers of drug treatment and recovery services, were NHS staff, the health Trust employing those staff required that the

research adhered to the conditions set out in an NHS Research Passport. This was applied for and approved in April 2019.

### 4.15 Conclusion

By design, critical research challenges the epistemological, ontological and axiological assumptions of natural science. The displacement of the structural-functionalist theory in the 1960s, by critical theory created a space for the development of contemporary critical analysis with its focus on political economy and the material conditions. Foucault influenced poststructuralism extends an analysis of power beyond that of class to an analysis of discourse, the productive nature of power and its intimate relations to knowledge while retaining a concern for the political economy, material conditions and the intersections of race, class and gender through an analysis of the effects of discourse and discursive practices.

# Chapter Five

# What's the problem with drug policy: Analysing problem representations

## 5.1 Introduction

On the 6th December 2021, the UK Government published its latest drug strategy, the third since 2010. Claiming a radical departure from any that had preceded it, the 2021 strategy, *From Harm to Hope: a 10-year drugs plan to cut crime and save lives,* promised to reduce the problems and harms associated with drugs through confronting illegal markets, reducing demand and by increasing access to 'world-class' treatment and recovery services. Using a WPR analytic (Bacchi and Goodwin 2016) and by producing a genealogy of government drug policy, this chapter sets out to show that any claims of a departure or radical policy shift are purely illusionary. A Foucault influenced WPR approach draws our attention to the productive nature of policies illuminating how the processes and practices of policy produce subjects, and how policy itself produces problems – problems that are represented as particular kinds of problems. The argument here is that many of the representations of 'drug problems' in the 2021 strategy are consistent with previous drug strategies and a policy of drug prohibition (and the harms produced by it) that dates back to 1961. Drug prohibition is a globalised system of drug control written into the domestic law of 150 signatory countries through a series of treaties and which mandates criminal sanctions for the production, supply, possession and use of a variety of psychoactive substances (Transform 2007). A solution-based policy intended to regulate, govern and limit the taken for granted harms associated with the 'problem' of substance use and people who use them. However, as Buxton *et al.* (2021) remind us, while the 1961 United Nations Single Convention on Narcotic Drugs is recognised as the key treaty underpinning the contemporary drug control system, efforts to control drugs have a much longer history dating back over a Century. The apparatus and technologies of modern drug control systems emerged

as early as 1875 with 'new problematisations' around the practices of 'self-intoxication' (Seddon 2016:400) and have been built upon, in response to historically situated problem representations, from the foundational principles established in the 1909 Shanghai agreement and 1912 Hague International Opium Convention, the first international drug control treaty (Buxton *et al.* 2021). Seddon for example notes that 'the concept of 'drugs' is not a scientific concept' but one derived from 'political or moral evaluation' (Seddon 2016:394). Seddon quotes the late historian Roy Porter by way of illustrating the deeply historicised nature of the notion of drugs and the assumed or taken for granted harms associated with them:

> If you'd talked about the 'drug problem' two hundred years ago, no one would have known what you meant. There was no notion then of 'drugs', in the sense of a small group of substances scientifically believed to be harmful because of addictive or personality destroying, the availability of which is restricted by law. The term 'drugs' as a shorthand for a bunch of assorted narcotics is in fact a twentieth-century coinage: if you'd mentioned 'drugs' to anyone in George III's time or in the Victorian era, they'd have thought you were referring to the remedies physicians prescribed and apothecaries made up (cited in Seddon 2016:394).

Both Seddon (2016) and Buxton *et al.* (2021) highlight the usefulness of producing a genealogy of drug control systems that combines social critique with an approach to historical analysis, enabling a consideration of the effects of contemporary drug policy through the lens of the past. What Foucault refers to as a history of the present:

> This process of addition and layering onto founding principles, norms and approaches has created an institutional path dependence in which history has conditioned and constrained contemporary actions (Buxton *et al.* (eds) 2021:17).

Buxton draws our attention to the expectation within the 1961 Single Convention that signatory countries 'should provide treatment, education, after-care, rehabilitation and social reintegration for drug addicts and users' (Buxton 2006:57). Buxton (2006) notes this as an acknowledgement of demand side concerns (concerns that remain a feature of current drug strategies) and a shift towards a detailed consideration of the causes of drug use.

### 5.2 A broken treatment system

*From Harm to Hope: a 10-year drugs plan to cut crime and save lives* is informed by a comprehensive two-part review of the drug treatment system, an acknowledgement that 'the treatment system is broken' (Black 2020) and that 'the old way of doing things isn't working' (HM Government UK Drug Strategy 2021:3). The review of drug treatment (Black 2020, 2021) was commissioned by the then Home Secretary, Sajid Javid in 2019 and claims to follow 'a traditional methodology of up-to-date analysis of the problems and then recommended policy solutions' (Black 2020:3). The methodology that Black describes here reflects a conventional view of public policy where 'policies are reactions to problems that sit outside the policy process waiting to be solved' (Bacchi 2018:5). By way of contrast, following a WPR approach (Bacchi 2009, Bacchi and Goodwin 2016):

> Governments do not react to problems that are assumed to be self-evident. Rather, they are seen to be involved in the creation or production of 'problems' as particular sorts of problems, with particular parameters, causes, effects and remedies (Bacchi 2018:5).

Black's (2020) review contained thirty-two recommendations (or remedies) including a significant 'invest to save' financial strategy. Yet like previous treatment reviews, it avoided any in-depth analysis of harms associated with the current legislative and regulatory frameworks and excluded from its scope any discussion of drug consumption spaces or diamorphine assisted treatment programmes (Transform 2021), choosing instead to focus on increasing capacity in a treatment system that it describes as broken and wanting (Finch 2021) and reinforcing taken for granted 'truths' about treatment, the 'problem' of drug use and the people who use them. A critical reading of the 2021 strategy and drug treatment review through a WPR and genealogical lens provides several entry points for the problematisation of problems including scrutinising the productive nature of policy and questioning if the review informs the

strategy or whether a history of drug strategies, and the problem representations that they contain, informs the review. In their review of the 2021 strategy, Winstock *et al.* (2021) suggest a case of history repeating itself when they point out that the 2021 Government strategy is 'strongly reminiscent' of *Tackling Drugs Together: A Strategy for England 1995 – 1998* with its promise to address supply and demand through law enforcement and prevent drug use and its harms through treatment. *Tackling Drugs Together: A Strategy for England 1995 – 1998* will be discussed further later in this section. However, it is worth noting here that the 1995 strategy, as MacGregor in MacGregor (ed) (2010) reminds us, set a template for drug policy and witnessed the emergence of what were to become familiar prescriptive texts and key strategic aims in future Government strategies:

> To take effective action by vigorous law enforcement, accessible treatment and a new emphasis on education and prevention to:
>
> - Increase the safety of communities from drug-related crime
> - Reduce the acceptability and availability of drugs to young people
> - Reduce the health risks and other damage related to drug misuse (MacGregor in McGregor (ed) 2010:2).

*Tackling Drugs Together: A Strategy for England 1995 – 1998* also saw the introduction of Drug (and Alcohol) Action Teams (DA(A)T) and a new commitment to health, local authority and police partnerships in tackling the 'problem' of drugs. Significantly, the newly formed collaborations gave rise to involvement with police enforcement and non-enforcement operations including education programmes and community safety partnerships and anti-drugs strategies providing greater opportunity to make the 'problem' of drugs publicly visible and justify restrictive measures in governing conduct. From this view of history, the 2021 drug strategy and its accompanying Combating Drugs Partnerships, represents less of a departure and more of a re-working of the key themes outlined in the 1995 strategy – themes which have been reproduced in every UK Government drug strategy published since.

### 5.3 Following Foucault: Rejecting the inevitable in a poststructural policy analysis

Foucault refers to the use of two analytical strategies or modes of analysis, archaeology and genealogy (Smart 1985) and which for Bacchi (2009) and Bacchi and Goodwin (2016) are central to a poststructural critical policy analysis. Whereas genealogy is concerned with the history of practices, 'the processes, procedures and apparatuses involved in the production of truth' (Bacchi and Goodwin 2016:46) archaeology draws attention to the power/knowledge relations that underpin contemporary practices (Bacchi and Goodwin 2016). For Bacchi and Goodwin (2016) while the initial task (question one) in a WPR approach to policy analysis is identifying problem representations, Foucauldian archaeology is concerned with highlighting the presuppositions and assumptions that make particular problem representations possible, exploring what needs to be in place for them to make sense (Bacchi and Goodwin 2016) and aligns closely with the second question in the WPR approach. Importantly, Bacchi and Goodwin (2016) remind us that the six questions and one step outlined in a WPR approach are intended to guide the process of analysis. The analytical crossover between various questions, steps and processes involved with a WPR approach does not require one to proceed in a sequential fashion.

Following Foucault, Bacchi 2023 notes that a genealogical approach avoids viewing history as a chronology of developments which give the impression of a sense of inevitability.

> A genealogical sensibility keeps a sharp eye open for the tensions and debates around crucial issues. We need to consider how we got 'here' from 'there'. Such a focus makes it possible for us to question the present, What Foucault (1990) refers to as a history of the present (Bacchi 2023).

For Bacchi the goal of genealogy (aligned to the third question in a WPR analytic) is to put into question any notion of problems being the 'inevitable production of natural evolution over time' destabilising the taken for granted effects of problem representations (Bacchi 2009:10).

Bacchi (2018) notes that central to the WPR approach to policy analysis is the focus on replacing 'problems' with 'problematisations'. Problematisations (problem representations) illuminate ways in which the concepts 'problem' and 'problems' operate historically and contemporaneously and produce insights into modes of governing and the production of 'objects and 'subjects'. For Bacchi (2009) the shift from problems to problematisations and the problem representations within them, distinguishes a WPR approach from more conventional forms of policy analysis. For Bacchi (2009) the goal of identifying problem representations is achieved through the identification of 'prescriptive texts':

> In a WPR approach, policies are 'prescriptive' texts since they tell us what to do. As a result, policies and their accompanying methods of implementation provide points of entry to the problematisations and problem representations that require scrutiny (Bacchi 2009:34).

In her review of the drug treatment system, Black claims to situate her analysis within a political economy and the financial impact of illicit drug markets:

> I took a market approach because the supply of drugs is driven by profit, and violence is often the result of competition for market share. Only by understanding the market and the drivers behind it can Government hope to disrupt it. The total cost to society of illicit drugs is around £20 billion per year, but only £600 million is spent on treatment and prevention (Black 2020:3).

The 'problem' identified here in Black's analysis is the illicit drug markets while the solutions proposed are increased access to drug treatment, recovery and prevention and disruption to illicit drug markets and supply chains. As previously noted, a WPR approach rejects the problem-solving nature of policy while arguing that problems are constituted and given meaning in policy. In this sense, Black's review fails to sufficiently probe or problematise the

taken for granted truths within the problem representations that she proceeds to analyse. Moreover, her market-based analysis fails to sufficiently consider the potential harmful consequences for PWUD from disruption to markets and drug supply chains (Carroll *et al.* 2020, Ray *et al.* 2023). WPR makes the case that among the multiple possibilities for constructing 'problems', governments play a privileged role in getting particular knowledge practices (discourses) understanding and meanings to 'stick'. Their version of problems (problem representations) are 'formed and constituted in legislation, reports and technologies used to govern' (Bacchi 2009:33). In this sense, problems take on meaning and lives of their own (Bacchi 2009). They exist within the 'true' impacting not only on the ways in which people are governed but on the way in which people govern themselves. Further examples of what Foucault (2010) refers to as 'statements' in the formation of discourse can be seen in the way in which problem representations make particular issues visible. While the governments assertion in the 2021 drug strategy that the old way of doing things isn't working, the old ways of representing the problems appears to be mainly just fine. The strategy pitches straight in with the all too familiar claim that:

> There are more than 300,000 heroin and crack cocaine addicts in England who, between them, are responsible for nearly half of all burglaries, robberies and other acquisitive crime. These serial offenders should be properly punished for the crimes they commit, crimes which cause misery in communities across the country (HM Government UK Drug Strategy 2021:3).

Foucauldian modes of analysis that have influenced the WPR approach are helpful here in unpicking the effects of drug policy. Whereas archelogy draws our attention to the embedded knowledges within discursive practices, genealogy illuminates and makes visible the struggles and processes by which truth and knowledge are historically produced and how they emerge at particular points in time. Kendall and Wickham have noted that in conducting Foucauldian archaeology:

> one finds out something about the visible in 'opening up' statements and something about the statement in 'opening up visibilities' (Kendall and Wickham 1999:25).

Kendal and Wickham draw on Foucault's 1997 analysis of the history of prison, *Discipline and Punish* to illustrate how:

> prison as a form of visibility (a visible thing) produces statements about criminality, while statements about criminality produce forms of visibility reinforce prison. Statements and visibilities mutually condition each other (Kendall and Wickham 1999:25).

In this sense, the 'statement' directly connecting people who use heroin and crack cocaine with half of all known burglaries, robberies and other forms of acquisitive crime, is a problem representation made visible in drug policy and constituted through Home Office research and criminal justice responses, reflecting Mol's 1999 assertion that:

> Realities are created by, rather than reflected in, social practices, including policy and research practices (cited in Bacchi and Goodwin 2016:6).

### 5.4 From problems to problematisations: Getting here from there

The 2010 and 2017 UK Drug Strategies reorientated the harmful effects associated with drugs and people who use them through representing the problem of harm as social harm; harm to communities, to the economy and to law and order:

> Approximately 400,000 benefit claimants, (around 8% of working age benefit claimants) in England are dependent on drugs or alcohol and generate benefit expenditure costs of approximately £1.6 billion per year (HM Government 2010:4).

Harm was directly attributable to levels of 'problematic drug use', a term which as Seddon (2010) notes, emerged with the arrival of the Drug Intervention Programme and the 2005 Drug

Act. The term problematic drug use represents the problem of drug use and the harm associated with it, not just as illicit drug use, but specifically, illicit heroin and crack cocaine use.

> Around 45% of acquisitive offences are committed by regular heroin/crack cocaine users. The criminal justice system provides a prime opportunity to tackle substance misuse and ensure the individual has access to the support they need to stop (HM Government 2017:12).

> As set out in the Modern Crime Prevention Strategy, Home Office research found that heroin/crack cocaine use could account for at least half of the rise in acquisitive crime in England and Wales to 1995 and between one quarter and one-third of the fall to 2012, as the cohort who started using in the late 1980s and early 1990s aged, received treatment, ceased using drugs or died (HM Government 2017:27).

These representations of the 'problem' of drug use (problem representations) align with discourses of financial burden referred to in Black's treatment review and the discursive practices (including scientific calculations) that not only constitute risk and harm to communities but make it visible through official reports and epidemiological data.

> In addition to overall prevalence, we will measure frequency (e.g., monthly) and type of drug use (e.g., opiates and crack) to provide an additional perspective on some of the most problematic drug use (HM Government 2017:6).

> We will provide a breakdown of what proportion of the most problematic drug users are accessing treatment and how long they have to wait in doing so, to ensure that we are reaching those who need support (HM Government 2017:6).

The key propositions of a WPR approach are that:

1) We are governed through problematisations
2) We need to study problematisations (through analysing the problem representations they contain) rather than problems
3) We need to problematise (interrogate the problematisations on offer through scrutinising the premises and effects of the problem representations they contain (Bacchi 2009 p. xxi).

The above policy statements (prescriptive texts) give up clear presuppositions and assumptions that not only does 'drug treatment work', but full (abstinence-based) recovery is the treatment option of choice, continuing to emerge in discursive practices and privileged historically in official Government policy documents.

> We are clear that reducing the harms caused by drugs needs to be part of a balanced approach. This means acting at the earliest opportunity to prevent people from starting to use drugs in the first place and prevent escalation to more harmful use, as well as providing evidence-based treatment options that can be tailored to individual need, to provide people with the best chance of recovery (HM Government 2017:6).

Through shifting the analytic focus from problem to problematisations, a better understanding of how problems are constituted in policy becomes possible. We begin to make sense of problem representations through a consideration of historical layering (archaeology). Mol (2002) reminds us that in this sense 'realities' and 'truths' are multiple, historically contingent and contested. Always partial or in a process of 'becoming' (Mol 1999). How we get here from there, is further illuminated through the additional analytic lens of Foucauldian genealogy where the aim of analysis is to emphasise the possibilities for challenging and destabilising taken for granted knowledge 'truths' and to consider how different representations of problems could be possible.

Bacchi and Goodwin remind us that for Foucault, a genealogical analysis produces a 'history of the present in which analysis sets out from a problem expressed in the terms of the present' (Bacchi and Goodwin 2016:46). Bacchi and Goodwin (2016) note that in this sense, genealogical analysis is not interested with a history of origins rather with tracing the process of decent and emergence. Smart (1985) makes a similar point, arguing that genealogy stands in opposition to the pursuit of a history of origins and to the idea of timeless and universal truths:

> Genealogy as the analysis of historical decent rejects the uninterrupted continuities and stable forms which have been a feature of traditional history in

> order to reveal the complexity, fragility and contingency surrounding historical events (Smart 1985:56).

Genealogically inspired questioning opens up a space for further problematisations of problem representations and aligns with the third step in a WPR approach.

### 5.5 A genealogy of UK drug policy: The struggle for regulation and governing practices

Between 1998 and 2010, the New Labour Governments of Tony Blair and Gordon Brown published no less than three Drug Strategies. The first, *Tackling Drugs to Build a Better Britain* 1998 was followed by an updated version in 2002 and a further strategy in 2008: *Drugs: Protecting families and Communities* 2008. The 1998 strategy and its 2002 update had their origins, as noted above, in the previous Conservative governments approach to illicit drug use which were set out in the White Paper, *Tackling Drugs Together: A Strategy for England 1995 – 1998.*

The White Paper, *Tackling Drug Together,* marked the beginning of performance management in the commissioning and delivery of drug treatment services. Measures introduced to evaluate the success of services and policies included; abstinence from drugs, reduction in drug 'misuse' and risk-taking behaviour; improvement in physical health and psychological wellbeing; improved social functioning; and a reduction in criminal activity. Key performance indicators were listed as:

- the percentage of injecting drug misusers who report using or sharing equipment in the previous four weeks;
- the number of drug misusers recorded on the RDMDBs (Regional Drug Misuse Database);
- the number of deaths attributable to the misuse of drugs (MacGregor 2006:404)

Familiar policy promises and familiar messages where statements and visibility coalesce to produce a rationale for action and a 'truth' for understanding problem representations:

> Illegal drugs are now more widely available than ever before and children are increasingly exposed to them. Drugs are a threat to health, a threat on the streets and a serious threat to communities because of drug-related crime.
>
> Our new vision is to create a healthy and confident society, increasingly free from the harm caused by the misuse of drugs.
>
> All drugs are harmful and enforcement against all illegal substances will continue. And we will focus on those that cause the greatest damage, including heroin and cocaine (HM Government 1998:1).

Like the 2021 drug strategy, the 1995 White Paper needs to be considered together with the background review that helped to inform it (MacGregor 2006). The Effectiveness Review Task Force was established in April 1994 to review the effectiveness of drug treatment services and was to report to Ministers in January 1996. The Effectiveness Review was published on 1st May 1996. It's main conclusion was that 'treatment works', producing a 'truth' that echoed through drug policy documents for years to come. Cost effectiveness studies emerged as an important part of establishing that 'truth' helped on by a public health discourse of health economics. The claim was made that treatment works and moreover, that it was cost-effective. Confidence in the statement was strong and it was supported by the science:

> For every £1 spent on treatment at least £9.50 is saved in crime and health costs. Treatment is seen as the way to break the link between drug misuse and crime (MacGregor 2009b:406)

The mantra treatment works remains largely unproblematised at this point within the problem representations that surround it. Steps four and five in a WPR approach begin to reveal 'silences' or subjugated knowledges within these problem representations, the political functions that treatment serves and the subjects that it produces.

The 1998 strategy *Tackling Drugs to Build a Better Britain* firmly established a drugs-crime nexus representing the 'drug problem' as one of crime and criminality and employing the

rhetoric of ‘tough on crime’ and ‘tough on the causes of crime’. As Duke points out, ‘American ideologies and practices such as coerced treatment, drug testing and drug courts gained acceptance within the drug policy community’ (Duke 2013:43) and with the emergence of Labour’s Drug Strategy centre piece, Drug Testing and Treatment Orders (DTTOs) along with prison based Counselling, Assessment, Referral, Advice and Throughcare (CARATS) the ground was prepared for the criminal justice system to become a key technology in an integrated system of treatment and control (Duke 2013). In 2002, the government published its *Updated Drug Strategy* further consolidating the strategic alliance of treatment and control. A key aim of the 2002 strategy was to ‘reduce the harm that drugs cause to society – communities, individuals and their families’ (MacGregor 2010:5). To this end, policy would focus its gaze on the most dangerous drugs and the most dangerous patterns of drug use. This was to be found in the then estimated 250,000 heroin and crack cocaine users in England and Wales. The ‘problematic drug user’. The 2002 update provided funding for the development of the Drug Intervention Programme (DIP) (Duke 2013) which, as noted earlier, was introduced under the 2005 Drugs Act (Seddon 2010) and which signalled further developments in the technologies for governing and regulating the conduct of PWUD.

> The aim of DIP was to get offenders out of crime and into treatment. It provided opportunities for drugs testing and treatment at every point of contact with the criminal justice system from arrest and bail through sentencing and imprisonment or community supervision (Duke 2013:43).

Through a genealogical lens of historically contingent ‘drugs problems’, it would appear that the principles of harm reduction had been re-worked and the public health vision proposed by Ashton and Seymore (2010) in the 1980s, a thing of the past, at least for now.

The 2008 drugs strategy *Drugs: Protecting families and Communities* extended further the role of the criminal justice system in both the treatment and regulation of PWUD. Drawing on

familiar conceptual logics that make not only the ‘problem’ of drug use and the people who use them visible, but ensure that the problem representation they contain are conceivable and understood:

> Drug misuse wastes lives, destroys families and damages communities. It costs taxpayers millions to deal with the health problems caused by drugs and to tackle the crimes such as burglary, car theft, mugging and robbery which are committed by some users to fund their habit. The drug trade is linked to serious organised crime, including prostitution and the trafficking of people and firearms. Drugs remain a serious and complex problem that we – along with all modern societies – must face (HM Government 2008:4).

Raising fear and public anxiety is a key feature and effect of drug policy and intersects with social production of stigma and other harms faced by PWUD. Politically, these techniques are an effective way of securing public support, defending and reproducing representations of the problem and justifying increased, often coercive, interventions:

> We want a society free of the problems caused by drugs. Our aim is that fewer and fewer people start using drugs; that those who do use drugs not only enter treatment, but complete it and re-establish their lives; and that communities are free of the drug related crime, anti-social behaviour and the fear these cause (HM Government 2008:4).

The 2008 strategy introduced notions of individual responsibility focusing on the problem of harms caused to children and communities through drug use and stating that ‘drug users have a responsibility to engage in treatment in return for help and support’ (HM Government 2008:5) Duke (2013), points out that within this emerging neoliberal agenda, new forms of coercive treatment where proposed through the government’s welfare-to-work system:

> We do not think it is right for the taxpayer to help sustain drug habits when individuals could be getting treatment to overcome the barriers to employment. In return for benefit payments, claimants will have a responsibility to move successfully through treatment and into employment (HM Government 2008:6).

Measuring successful treatment outcomes was a key focus of the 2008 strategy and built on the introduction a year earlier of the Treatment Outcome Profile (TOP). Something which the National Treatment Agency (NTA) prided itself on and ironically would bring both them and their claims that treatment works into question. However, in terms of measuring the 'quality' or 'success' of drug treatment interventions, epidemiology has limited value. TOP was introduced to drug treatment in 2007 and, according to the NTA provided service users, clinicians and commissioners with objective, measurable and comparable information on individual behaviour change that would improve practice at both an individual and strategic level. Commenting on the limitations of the TOP one drug treatment service provider noted that:

> Treatment effectiveness should be measured against whether the individual has achieved their goals. Asking someone to rate how they feel on a scale by giving you a score for how they feel right now, is so subjective. Within five minutes that score might have changed completely if someone says something to upset them (Jamie, AOD treatment professional).

Another treatment provider noted the potential absurdity of a metric that determines treatment 'success' on the basis of the numbers of people exiting treatment and not re-presenting within six months (a standard Public Health Outcomes Framework question):

> If you leave treatment and you don't return within six months but you end up dying, you are still regarded as a 'successful completion'. How in the world could that ever be right? Actually, the way things are recorded now, it's like how long does it take you to get triaged and then started on this treatment modality or that treatment modality and so on. Let's just cut to the chase, how long does it take for your need to be identified and for you to then get onto the evidence-based intervention? (Aidan, Consultant Psychiatrist AOD treatment professional).

However, while treatment outcome measures and similar client profiling scales fail to adequately describe the quality of drug treatment experience, they do capture individual and behavioural information essential for the governing of people conduct.

In his analysis of the problematisation of parental substance use, Flacks (2019, 2021) notes how the 2008 strategy places an emphasis on the damage caused to children's wellbeing through parental substance use. Parents are described as the 'single most important factor in a child's wellbeing' (Flacks 2021:114) while the 2008 strategy makes repeated reference to drug using parents and the harm done by parents to younger children (Flacks 2019:484). For Flacks, the focus on parental responsibilisation coincided with attempts by New Labour to place special emphasis on the neoliberal ideology of individualism and responsibility in health care and policy development.

## 5.6 Analysing the effects of drug policy

The purpose of a poststructural analysis, analysing problem representations through a WPR approach, is to offer an assessment of policy that, rather than evaluating and measuring policy outcomes, examines three 'overlapping kinds of effects: discursive effects, subjectification effects and lived effects (Bacchi 2009:69). Ritter summarises this difference when she notes that:

> By effects here we are not interested in charting whether particular policies achieve their stated aims (such as reducing harms) but in the accounts of (other) effects of policy. This includes interrogating how the problem a policy addresses emerges in the process, how the formulation of the problem has constitutive effects, how knowledge claims are similarly produced within the policy process, as well as how the subjects of drug policy, people who use drugs, are constructed within policy and hence governed (Ritter 2022:19).

When in 2010, David Cameron set out the Big Society agenda, the underlying propositions of neoliberalism, empowerment, freedom, responsibility and citizenship (Duke 2013) found some common ground with over a decade of drug policy problem representations. As noted above, WPR makes the case that among the many competing and contested possibilities for contrasting problems, governments play a privileged role in getting their understanding and meaning – their

problem representations to stick. Through the familiar claims of providing something different, the 2010 UK Government drug strategy, *Reducing Demand, Restricting Supply, Building Recovery: Supporting people to live a drug free life* wasted no time in distancing itself from previous Labour Government strategies by promising to provide an abstinence-based drugs strategy, benefit cuts for problem drug users, and compulsory residential drug treatment (Duke 2013:44) stating that:

> A fundamental difference between this strategy and those that have gone before is that instead of focusing primarily on reducing the harm caused by drug misuse, our approach will be to go much further and offer every support for people to choose recovery as an achievable way out of dependency (HM Government 2010:2)

Where previous government drug strategies have typically been informed by treatment reviews, the archaeology of the 2010 strategy can be found in the politically constructed notion of a 'broken Britain' and a series of reports by the right-wing policy think tank the Centre for Social Justice (CJS). Positioning itself in opposition to the 'harm reduction hegemony' and its ideological undercurrents that have underpinned ten-years off failed drug policy, the CSJ 2007 report, *Breakthrough Britain, Volume 4, Addictions: Towards Recovery*, re-sets the 'problem of drugs' by blaming methadone maintenance prescribing for perpetuating addiction and dependency while marginalising 'recovery' and rehabilitation treatment:

> Under the ten years of Labour's drug strategy, policy itself has become an intrinsic part of the problem. It has been a costly investment failure. The combination of centralised targets and a 'medical management' approach to treatment has further entrenched addiction, adding to intergenerational cycles of substance dependency which are particularly damaging children (CSJ 2007:10).

As noted in chapter two of this thesis, the reorientation of drug policy towards total recovery (abstinence-based) treatment, has had a profound effect on the treatment sector in the UK from around 2007, see for example Ashton (2007), McKeganey (2011). As Pautz and Heins (2016) have noted, the CSJ, established by former Secretary of State for Work and Pensions Iain

Duncan Smith in 2004, helped to shift the discourse about causes of poverty from money to poor schools, family, dependency, debt and addiction.

Research conducted by the Centre for Drug Misuse Research, University of Glasgow, UK, McKeganey *et al.* (2004) concluded that the majority of a sample of 1,007 PWUD prioritised abstinence as a goal when seeking treatment. This research illuminates the importance of 'testimony' and opens up an analytical topic for a WPR approach, that of discursive subjectification, how problem representations play out in people's lives through producing subject positions (Bacchi and Goodwin 2016).

> For the first time experiences and views of recovering addicts, their families and those working with – their counsellors, substance misuse workers, addiction psychiatrists, drug action team managers, voluntary sector providers and academics have been listened to in this report (CSJ 2007:3).

Lancaster *et al.* note that while greater 'consumer' participation in health policy can stand in opposition to the privileging of objective scientific knowledge within evidenced policy, the discursive practices constituted in power/knowledge relations produce tensions about the 'relative value of other ways of knowing' (Lancaster *et al.* 2017:61).

> If knowledge operates hierarchically, we begin to see that far from being a neutral concept, evidence-based policy is a powerful metaphor in shaping what forms of knowledge are considered closest to the 'truth' in decisions making processes (Lancaster et al:61).

In other words, knowledge operates within a hierarchy of credibility with alternative discourses (knowledges) being subjugated or quietly silenced. Following a WPR approach, analysis of discursive effects illuminates how the 'terms of reference' established in particular problem representations 'sets limits on what can be thought and said' while subjectification effects reveals how subjects 'are implicated in problem representations, how they are produced as specific kinds of subjects' (Bacchi and Goodwin 2016:23). For Bacchi and Goodwin (2016) a WPR analytic includes a consideration of how the discursive and subjectification effects of

problem representations translate into people's lives as lived effects. As Bacchi and Goodwin (2016) have noted, the interconnected effects of discursive practices can coalesce in what Foucault refers to dividing practices which separate people and groups from one another and can produce subjects as governable subjects divided within themselves. Note for example how discourses of recovery construct a notion of 'normal' which reproduce the binary opposites of addiction and free-will, independence, self-control, responsibility, productivity and autonomy (Moore *et al.* 2017). As previously noted, recovery focused treatment relies on a 'recovering addict' identity within which exists both the possibility to promote the 'normal' and the potential to reproduce the stigmatising and pathologising ideas about people who continue to use drugs (Fomiatti *et al.* 2017). In this sense, different ways of 'knowing drugs' for example those associated with beneficial or pleasurable aspects of drug use become subjugated knowledges that are inconsistent with the notion of normal within an abstinence focused recovery identity and a policy and public discourse of binary opposites between states of addiction and health and responsibility and irresponsibility. Lancaster *et al.* summarise how the discursive effects of policy play out in the lives of PWUD when they say that:

> Drug policy processes restrict[ed] possibilities for imagining the multiple ways in which 'consumers' (and their interests) might be understood. In a social and political environment where policies and practices already constitute people who use drugs as irrational and illegitimate political subjects we suggest that the very processes which purport to engage people who use drugs in making decisions about policies governing their own health may also be partially shaping these subjectivities (Lancaster *et al.* 2017:66).

The argument here is that how problems are represented effects how they impact unevenly on different people's lives. On the needs of PWID the 2010 strategy noted that:

> We will continue to examine the potential role of diamorphine prescribing for the small number who may benefit, and in light of this consider what steps could be taken, particularly to help reduce their re-offending (HM Government 2010:18).

Neatly combining the illusion of compassion while representing the problem of injecting drugs as offending, any 'examination of potential benefits' of prescribing injectable drugs would take place within the context of an abstinence-based drug strategy. Moreover, in its formative report three years earlier, the CSJ (2007) regarded heroin prescribing as outdated, unnecessary and ineffective against the modern drugs problems.

*Reducing Demand, Restricting Supply, Building Recovery: Supporting people to live a drug free life* was published in December 2010 by the Conservative / Liberal Democrat coalition Government confirming its intention to make clear that individuals are accountable for their actions:

> We will increase the responsibility of individuals to work with those who are there to support them to tackle and overcome their dependence (HM Government 2010:3).

Any longer-term benefits from maintenance prescribing established in the Rolleston clinics as part the British system of treating drug use dating back to 1926 were severely curtailed when the 2010 strategy announced that:

> For too many people currently on a substitute prescription, what should be the first step on a journey to recovery risks ending there. This must change. We will ensure that all those on a substitute prescription engage in recovery activities and build upon the 15,000 heroin and crack cocaine users who successfully leave treatment every year free of their drug(s) of dependence (HM Government 2010:18).
>
> We will create a recovery system that focuses not only on getting people into treatment and meeting process-driven targets, but getting them into full recovery and off drugs and alcohol for good. It is only through this permanent change that individuals will cease offending, stop harming themselves and their communities and successfully contribute to society (HM Government 2010:18).

Drawing on research findings such as those outlined above and the effects of discursive subjectification, the 2010 strategy continues:

> Our ultimate goal is to enable individuals to become free from their dependence; something we know is the aim of the vast majority of people entering treatment. Supporting people to live a drug-free life is at the heart of our recovery ambition (HM Government 2010:18).

As noted in chapter two, the operationalisation of this ambition was realised with the publication in March 2012 of the Inter-Ministerial Group on Drugs Report, *Putting Full Recovery First* outlining the Governments 'roadmap for building a new treatment system based on recovery' (Department of Health 2012:2). On 27th March 2012 the Health and Social Care Act received Royal Assent bringing in the most wide-ranging reforms to the NHS since it was founded in 1948 (Kingsfund 2022) and writing abstinence-based treatment into policy through the 2010 strategy and its 2012 roadmap. The 2012 Health and Social Act came into effect on the 1st April 2012 realising another ambition of the 2010 strategy, the abolition of the National Treatment Agency with many of its functions being subsumed by the newly created Public Health England (PHE). Moreover, responsibility for commissioning and implementing recovery orientated drug treatment services moved from the NHS to Local Authority Public Health commissioning teams. The 2010 coalition Government's strategy remained in place for seven years positioning the 'problem' of drugs within a politics of austerity and, as this research suggests, introduced a number of harm producing policies with deleterious effects for people who inject drugs.

Data from the ONS, cited in the Government's 2017 evaluation of the 2010 strategy, show a significant decrease in the number of drug related deaths between 2008 and 2012 since when deaths rose steeply and continued to reach record breaking levels year on year. ONS data on drug related deaths records the year the death was registered rather than the year it occurred. Delays in deaths being reported can often result in a lag of between twelve and eighteen months (ONS 2023) meaning that the actual increase in deaths is likely to correlate more directly with the introduction of the 2010 strategy. *An evaluation of the Government's Drug Strategy 2010*

also noted that 'new presentations to treatment for opiates in England fell sharply from 55,493 in 2009/10 to 45,491 in 2011/12 (HM Government 2017). Keen to deny the increase in drug related deaths as policy effect, a report from Public Health England *Understanding and preventing drug-related deaths* considered a number of factors that increase or protect against drug related deaths and concluded that:

> Analysis of the treatment population did not establish a direct relationship between the policy focus on recovery and [drug related deaths] but poor recovery-orientated practice could put people at risk. Drug-related deaths are not always sufficiently investigated, with a lack of routine testing for some drugs and the near-absence of testing for others (Public Health England 2016:15).

The 'problem' here is represented as a lack of access to testing and the 'risks' associated with using a combination of drugs rather than a focus on the lack of access to appropriate, meaningful and supportive treatment and access to a range of prescription options that could reduce the tendency to use combinations of drugs and therefore reduce harm.

In July 2017 the Conservative Government published a refreshed rather than new *Drug Strategy* and as Brown and Wincup (2020) have noted, it adopted a similar structure to the 2010 strategy with its content reflecting the key themes and problem representations of the previous strategy; reducing demand, restricting supply building recovery. Brown and Wincup (2020) remind us that the 2017 strategy also introduced (or re-introduced) the additional theme of global impact. Problem representations around global impact raise concerns about the changing nature of drugs, particularly the emerging threat of 'new' psychoactive drugs while affirming established risks of injecting drug use and HIV.

> Significant progress has been made in the global response to HIV, but we cannot afford to be complacent. We are deeply concerned that HIV transmission among people who inject drugs in low- and middle-income countries remains alarmingly high. Between 2011 and 2015 new HIV infections among people who inject drugs increased by a third, accounting for more than 40% of new infections in some countries (HM Government 2017:40).

Against this backdrop, as Brown and Wincup point out, drug use is presented as increasingly risky with 'those deemed to be most at risk repeatedly described as vulnerable' (Brown and Wincup 2020:3). Foucault's notion of discursive subjectivity is useful here in illuminating how the 'vulnerable subject' is produced in the strategy and the effects of that subject position on lived experience. Brown and Wincup (2020) draw our attention to the potential effects of being labelled (or not) as vulnerable and arguing that vulnerabilities, as they are problematised in drug policy, operates as a subtle disciplinary mechanisms to regulate the behaviours of those deemed to be vulnerable, ignoring the wider social, political and economic factors that work to produce vulnerabilities in the first place or adequately describe how an individual's vulnerable status positions them in relation to risk. Returning to the emergence of harm reduction policies in the mid-1980s discussed in chapter two, and the re-emergence of concerns around HIV and PWID, noted above, it is clear to see how problematisations of HIV and injecting drug use position those deemed to be vulnerable as being both at risk of infections and responsible for spreading infection through a variety of drug using and non-drug using social interactions.

Following Brown and Wincup (2020) Alexandrescu and Spicer (2022) have argued that 'classificatory logics' that position vulnerability and risk in relation to substance use, risk 'blurring the boundaries of care and control' and silencing the structural inequalities and material insecurities that drive the production of drug related harm. Alexandrescu and Spicer (2022) propose the concept of a stigma-vulnerability nexus and argue that notions of vulnerability are produced within the context of a political economy of drug related harm. They draw, for example, on Spicer's (2021) analysis of 'county lines', a term increasingly employed to describe a model of heroin and crack cocaine supply, and is heavily associated through particular problem representations, with notions of vulnerability. In this analysis of vulnerability, Spicer (2021) suggests that focusing our gaze only on the exploitation and

grooming of mainly young people as an explanation of their vulnerability closes off a consideration of vulnerability as being a product of structural failings.

## 5.7 Harm Producing Policies

Over the past thirteen years, UK drug policy has shifted from being characterised by the public health imperatives of infection control and health protection through various crime reduction initiatives to a recovery orientated treatment system characterised by neoliberal notions of resilience, individual responsibility and self-governing practices. However, these policy shifts have been propped up by the broader political imperatives of prohibition and regulation. Identifying and scrutinising the problem representations within drug policy over that time illuminates a shift away from the welfare state towards the criminal justice system as a primary site for dealing with social issues associated with drugs and people who use them – governing the conduct of conduct. Since 2010 the drift into neoliberal responsiblisation for states of health and wellbeing has seen an intensification of the exclusionary effects of drug policy and the normative effects of an abstinence-based recovery agenda. Exclusionary and stigmatising effects that arguably impact more negatively and deleteriously on PWID than on any other section of the drug using community. Record levels of drug related deaths among people who use heroin and cocaine, many of whom are PWID continue to be reported each year while inadequate provision of sterile injecting equipment, Slater *et al.* (2023) leave PWID at risk from blood borne viruses and other injecting related infections. On-going mortality and morbidity rates among PWID, (UK Health Security Agency 2023) confirm the level of risk associated with injecting drug use and reinforce problem representations and the discursive practices that promote abstinence within government policy choices.

Some of the most socially damaging and harmful effects of Cameron's 'Broken Britain Project' where experienced across public policy, including drug policy, as a result of the economic and

political choice of austerity measures that informed both the 2010 and 2017 UK Government strategies. As previously noted, a number of commentators have described an association between the levels of harm experienced by PWID, structural inequalities and material instability Rhodes (2002), Stevens (2011), Brown and Wincup (2020). Edwards for example (2017) has noted that drug fatalities have been significantly higher in areas where drug treatment budgets have been most severely curtailed. From this position it follows that one of the strongest indicators for a drug related death is being structurally and materially disadvantaged. In this sense, the effects of drug policy impact most negatively on those labelled as vulnerable and at risk through a hierarchy of discrimination and stigma and experienced within harm producing policies and practices. A social harm perspective is used here to complement the WPR approach by seeking to understand the aetiology of harm, how harm is produced and experienced differentially according to different subject positions.

The notion of harm producing policies is closely aligned to the concept of harmful societies, Pemberton (2016) and a social harm perspective, Hilliard *et al.* (2004) that takes into account harms that result from both intention and indifference. Following this line of analysis, a social harm perspective understands and allocates responsibility for harm not only with the individual actor but with those responsible for creating policy. The claims for example by Prime Minister David Cameron and then Chancellor George Osbourne that we are all in it together with a shared responsibility is meaningless and irrelevant to the PWID who lives are effected by experiences of harms produced in those policy choices.

**5.8 The social production of harm**

Following analysis guided by a WPR approach, the argument here is that representations of the ‘problem’ of drugs and the people who use them, are constructed within a determining context of prohibition and a legal framework that has characterised contemporary drug policy for over

five decades. A consideration of discursive, subjectification and lived effects of policy representations illuminates an historicised emphasis on representations of drug problems as particular kinds of problems and the subject positions available within them. Brown and Wincup (2020) for example remind us of how the discursive effects at play in adopting a particular problem representation – drug use as a crime problem, silence alternative discourses and knowledge practices which restrict the possibilities for harm reduction measures. Similarly, subject positions produced in discursive practices (the subjectification effects) produce and reproduce the stigmatising effects of binary opposites between states of addiction and health, vulnerable and resilient or a person who injects drugs and a person in recovery. This chapter highlights the importance of  a poststructural critical policy analysis and the usefulness of a WPR approach in exposing some of the hidden effects of particular problem representations. Following Foucault, Bacchi and Goodwin have noted that:

> People know what they do; they frequently know why they do what they do; but what they don't know is what what they do does (cited in Bacchi and Goodwin 2016:30).

Testimony from both drug treatment commissioners and drug treatment providers confirms a relational position between problem representations in policy, commissioning priorities and what is provided in drug treatment services. This relational position was clearly articulated when, in its 2012 report *Putting Full Recovery First* the government signalled an intention to re-orientate local treatment provision through changes to commissioning structures. Changes brought about through this re-orientation ushered in an abstinence-based drug treatment system and the introduction of a number of harm producing policies that have impacted particularly deleteriously on PWID. The commonality in UK drug policy is in its continual seeking out of governmental possibilities through normalising discursive practices. As the latest drug strategy, *From Harm to Hope: a 10-year drugs plan to cut crime and save lives*, extends its governmental

gaze deeper into the lives of individuals the possibilities for regulating and disciplining behaviour – governing the conduct of conduct, seem endless:

> The will be no implicit tolerance of so-called recreational drug users. We cannot allow the impression to be given that occasional drug use is acceptable. It isn't. So, there will be new penalties for drug users. Drugs cause crime and crime ruins innocent lives (HM Government 2021:4).

> This strategy is unashamedly clear on our position: Illegal drug use is wrong and unlawful possession of controlled drugs is a crime. We must take quick and decisive action to reduce the use of drugs recreationally. A new and bold approach – supported by an additional investment of £25 million – will be rolled out within three years to set the framework for the next decade and drive down rates of illegal drug use (HM Government 2021:48).

A stated ambition of the 2021 strategy, and central to this 'bold approach' to drive down rates of illegal drug use is, as noted earlier, a commitment to disrupt supply chains and frustrate the illegal markets, a potentially harm producing policy in itself, as evidence suggests, Carroll et at (2020), Ray *et al.* (2023) that interruptions to regular and trusted supplies results in the market gaps being filled by unfamiliar suppliers and substances of unknown quality or purity.

In April 2022 the Taliban prohibited the cultivation of opium poppies in Afghanistan triggering a major disruption to international opium supply chains. Afghanistan produces more than 80% of the worlds opium with heroin made from Afghan opium making up 95% of the market in Europe (Limaye, (2023). Commentators have warned about the repercussions of disruption as evidence mounts for synthetic opioids many times stronger than heroin and morphine fill the space in the illicit markets.

Evidence of potent synthetic opioids being linked to overdose deaths in England is already emerging, (Mahase 2023), yet the Governments first annual report, *From harm to hope: a 10-year drugs plan to cut crime and save lives 2022 – 23* fails to mention the risks associated with these harm producing polices, instead reporting that:

> In this first year of strategy, we have fully mobilised an end-to-end plan to tackle drug supply with a focus on the supply chains that cause most harm. As part of our £300 million supply 'attack' plan to make the UK a significantly harder place for organised crime groups (OCGs) and lower-level criminals to operate, we have fully established and stepped-up core programmes, including our flagship County Lines Programme and Project ADDER as well as work to tackle OCGs (HM Government 2023).

The problem with drug policy is that it produces problems rather than solutions. The representations of drug problems that it produces characterise risk, vulnerability and harm as particular kinds of problems, defining the very problems it sets out to resolve.

PWID experience daily the direct effects of harm producing policies such as those outlined in the 2021 strategy. Discursive practices conspire to produce stigmatising labels while hierarchies of evidence silence and subjugate alternative knowledges sources limiting the practices of harm reduction. Guise *et al.* for example assert that critiques of the evidence for overdose prevention centres are based in deep-seated presuppositions of 'truth' 'that privileges randomised controlled trials as the most rigorous form of evidence' (Guise *et al.* 2023:2) while pointing out that the implacability of such methodologies in gaining an understanding of the diverse contexts in which overdose prevention centres operate.

In the face of what could end up being one of most serious risks to the lives and wellbeing of PWID the treatment offer rigidly remains one of abstinence-based recovery with any hope of drug user informed harm reduction strategy being assigned to the past and the 'old way of doing things'. In the absence of an updated action plan to reduce drug related deaths, the Government's Office for Health Improvement and Disparities (OHID) published *Guidance for local areas on planning to deal with potent synthetic opioids* the only direct reference to PWID in the guidance was:

> Local areas and their services may need to provide safer drug use messages to people who use drugs, mainly to those who inject opioids and especially at time of heightened risk. This heightened risk could be because supplies are adulterated

> or because people are more likely to be vulnerable – for instance at Christmas (OHID 2023)

Policy representations of drug 'problems' continue to prioritise law enforcement and drug use reduction while stigmatising discursive practices fail to identify or respond to the needs of PWID, leaving them at a considerable distance from a policy aimed at addressing the production of drug related harm, and cut off from the potential harm reducing possibilities of drug treatment. When policy effects are considered from a WPR analytic and viewed through the lens of a social harm perspective, the 2021 drug strategy with its claim of ascendency 'from harm to hope' reveals a punitive and regressive harm producing policy shifting the balance of effect from hope to harm while the daily realities of many PWID are experienced as decent from hopelessness to harmfulness.

### 5.9 Conclusion

By producing a genealogy of drug policy, this chapter sets out an analysis from a 'problem expressed in the present' (Bacchi and Goodwin 2016). It asks the question what is the problem with drug policy and challenges claims that the latest UK drug strategy is fundamentally different to those that had preceded it. WPR analysis shows the key problem representations of crime, public order and moral contagion to be consistent over the past two decades and illustrates how these problems representations increase harm rather than reduce it. The chapter adopts a social harm perspective, asserting that harm is not only produced in policy through the policy representations that it contains but through discursive 'truths' have become embedded within popular narratives through the social constructions of 'otherness', fear, discrimination and stigma and how the dominant narratives of public response to drugs and people who use them amounts to the social production of harm and a justification for further punitive and authoritarian responses.

The next chapter considers in more depth the discursive and subjectification effects in producing the addicted subject while the following chapter builds on the lived effects considering how PWID are governed through professional discourse.

# Chapter Six

# Producing the Addicted Subject

> Knowledge linked to power, not only assumes the authority of 'the truth' but has the power to *make itself true*. All knowledge, once applied in the real world, has real effects, and in that sense at least, 'becomes true' (Hall 2013:33)

## 6.1 Introduction

This chapter considers how addiction as an object of knowledge is produced through particular problem representations and how, following Foucault's theory of discourse, discursive practices make certain subject positions available (Bacchi and Goodwin 2016). Using Bacchi and Bonham's (2016) poststructural interview analysis (PIA), this chapter draws on interview texts to illustrate how certain subject positions have been adopted by interviewees and how expert knowledge linked to power produces a 'truth' about alcohol and other drugs that has real world effects for people who use them. As outlined and discussed in previous chapters, the research employs the idea of 'plugging in' as a way of dealing with multiple texts. In a departure from thematic analysis, 'plugging in' shifts the focus of engagement from the 'concept' to the 'process'. Using Jackson and Mazzei's (2012) example of 'thinking with theory' enables the analysis to shift the gaze between literature, theoretical concepts and interview texts, focusing on process, how things are connected and how 'truth' is claimed in these connections.

## 6.2 Producing addiction

Addiction is increasingly used to explain a range of complex and often disparate patterns of human behaviour (Netherland 2012). Behaviours including, but not limited to, the use of alcohol and other drugs, gambling, excessive eating, sexual urges and desires and displays of an exceptional commitment to work (workaholics), behaviours that have all come under the

gaze of the ‘addiction specialist’ and have come to characterise discourses of addiction. Discourses of addiction can be understood within the productive relations of knowledge and disciplinary power (Keane 2002). A system of representation through which topics are defined and objects of knowledge produced (Hall 2013). This analysis of addiction discourse draws directly on Foucault’s conceptualisation of power/knowledge and his assertion that discourse was not conceived as language but as practices – discursive practices – an assemblage of ideas, practices and power relations that are concerned in the production of knowledge and meaning (Bacchi 2009, Bacchi and Goodwin 2016). It is in this sense that Fraser *et al.* (2014:26) note that:

> Addiction can be understood as a culturally and historically specific set of ideas and practices that shapes the varied problems and predicaments of alcohol and other drug use into a singular and somewhat abstract entity: a disorder of compulsion located in the individual.

The idea of an individual pathology is of particular significance in producing the addicted subject. As with many forms of deviant behaviour the idea of individual pathology has become central in the construction of an object of study and target for intervention. Medical and scientific discourses have emerged as the most influential and authoritative source of knowledge concerning addiction. A knowledge that privileges the language of science and medicine with holding a ‘truth’ about addiction and a promise of revealing the neurological actions of the ‘compulsive brain’, the psychological performances of the mind and the physiological functioning of the body. A scientific knowledge that produces addiction as an objectively verifiable disease or disorder (Fraser *et al.* 2014).

Problematising the notion of addiction as a disorder quickly draws us to a state of uncertainty over any biological basis of the disease and an absence of consensus within the scientific research community as what the term actually means. Szasz (1975) for example points to the

pharmaceutical industry's pursuit of non-addictive drugs for the treatment of pain relief on the premise that 'addiction' is a condition caused by drugs and that some drugs are more and others less 'addictive'. For Szasz, people do not use drugs habitually because the drugs are addictive, people use drugs habitually because they like the euphoric, calming or settling effects that they induce. From this position, using drugs is not a pathological behaviour, an irrational response to rational conditions, it can be a solution, beneficial and pleasurable, a rational response to often irrational conditions and circumstances. Szasz (1975) captures the antitheses here when he asserts that the search for a non-addictive drug that produces euphoric effects is absurd, just as it would be absurd to search for non-flammable petrol. Addiction is a socially, politically and economically constructed (and regulated) concept because people like to experience the use of drugs. However, as Leshner (1997) has argued, attributing addiction to the pharmacological properties of drugs assumes the problem of addiction to be based on whether or not cessation is followed by dramatic physical withdrawal symptoms – the more sever the symptoms are – the more dangerous the drug is. Leshner rejects this position arguing that it is not withdrawal symptoms but whether the drug produces compulsive drug seeking and taking behaviour that determines addiction.

As noted in chapter two, Seddon (2007) reminds us that the Misuse of Drugs Act 1971was introduced as a risk and harm-based classification system that ranked substances according to the level of risk and harm that they were likely to cause to the individual. Following Lesnhers' argument, the Misuse of Drugs Act is a classification system based on risk and harm to the individual but not necessarily the risk of addiction. For Szasz (1975) drug use is not intrinsically a health problem but a problem of morality. Classification systems, including the Misuse of Drugs Act, classify drugs on the basis of their relative risk and harm to social order and public health. The extent to which levels of harm and risk are ascribed to the use of drugs beyond their pharmacological properties includes the means by which the drugs are administered. Berridge

(1979) notes how moral as well as medical perceptions shaped the discourses of disease and addiction. For Berridge (1987, 1979) moral as well as medical discourses surrounding the advent of hypodermic morphine use towards the end of the nineteenth century were significant in the emergence of a disease concept of addiction and the increased certainty of acquiring it that injecting drugs brings. The following extracts illuminate some of the moral context of injecting drug use (IDU) as well as the subject positions opened up within the discourse when interviewees were asked if they think that people who inject drugs see themselves differently to people who use drugs but don't inject?

> I do yeah. I do. I feel ashamed. I was brought up properly. I was brought up right and I was the only one who ended up on drugs. After being clean for 4-years I ended up back on it and then it led to injecting again. I've got a good family who don't want know me no more (Miles, PWID).

> Well, it's like I remember when I first started injecting my friends who were still smoking, one of them turned round and said what are you injecting for? like he almost told me off because I was injecting. But it's funny actually because a few years later I found out that he was injecting and I called him a big hypocrite (laughs) but yeah, in a way he told me off like I was doing something wrong. Also, I've heard comments from other people who inject, when they see someone not injecting, they say they don't have an addiction because they're not injecting. They see it like, if you're smoking you don't even have an addiction so why are you bothering. I think that's how they see people differently (Keith, PWID).

While interviews with PWID mostly reflected decisions to inject based on rational choices, motivated by cost-effectiveness and an increased pleasure associated with the high, the impact of moral judgement is clear. Hammersley and Dalgarno (2012) have noted that many of the health and social problems associated with IDU result from criminalising and stigmatising policies. Chapter five refers to these as harm producing policies.

Drugs first came under legal control in 1868, not to reduce the harms they cause to people who used them, but as Grayling (2016) points out, to protect the business interests of pharmacists who wanted the exclusive right to dispense them. While doctors retained control over the addict

within an overall framework of Home Office authority, ‘the prominence of morals within the discourse of disease carries over into discourses of addiction as social problems and the social problem of addiction’ (Berridge 1979:85). From that point of convergence, doctors have been in an unhealthy governmental alliance with the state reinforcing ideas of moral as well as legal prohibition:

> The thought drugs becoming legal scares me. You never think you’re going to get addicted to a drug until it happens and then you’re stuffed. It’s hard to convey to someone what addiction is and how serious it is and how life changing and damaging it is. (Natalie AOD treatment professional)

### 6.3 The quest for scientific respectability

> Scientific advances over the past twenty years have shown that drug addiction is a chronic, relapsing disease that results from the prolonged effects of drugs on the brain. As with many other brain diseases, addiction has embedded behavioural and social-context aspects that are important parts of the disorder. (Leshner 1997:45).

Leshner (1997) goes on to assert that scientific research methods have revealed significant differences between brains of addicted and non-addicted individuals. Moreover, brain imaging techniques (National Institute on Drug Abuse (NADA) 2020) have determined common elements of addiction irrespective of the substances involved. The argument is that if addiction is a consequence of fundamental changes in brain function then effective treatment needs to concern itself with reversing or compensating for those changes.

The influence of neuroscience and the brain disease model of addiction has been particularly significant in public health policy and alcohol and other drug treatment systems. Advances in brain imaging techniques and the promise of new pharmacological treatments including anticraving medications are developed within the discursive practices of science and medicine that claim to be epistemologically value free and politically neutral. However, through the lens of critical analysis, problematising neuroscientific discourse exposes a number of fundamental

contradictions in its account of addiction (Fraser *et al.* 2014; Fraser 2015; Barnett *et al.* 2018). Changes in brain structure and function resulting from the use of intensely stimulating substances are attributed to neuroadaptation and neuroplasticity and are at odds with the brain disease model that characterises changes in the addicted brain as ‘remarkably enduring if not permanent’ extending beyond any period of engaged alcohol and other drug use (Fraser *et al.* 2014:52). In his article ‘Addiction is a Brain Disease’, Leshner (2001) argues that the process of addiction involves an individual crossing a threshold, the possibility of returning from, to a former state of occasional or controlled drug use, is extremely remote. The point at which an individual crosses that threshold, from non-addicted occasional user to brain diseased addict is however less clear in his description. Moreover, Leshner (2001) acknowledges that there is no clear biological or behavioural marker available to determine that transition or who is more likely to be subject to it.

Central to ‘addiction as a brain disease’ discourse is the conviction that the intense experiences associated with substance use ‘hijack’ the brains reward system artificially elevating sensations of pleasure. Continual use results in suppressing the pleasure effects associated with ‘normal’ activities, such as eating or sex, to a point where they become relatively insignificant (Vrecko 2010). While changes in brain structure and function have a totalising effect on addiction according to this argument – once an addict always an addict – neuroscience is not able to explain the process or identify the mechanisms responsible for these long-lasting changes that become hard-wired into the brains circuits (Leshner 2001). While claims of precedence for a brain disease basis of addiction exists as a majority view within the biomedical community the view has not achieved hegemonic status. Critics of the irreversible nature of the once addicted – always addicted logic of the brain disease addiction point to the often-cited example of ‘addicted’ military personnel returning from the conflict in Vietnam during the 1970s. The ‘fact’ that these ‘addicts’ could quit heroin use and remain free-from any intense drug seeking

and using behaviours destabilises the hijacked brain thesis (Robins 1993, Satel and Lilienfeld 2014).

In spite of the lack of any substantial evidence confirming a biological or neurological basis for addiction, popular conceptions of alcohol and other drug use are cast in the language of science (Cambell 2007) raising questions over the real-world effects of discursive practices and subject positions that they make available. Moreover, despite extensive neuroscientific research efforts, many of the clinical promises made by addiction as a brain disease discourse have not been realised (Barnett *et al.* 2018).

Critical theory has long challenged the value free and politically neutral claims of scientific knowledge, arguing that scientific accounts are no more objective or robust than other forms of knowledge but that knowledge produced in the discursive practices of natural sciences are more often dominant forms of knowledge. Knowledge is neither produced or operates in a political vacuum and as Fraser (2015:40) points out, the neuroscience of addiction has political origins'. Scientific research into addiction carried out at the National Institute on Drug Abuse (NIDA) during the 1970s was generously funded by the American government's Nixon administration at a time when illicit drug use was targeted as the primary cause of social disorder (Vrecko 2020, Fraser 2015). NIDA consolidated research on neuroscientific methods throughout the 1980s and 1990s supported by the Reagan and Bush administrations to produce scientific 'truths' about addiction and the brain reward system (Satel and Lilienfeld 2014:1). That the 'once an addict, always an addict mantra was resurrected and 'repackaged with a new neurocentric twist' recasting addiction as a chronic relapsing brain disorder. For Leshner:

> Recognising addiction as a chronic, relapsing brain disorder characterised by compulsive drug seeking and use can impact society's overall health and social policy strategies and help diminish the health and social costs associated with drug abuse and addiction (Leshner 1997p.45).

Addiction as a brain disease discourse was advanced relentlessly by NIDA and its then Director, Alan Leshner. NIDA is currently the world's largest funder of scientific research on health aspects of drug use and addiction underlining their influence in supporting and promoting particular research interests. Biographical details of the current Director, viewed on NIDA's website, clearly demonstrate an unwavering commitment to a brain disease discourse:

> Dr Volkow's work has been instrumental in demonstrating that drug addiction is a brain disorder. As a research psychiatrist, Dr Volkow pioneered the use of brain imaging to investigate how substance use affects brain functions. In particular, her studies have documented how changes in the dopamine system affect the functions of brain regions involved with reward and self-control in addiction https://nida.nih.gov/about-nida/directors-page/biography-dr-nora-volkow

Neurological constructions of addiction attempt to address the crisis of legitimacy and reaffirm a confidence in scientific respectability. As Satel and Lilienfeld note, the arrival of brain imaging introduces visual proof to the 'truth' that addiction is a brain disease. Neuroscientific discourse on addiction has an undeniable impact and a power to make itself true. A knowledge that operates through what Foucault refers to as practices and statements within models of alcohol and other drug treatment shaping subject positions and producing the addicted subject. Within the contested arena of knowledge production critical commentators have questioned both the political neutrality of neurological research science and the value-freedom its conceptions of addiction. Fraser (2015:42) for example asks:

> Can neuroscience really explain and solve addiction, or, again, are scientists inventing or overstating its uses and merits to shore up their relevance and bind us to them (and their technological solutions) even more tightly?

Fraser goes on to argue that for science to ever truly comprehend the nature or effects of the knowledge that it produces and the relationship between that knowledge and other knowledge's, it must 'escape the fantasy that science can proceed in isolation of politics and political processes' (Fraser 2015:43).

### 6.4 The truth about drugs and addiction

This chapter began with a quote from Stuart Hall, drawing our attention to the relationship between power and knowledge in the production of 'truth'. Scientific medical and popular discourses of addiction are sites engaged in struggles over competing knowledges in the production of 'truth' about drugs, 'what Foucault called the general politics of truth' (Keane 2002:8). Here, Foucault is referring to the 'rules' that separate true from false and the 'effects of power attached to the true' (Foucault 1980:132). As this analysis has illustrated, knowledge is neither produced or operates in a political vacuum. Competing knowledge discourses are produced within the power/knowledge relations of 'practices' (Bacchi and Goodwin 2016) and mobilised through 'technologies and strategies of application' (Hall 2013:33) through political institutions and subject to historical context:

> There is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time, power relations (Foucault 1977:27).

Moreover, it is through discourse practices that knowledge takes on meaning. 'Nothing which is meaningful exists outside of discourse' (Hall 2013:29). Foucault's emphasis on discourse as knowledge and meaning is not to deny that things can have a real material existence in the world (Hall 2013). His assertion is that things do not have meaning outside of the discursive practices that define them (Mills 2004).

People who use drugs, like people who drive cars, are not a homogenous group. They share a common practice but are motivated to engage in and sustain that practice for a wide variety of reasons. Conflating drug use into a single pathology located within the person as a brain disorder denies that person agency casting their relationship with drugs in terms of a deficiency and effectively silences any consideration of the possible benefits or pleasures associated with prolonged drug using practices (O'Malley and Valverde 2004; Moore 2008, Duncan et al;

Dennis 2007; Keane 2017). Deficit-based explanations of drug use, legitimised and validated through medical science, are popularised within dominant discursive practices reproduced and defended in relationships between policy, commissioning and delivery of alcohol and other drug treatment support. The position of these commentators is summarised in the following interview extract:

> People are much more comfortable talking about pathology, and the system is set up to reward those who frame it in terms of pathology. So, all the benefits accrue from casting yourself as somebody who's got a problem – who's like got a problem that's so extreme and irresolvable. Everything is invested in playing down the pleasure aspects and playing up the compulsion aspects and the kind of pathological aspects of it basically (Phil, PWID).

The effects of privileging particular knowledges while subjugating others are significant in the production of the addicted subject. Vrecko (2010) reminds us that addiction is characterised and explained in terms of neurobiological effects yet it is almost always diagnosed on the basis of subjective reporting of impairments to social functioning, loss of control, work and/or relationship problems. Dwyer and Fraser (2015, 2016) highlight the significance of screening and diagnostic tools in identifying and measuring addiction. In their detailed analysis and critique of two key diagnostic tools; the Diagnostic and Statistical Manual (DSM) and International Classification of Diseases (ICD), Dwyer and Fraser (2016) note that the two systems epitomise the disease of addiction through a detailed symptomatology of the condition. Moreover, as Dwyer and Fraser (2015) have noted, the scientific literature typifies the two systems as providing valid and reliable evidence of an objective and accurate diagnosis of addiction. However, while scientific literature support a realist legitimacy, critical analysis has problematised the concepts to reveal alternative 'truths'.

> Obviously you're going to get individuals who have been coerced into it [using drugs] and become hooked. But what's most apparent when you are involved with addiction services is to see how easy it is to get addicted. We all have a view of addiction and addicts but I think (pauses) I don't think a lot of people understand

> how easy it is – that it can get a grip on you – whoever you are (Laura, AOD treatment commissioner).

> So, a lot of drug use, the actual root cause, is trauma, childhood sexual exploitation, domestic violence – all that toxic background and history that leads to taking drugs. They might use initially as a way out – to make themselves feel better temporarily. But it's the force of addiction that quickly spirals into …. (pauses) I'm addicted now and I need to take more and more to feed it – to feel better and numb the pain (Richard, AOD treatment commissioner).

The above extracts reflect a realist account of addiction, as a taken-for-granted fact, an entity that pre-exists its arrival in discourse or its discovery by scientific research – disorder of compulsion located within the self that can 'get a grip on you – whoever you are' and has a 'force' that can quickly spiral out of control. PIA reveals here the effects of how discursive practices, privileging 'addiction' with 'status and 'authority', are involved in the processes, procedures and production of 'what is said as sayable within the true' (Bacchi and Bonham 2016:116).

In their (2015) critique of the logic of diagnostic tools, Dwyer and Fraser unmask the processes of 'symptom learning' and 'feedback effects'. Their argument is that diagnostic tools have a profound effect on producing the addicted subject. As noted above, diagnosis of addiction is based on a symptomatology questionnaire. Within the administration of these interactions, people diagnosed with the 'disease of addiction' are advised that 'it is the particular symptoms identified by their answers' including; loss of control, a craving or compulsion to use a substance regardless of harm caused, a sense of shame or guilt associated substance use and/or neglect of social obligations, 'that constitute their disease' (Dwyer and Fraser 2015:1194). When the 'addicted subject' encounters questions about these particular feelings and experiences, in subsequent assessments, they recognise them as symptoms of their disease and answer positively'. Once exposed to the processes and mechanisms of diagnostic tools, the

addicted subject acquires and assimilates the 'expectations, language and concepts at work in diagnosing the condition' (Dwyer and Fraser 2015:1194).

Hacking illuminates this further by reference to the notion of 'making up people'; the classification of particular 'human kinds' through a system that 'opens up or closes down possibilities for human action' (Hacking 2002:22) that only make sense within a particular conception of knowing (Hacking 1995:351). Social change creates 'new categories of people' (Hacking 2002:100) 'through the actions of people from below and through expert discourses from above (Dwyer and Fraser 2015:1191). Expert discourses open up spaces for new subject positions and for personhood and identity as people adapt and grow into their new categories.

> Reducing the identification of problematic substance use and addiction to one or two questions – very often of the form, 'have you used a substance?' – conflates any use of a substance with harm and / or addiction. This makes more people available for enrolment into the population of addicted and simultaneously enacts addiction as a simple unidimensional entity (Dwyer and Fraser 2016:230).

Screening and diagnostic tools involve normative practices that produce the addicted subject in clinical encounters, making certainty where there is none. Through the interactions of treatment institutions, the addicted subject becomes an object of interest, suspicion and regulation. Once used to regulate the conduct of others, discourses reveal their disciplinary and governmental capacity, a theme that is discussed further in the next chapter.

In his critique of drugs, Derrida (1993) reminds us that 'drugs' and 'drug addiction' are essentially normative concepts, derived of institutional evaluations or prescriptions.

> There are no drugs in 'nature'…. As with addiction, the concept of drugs supposes an instituted and an institutional definition: A history is required, and a culture, conventions, evaluations, norms, an entire network of intertwining discourses, a rhetoric, whether explicit or elliptical…. The concept of drugs is not a scientific concept, but is rather instituted on the basis of moral or political evaluations: it carries in itself both norm and prohibition, allowing no possibility of description or certification – it is a decree, a buzzword. Usually, the decree is of a prohibitive nature (Derrida 1993, cited in Fraser and Moore (eds) 2011:10).

What Derrida is pointing out here is that the category 'drugs' is intrinsically political in nature, historically and culturally contextualised, constituted in discourse and produced through particular problems representations. Just as Hall (2013) has asserted that nothing of meaning exists outside of discourse, could it also be possible that, following a poststructural discourse analysis, that there is no fixed reality or truth about drugs beyond that defined and disseminated by discourse and the production of knowledge. Are realist claims of so-called irrefutable biological 'facts' about drugs or the neurobiological basis of addiction themselves socially, historically and politically produced? From a constructionist perspective the truth about drugs is a form of ontological politics, created by rather than reflected in social practices (Mol 1999). In this sense, addiction is symbiotic with modern neoliberal society both reliant on a continued mutualism for meaning that once applied becomes real.

Berridge and Edwards (1987) document a history of the transformation of perceptions and meaning of opium use in the nineteenth century. A historical shift that witnessed opium use redefined by the medical profession as a disease requiring medical intervention. Doctors became 'the custodians of a problem which they had helped to define' (Berridge and Edwards 1987:76). In this sense, the reality of addiction is produced in practices; in clinical encounters, in health policy meetings and through diagnostic tools.

**6.5 Subjectification, subject positions and identity**

Subjects are produced through a process of 'subjectification' (Bacchi and Goodwin 2016:49). A process, which as Hall (2013) points out, operated at two levels. Firstly, discourse itself produces subjects. For example, the addicted subject who displays specific characteristics, attributes and behaviours defined within the discourse. Secondly, discourse produces a 'place' for the subject where the 'reader' or 'viewer' (professional and treatment service commissioner, observer and commentator), are also 'subjected to' the discourse and where the discourses

‘particular knowledge and meaning makes most sense’ (Hall 2013:40). The notion of the addicted subject only makes sense within the discourse that defines them. Processes of subjectification then, are not limited to the direct effects of ‘expert knowledge’ but extend to how expert knowledge within discourse is produced, reproduced and defended. How discursive practices (knowledges) become hegemonically hard-wired into the very fabric of society and everyday life (Rose 1999:264) and take on a taken for granted truth.

Poststructural theory is well suited to the challenges of questioning taken for granted truths as a real-world effect of constructed discourse. PIA, outlined in chapter four, offers a ‘methodology solidly grounded in Foucauldian influenced thinking’ (Bacchi and Bonham 2016:114). The starting point for PIA is noting *what* people say and considering how it is possible for these things to be said; what meanings need to be in place for things said to be intelligible and how certain things said come to be accepted as ‘truth’ (Bacchi and Bonham 2016:117). Importantly, subjects produced in discourse are, in a Foucauldian sense, ‘provisional’. Discourse, as noted earlier, is the product of the processes in power/knowledge relations and is fluid, relational and historically specific. Subjects therefore are always ‘in process’ with opportunities for modification through alternative subject positions (Bacchi and Bonham 2016:115). Baxter (2016) aligns this process with the construction of identity.

> Individuals are never outside cultural forces or discursive practices but always ‘subject’ to them. Their identities are governed by a range of ‘subject positions’ (‘way of being’), approved by their community or culture, and made available to them by means of the particular discourse operating within a given social context (Baxter 2016:37)

Importantly, identities, like the subject positions that make them available, are multiple and diverse, subject to change and sometimes contradictory. For example, subject positions available within addiction discourse include; the addicted subject, the ‘recovering addict’, the ‘person who injects drugs’ (PWID), the ‘treatment professional’ (addiction specialist),

‘treatment service commissioner’ and so on. Identity involves positioning yourself into one or more subject positions. For Bacchi and Bonham (2015, 2016) conceiving of subjects as ‘in process’ makes it possible to treat interviews ‘or more precisely interview transcripts – as texts’ (Bacchi and Bonham 2016:115). Bacchi and Goodwin use the language of ‘performativity’ to describe how in poststructural analysis, ‘a performative is that which brings about what it names’ (Bacchi and Goodwin 2016:30). The following interview extracts illustrate contrasting performative identities constituted within addiction discourse:

> It should be taken out of the law and classed as a medical condition. People take drugs because they are self-medicating – the drugs make them feel better. If the treatment centres want to find a use for themselves, perhaps they should try finding out why people are taking the stuff in the first place. The chances are it’s probably because of the home life or low self-esteem or whatever. If they could work on that instead of this obsession they’ve got about getting people into recover and then cutting them down and kicking them out the other end ‘cured’ (Giles, PWID).

> How are you helping the addict by taking them off the programme that they were doing really well on and sending them back out – you’re sending them back out to the lions – that’s what it feels like (Mark, PWID).

Phil describes how, for him, the subject positions available in drug treatment discourse can create tensions between personal and ‘treatment identities’ and how he has attempted to navigate treatment services in order to manage some of those tensions:

> I’ve always sought to minimise the amount of contact that I have with the treatment system because for me the benefits of the treatment system hinge upon the legitimate legal supply of injectable opioids. Everything else associated with treatment, for me, has just been a burden (Phil, PWID).

Phil is an articulate and well-informed individual and has previously worked in academic drug research. It is possible that Phil’s background and professional insights help him to navigate some of the harm producing effects of drug policy and of drug treatment, recognising as he does, how drug treatment policy has the capacity for producing problems rather that solutions:

> Rather than providing any solutions, it [drug treatment] gets in the way of me living my life the way I want to live it. Or the solutions it does provide are like (pauses) it takes me from a state of leading a criminal lifestyle essentially. I would be committing crimes on an on-going and regular basis. Because you're so vulnerable and so visible, it means that you're going to get arrested. Repeatedly arrested over and over again. So, what treatment does for me, and has done for me, is taken me from occupying that criminal status – from occupying a criminal identity (Phil PWID).

Phil isn't rejecting the notion of a constructed addicted subject position here, on the contrary, he appears to be engaging (understandably) as a 'treatment subject' in a way that minimises attention from the criminal legal system at the cost of reinforcing a medical model of drug use and drug treatment:

> By a stroke of a prescription pad and pen [treatment] transforms me into someone who is doing something legal – who's in receipt of treatment basically. So, it's the same act of injecting, the same effects, the same drugs. Everything about it is the same, but treatment moves me into a different category where I don't have to worry about being arrested (Phil, PWID).

Following Foucault, Bacchi and Goodwin (2016) point out that people's identities do not precede their performances but are constituted in and given meaning through them. While Foucault's conception of self/identity is consistent with his views on subjectivity, he is also interested in addressing, as Jeffrey and Troman (2011) have noted, the question 'being' and 'becoming'. For Foucault there is intention and calculation involved in peoples' adoption of identities. Foucault describes the power relations at play as both intentional and non-subjective (Bacchi and Goodwin (2016).

> People know what they do; they frequently know why they do what they do; but what they don't know is what what they do does (cited in Bacchi and Goodwin 2016:30).

One of the intentions of PIA is to highlight contingency and the political character of subjectivity, subject positions and identity. In doing so the analysis opens up space for contesting the taken-for-granted 'truths', assumptions and realities that are produced in and

through discursive practices. Questioning discourses and the subject positions that they make available is the basis of changing the reality – changing the 'truth' about drugs and addiction. The following interview extracts illustrate the potential for challenge and resistance to taken-for-granted 'truths' in drug treatment that are defended and reproduced through discursive practices. Reflecting on the extent to which discourse effects treatment interventions, Phil (PWID) comments that:

> I believe it does, I believe it makes an enormous difference. I believe it's all discourse to be honest. I mean everything that people do in drug treatment is informed by discourse. Discourse provides people with the rationale and justification for doing what it is that they do and why they're doing it (Phil PWID).

Phil appears to differentiate between certain 'expert' knowledges in a way that might resemble a Foucauldian understanding of discourse as knowledge. This appears to favour or privilege a particular kind of knowledge – a knowledge acquired through rigorous study and practical application. Knowledges (discourse) that have the capacity and ability to produce 'truths' and silence alternative accounts:

> Unlike most other fields of expertise, where you've got like a huge background of expertise, look at something like engineering, or being an electrician, you can't be a practitioner in those fields until you've mastered, until you've done your apprenticeship, until you've mastered the theory basically. There's a discourse in those fields that's rigorous because it needs to be. Without the rigour it doesn't work, the fucking bridge doesn't stay up. The fucking plane doesn't stay in the air (Phil PWID).

Phil's comments here are interesting in that they appear to be supportive 'expert' knowledge ie the scientific knowledges of civil and electrical engineering and, by way of reference to a perception of rigour, a support extended to other scientifically orientated disciplines including medical science. Yet, at the same time, offer a more critical perspective on discourses and open up a space for discussing the knowledge base for other subject positions. Discourses that, for

example inform the processes of drug treatment commissioning or models of drug treatment recovery:

> Well drug treatment isn't like that. Drug treatment (pauses) people believe that it's all based on opinion and that everyone's opinion is as valid as everyone else's. All that matters (pauses) because there's a lack of rigour, people aren't familiar with the body of literature that shows what works and what doesn't work, so they latch on to whatever the latest idea, the latest fucking half-witted idea is used to justify whatever it was that they were going to do anyway. I think that's the way discourse works in practice. It provides people with a kind of shopping list that they can pick and choose from while feeling free to disregard all the stuff that has a fairly secure knowledge base (Phil, PWID).

What is of particular interest here is that within addiction treatment discourse there are, as noted earlier, multiple variations on subject positions available, subject to situational and historical context. However, within problem representations constituted in contemporary drug policy, there are essentially two key subject positions available within the practices of addiction discourse. The addicted subject is likely to be criminalised or pathologised.

So far this thesis has set out some theoretical standpoints of realist and constructionist arguments on the notion of addiction. The analysis now considers some of social, structural and political mechanisms that have shaped and constructed addiction in neoliberal capitalist societies. Using PIA to drill down into the lived experience of people who use and inject drugs (PWID) and the effects that discursive practices have on their lives and on risks to their health and wellbeing.

Poststructural policy analysis directs our gaze towards the effects ('discursive', 'subjectification', 'lived') that are produced in and through particular problem representations (Bacchi and Goodwin 2016). Through an analysis of discursive effects of representations, we can reveal the 'terms of reference', the limitations on what can be thought, said and written about, and how subjects are produced as 'specific kinds of subjects' within particular problem representations (Bacchi and Goodwin 2016). In this sense, the notion of addiction becomes a

determining context (Scraton and Chadwick 1993) for the lived experience of the addicted subject.

### 6.6 Treatment as a determining context for addiction

In his paper on 'Scapegoating Military Addicts' Szasz writes:

> One of the most clear-cut regularities of social behaviour is the scapegoat principle: When things do not go well, people blame the difficulty on individuals or groups who are innocent but defenceless. Through this moral exchange, the scapegoat becomes the guilty, and the scapegoater innocent (cited in Rock (ed) 2006:247).

Throughout the 1960s and 1970s, illicit drug use, particularly in America, was targeted as the primary cause of social disorder. Economic instability, racial conflict and the publicly visible suffering played out during the conflict in Vietnam were far from the promise to America of a great society. While racial, cultural and political anxieties concerning drug use and people who use them certainly pre-date the 1960s (see for example Berridge and Edwards 1987, Redfield and Brodie 2002) the decade between the mid-1960s and the mid-1970s represents the emergence of a contemporary system of addiction treatment and the prominence of biological and neuroscientific research underpinning explanations of the effects, harms and social problems associated with the use of drugs (Vrecko 2010). Medico-legal discourses intersect with the emergence of disciplinary and governmental techniques 'capable of reconceiving' the identity of the addicted subject 'in the language of pathology' (Fraser and Moore 2011:7).

This assemblage of knowledge practices and techniques of scientific classification intersected with regulatory governmentality to culminate in a global war on drugs. A war that was, and continues to be waged disproportionately against the innocent, the scapegoated socially and politically constructed addicts who's inability to control excesses of consumption, rejection of a disciplined social order, came to represent a threat of moral contagion. The addicted subject

would become locked into a cycle of repressive, punitive and harm producing drug policy and practice. Aiden, a Consultant in Addiction Psychiatry, notes how taken-for-granted assumptions and 'truths' about PWUD are reproduced in drug treatment producing harmful effects and consequences:

> I can't think of any other group of patients who would have to go and pick up their medication every single day from the pharmacy. I mean look, lots of people are prescribed controlled drugs, the majority are not people with drug addiction issues. Nobody knows if they're using their drugs appropriately or if they're storing them safely, or if they're giving them to their next-door neighbour – do you know what I mean? – nobody knows but because they're not badged as a drug addict it's assumed that they are managing their drugs appropriately. For people with an addiction, it's assumed that they are not to be trusted. It's assumed that they will misuse their medication. So yeah, I think it does stem from culture and societal approach, it stems from the criminalisation of people, linking certain types of drug use to morality and criminality (Aiden Consultant Psychiatrist).

Here, Aiden identifies aspects of the drug treatment system that not only deny PWUD their individual agency but, through the construction, and potential rejection of an addicted subject position, produces the conditions for drug related harm:

> These are people with capacity right, these are people who are making decisions about their lives every single day. They probably know more about their medication than anyone, and we believe that we are keeping them safe by doing this. In fact, it might not be keeping them safe, it might be making it harder for them to stay in treatment or to access treatment in the first place (Aiden, Consultant Psychiatrist).

Analysis of the above texts provides an example of how 'things said put into question pervasive ways of thinking' (Bacchi and Bonham 2016:113) and the political consequences of discursive practices. Destabilising taken-for-granted assumptions about people who use drugs through an analysis of what makes it possible for certain things to be said opens up a space for considering any 'moral' basis to discourse and its effects on practice.

> There's a moral basis to it as well. There's a couple of things that I've always thought about the drug treatment system. One is that by and large people who work in the drug treatment system fall into one of two categories; people who

> really don't like the people who they're paid to work with and people (laughs) who are overly fond of the people they are paid to work with and have a like hero worship, you know, read one too many Hunter. S. Thomson books and so see drug addicts as some sort of heroic figures. They wouldn't want to live that life for themselves but they think it's cool that someone else does so they're quite happy to facilitate that (Phil PWID).

Phil's testimony here again aligns with the notion of a constructed addicted subject and reveals some of his own problematisations of the world in which he lives and the stigmatising effects of practices and how things said give meaning to the stigmatising effects of addiction discourses:

> So, you've got them, and they're a pain in the arse, but the other lot, the other people who think you're the scum of earth, they'll do what they have to because that's how they earn their money, but they would rather be working with anybody but you basically. It's funny, because I think that people who use treatment services, they know who those people are, they recognise those categories, they've been exposed to them their whole lives. You know when somebody thinks you're a piece of shit, the whole pile of fucking micro aggressions that you become really closely attuned to (Phil PWID).

Phil is opening up a consideration of the normative implications of discursive practices and the processes by which individuals 'become entangled in the discursive practices, and the mechanisms by which 'individuals' acknowledge themselves as particular types of subjects' (Bacchi and Bonham 2016:119):

> You know if treatment services are starting out from a place of mistrust, clients are not going to trust them. If they can't provide people with a service of any value or any meaningful (pauses) people just won't stay. They just won't. The 40mgs isn't enough to keep them engaged basically (Phil, PWID).

Issues of trust and morality are deeply embedded within discourses of addiction. Addiction is more than a concept; it is a practice that has real life effects and which are produced and reproduced in and through power/knowledge relationships. Chapter five discusses how discourses of addiction, constituted in problem representations are reproduced within a political

economy of policy, through commissioning and procurement processes, and delivered and monitored in drug treatment systems.

PIA reveals how informal practices are also important sites for the reproduction of discourses as illustrated in the following interview extract:

> I think you pick certain things up from your seniors. There’s like an inherent distrust , not just of people who use drugs, there’s a big overlap with mental health as well as other functional disorders. It’s not something that you’re taught. As a junior doctor you pick certain things up from watching your seniors – the seniors are weary of prescribing this or that drug therefore I should be because obviously it's a bit dangerous if I’m doing it. I think it’s informal the way you pick certain things up (Jody, Public Health Registrar).

Just as discourse can ‘rule in’ the terms of reference around a particular topic constructing meaning and governing acceptable conduct, so too, by definition, can it ‘rule out’, set limits, restrictions and subjugate alternative narratives, behaviour and conduct in relation to a particular topic or constructing knowledge about it (Hall 2013). It is through a consideration of these relations that an analysis of the effects of knowledge reveals the subject positions available within discursive practices and how subjects are constructed within particular problem representations (Bacchi and Goodwin 2016).

Neurological science now forwards an epistemological claim for overcoming the stigma associated with addiction by acknowledging the development of ‘neural vulnerability’. A vulnerability that, according to Szutoriz and Hurd (2022), develops before biological and psychosocial maturity and can be mediated through drugs or other epigenetic techniques. The argument here appears to be that if the basis of addiction is epigenetic, and therefore involuntary, the addicted subject cannot be responsible for its existence or the behaviour it brings. This again takes us back to a realist assertion that addiction exists prior to its social construction, moreover, it wrongly assumes that vulnerability de-responsibilises individuals or removes the stigma associated with the social and material conditions often experienced by the

addicted subject (Alexandrescu and Spicer 2022). The addicted subject is both a stigmatised and stigmatising identity (Lancaster *et al.* 2014). This is not to suggest that PWUD passively accept a stigmatising subject position. As discussed, following Foucault, people's identities do not precede their performances but are constituted and given meaning in and through them. In the analysis of interview texts, earlier in this chapter, observations were made of an assertion that the treatment system was organised in such a way as to ensure diminishing rewards for those who resist treatment and engage in becoming an addicted subject. As noted by Moore *et al.* (2017), this 'addicting' of PWUD constitutes addiction as a binary opposite to health and wellbeing. Foucault uses the term 'dividing practices' to describe the construction of opposition between groups and is useful here in relation to subject positions made available in discourses of addiction. Note for example the addicted subject who displays a disorder of compulsion and lacks any control over consumption in contrast to that of the recovering addict governed through a belief that self-control is freedom.

In reducing the concept of addiction to a disorder of compulsion, Reith (2004:286) notes how discourses of addiction turn the ideals of neoliberal consumerism on their head:

> transforming freedom into determinism and desire into need. Whereas the consumer chooses to act, addicts are forced to do so. Now, there are no choices only rules.

As Reith (2019) notes, neuroscience has shifted the discursive dial, locating addiction as a disorder of the brain and the psyche. A shift that has given increased justification to an assemblage of disciplinary mechanisms and techniques to govern the conduct of the addicted subject and the unpredictability of a disordered brain. As discussed further in the next chapter, conceptualisations of excessive and pathological consumption intersect with governmental discourses and the practices that make populations amenable to intervention and regulation (Miller and Rose 1990). Sedgwick (1993) has noted that with the proliferation of activities

defined as excessive and pathological, there is nothing that cannot be problematised as a form of addiction in contemporary society. Newly pathologised activities, those that neoliberal capitalism presents as the 'ultimate emblems of control and consumer choice' become assimilated in an epidemic of addiction (Sedgwick 1993:132).

The dual imperatives of resilience and responsibility have now established the conditions for an outcome-based public health commissioning framework for alcohol and other drug treatment services that prioritise the political priorities of abstinence-based recovery.

Recovery can be characterised by its 'prescriptive focus on identity transformation' (Fomiatti, Moore and Fraser 2017:181) through a series of normalising practices. May (2001) notes that the 'recovering addict is a source of social celebration' (May 2001:197) and is in itself an expression of identity politics. The recovering addict identity is a subject position made available within discourses of addiction within which exists the potential to reproduce the stigmatising and pathologising ideas about people who continue to use drugs (Formiatti, Moore and Fraser 2017). In adopting the identity of a recovering addict, the person first has to acknowledge the subject position 'addict' and an addiction discourse that reproduces pathology, criminality and stigma assembled around the making of the addicted subject.

**6.7 Conclusion**

The aim of PIA is not to engage participants in discovering their 'true' experiences or perspectives, but rather to 'reveal how their experiences and perspectives are produced through prevailing discourses' (Cooke *et al.* 2020:5) how discourse and discursive practices set limits, 'rule-in and 'rule-out' the terms of reference (Hall 2013) around particular topics, meaning and understanding, through which people know and speak about their worlds. The argument here in poststructural thinking is not to deny that 'addiction' is  experienced as 'real' effect, but that

just as addiction discourse emerged within a particular historical, social and political context, so to have the effects of addiction and the real-world experiences of risk, stigma and harm.

Poststructural policy and interview analysis asserts that subject positions are always provisional, that identities are 'becoming' rather than fixed. From this position it might appear imminently logical for the person who uses drugs to simply resist adopting the addicted subject identity. However, as illustrated throughout this chapter, the addicted subject is produced in problem representations and within the discursive practices that operate within the institutions of contemporary neoliberal society. A political economy that encourages and depends on consumption of commodities and a public health system that promotes individual resilience and a belief in individual responsibility.

In their analysis of early years educational experience, Cooke *et al.* (2020) using PIA, observed a discursive tension between investment – outcomes priorities and children's rights. The analysis in this research aligns with this position, with the polarising and dominant priorities of investment – outcomes, situating PWID as commodities in a transactional relationship. When PWID reach out to services with the intention of reducing risk and harm they reach into the broader institutions of discipline and regulation where the discourses of addiction are produced, defended and reproduced. Where the stigmatising effects of harm producing policies and practices are inescapable within a treatment system that is a determining context for discourses of addiction.

# Chapter Seven

# Governing People Who Inject Drugs Through Professional Discourses

## 7.1 Introduction

Imagine a threat to society so wide reaching that it undermined national security through immigration crimes, people trafficking and modern slavery, put at risk the public health and the welfare of children and young people through communicable diseases, neglect and sexual exploitation. A threat that de-stabilised the economy, drove up violent crime and increased the burden on benefits and the welfare system, a threat that was responsible for half of all thefts, burglaries and robberies. Imagine a threat that caused over 3,000 preventable deaths every year, disproportionately increased demands on the health service and cost society and the tax payer in England alone, close to £22 billion a year. Imagine that threat was represented as the problem of illegal drug use, a problem not attributed to the failings of legal frameworks for the control and regulation of substances, but as a problem of 'misuse'. A problem of self-control, self-discipline, deviant and disordered compulsion located within the individual and explained in terms of pathology and rule breaking. A disorder that anyone could be at risk of acquiring simply by being repeatably exposed to illegal substances.

In its 2021 ten-year plan and subsequent 2022 White Paper, *Swift, Certain, Tough: New consequences for drugs possession*, the Government and then Home Secretary, narrate the 'horrifying' consequences of drug use and the 'devastating' impact that unrestricted access to illicit drugs have on families and communities and confirm their intentions to use drug treatment as a mechanism for governing the conduct of PWUD. The 2021 UK Government Strategy and ten-year plan announced a cash increase of £148 million to cut crime and protect people from the harms caused by illegal drugs. Eighty million pounds of this new investment

will go into drug treatment and recovery services increasing the volume of treatment and recovery provision by 20% through 'a phased expansion of treatment capacity with at least 54,500 new high quality treatment places' (HM Government UK Drug Strategy 2021:9). These newly acquired 'high quality' treatment places will include 21,000 targeted at opiate and crack cocaine users. Seven thousand five hundred places will be targeted at people who are sleeping rough or who are at immediate risk of sleeping rough and there is an ambition to provide a treatment place for every offender with an 'addiction'. While PWID make up a significant proportion of potential treatment populations targeted, there are no specific services for PWID suggested in the plan. Overdose prevention centres have been ruled out on the basis of lack of evidence (Holland et al. 2022a, Holland et al. 2022b) while heroin assisted treatment programmes have been decommissioned due to concerns over cost effectiveness (Poulter *et al.* 2023). Instead, an assumption that more 'treatment' will provide a solution through tighter restrictions, regulation and governing practices. Fraser *et al.* have summarised the logic of a restrictive response to illicit drugs in light of the risk and harms that they present:

> Potent substances are understood to cause harmful psychological or, more recently, neurobiological states and, in turn, problematic, often criminal – certainly destructive – behaviour. It follows that we must act to reduce the availability of drugs, our desire for them and their negative effects wherever we can. We must turn to science to help us understand drugs and addiction objectively and to lead the way in responding to the profound social problems of addictions (Fraser *et al.* 2014:1).

Earlier analysis in this thesis illustrates how unpacking the ambition of policy, i.e., what the policy proposes to change, working backwards from those proposals for change, reveals what is wrong with the policy and what the problem is represented to be (Bacchi 2009, Bacchi and Goodwin 2016). It could be argued that the careful and skilfully crafted narration, the policy representation, becomes part of the 'problem' of drug use rather than part of the solution. The last chapter argued that the addicted subject is constructed through problem representations and

discourse, through the power/knowledge relations of practices and through the process of subjectification to become a subject of treatment. This chapter now considers how drug treatment has emerged as a mechanism of government, as part of a regulatory system associated with modern neoliberal society, as an assemblage of a medico-legal legislation, disciplinary and self-regulating practices. Bacchi and Goodwin (2016) assert that it is through these regulatory and disciplinary practices that societal norms are produced – normative practices that encourage the production of governable subjects who engage in self-surveillance and self-regulation.

While the medical provision of morphine or heroin was established under what became known as the British System for the treatment of addiction (MacGregor and Ettorre 1987, Spear 2002, Seddon 2007) in the mid 1920s, it was not until the 1970s that the current system of drug treatment adopted new approaches due to public health gaining influence within a psychiatric model of drug treatment (Berridge 2013). For Berridge (2013) the new public health model moved closer to medicine with medical treatments becoming synonymous with public health interventions. New public health discourse with its focus on prevention, the inclusion of social as well as environmental factors in its understanding of health problems, embodied both psychopharmacology and the science of epidemiology seeking to 'avoid blaming the victim' for states of ill health (Ashton and Seymore 1996:21). Health was determined by social and environmental factors as well as individual biology. However, the extent to which the new public health, with its emphasis on epidemiology has avoided responsibilising individuals for their health status within a framework of resilience and self-care is contestable when subject to critical analysis (Berridge 2013).

### 7.2 Public health discourse and epidemiology: Governing by numbers

The second review of drug treatment Chaired by Sir Russell Brain, a neurologist and former president of the Royal College of Physicians, published its report in 1965 (Berridge 2013). The

report recommended curtailing the prescribing of morphine and heroin from General Practitioners and the establishment of specialist treatment centres (Drug Dependency Units DDUs) under the leadership and supervision of Consultant Psychiatrists. As Berridge (2013) has noted, the influence of public health discourse was of particular relevance in this shift in the balance of expertise – addiction had the potential for social contagion.

Following the publication of the 1965 Brain Report, notification to a central authority became a requirement for anyone seeking treatment for an addiction. Unlike other public health notification systems, for example infectious diseases, which were notified to health departments, the central authority for the notification of 'addicts' was the Home Office. This confirmed a medico-penal alliance that has been retained in policy to the current day (Stevens and Zampini 2018). Newly established DDUs became sites of a new governmentality, 'an alliance between older and newer forms of public health and psychiatric concepts' (Berridge 2013:193) institutions not just concerned with treating the individual 'addict' but with governing the conduct of those individuals and with controlling the spread of 'addiction' into the wider community. Epidemiology, as Peterson and Lupton have noted, becomes a highly significant element of the new public health approaches:

> [It] performs sociocultural and political functions – such as constructing and perpetuating both material and symbolic distinctions between social groups – in ways that are rarely recognised from within public health. Epidemiological knowledge is taken up by contemporary public health practitioners and presented to members of the lay public via health education and health promotion as a set of objective and given 'truths' (Peterson and Lupton 1996:59).

The turn to epidemiology became a key influence in drug policy and response throughout the 1980s as methods of capture/recapture were employed to estimate the size of the population of PWID (Ruiz, *et al.* 2015). Governing by numbers was the latest governmental technique in the kaleidoscope of public health risk surveillance (Peterson and Lupton 1996). The introduction

of evidence-based drug treatment collapsed multiple and complex problems into easy to calculate treatment outcomes (Moore and Fraser 2013) while the incorporation of surveillance techniques and risk stratification models into harm reduction practices (discourses) constituted a biopolitics of drug use and PWID within a broader framework of policy responses associated with the prevention of transmission of HIV infection. Walmsley (2012) for example notes how the discursive practices of harm reduction focused not just on reducing harm to the individual who was using drugs but on reducing the level of risk and harm associated with the drug using population. Within this context the expert gaze was directed towards identifying and understanding the risk of infection between PWID while the science of public health epidemiology and risk surveillance monitoring would predict patterns of risk behaviour that are liable to produce and increase risk. Central to the emergence of new surveillance techniques were the notions of 'high risk' groups and 'high risk' activity such as needle and syringe sharing and other drug injecting practices and an examination of the socio-economic, cultural and political spaces between PWID and their link with the wider population (O'Malley 1999). As Walmsley (2012) has argued, the productive relations of knowledge and disciplinary power gave rise to discursive practices for governing the conduct of PWID.

### 7.3 Biopolitics – extending the gaze of health care into the lives of PWID

As noted in Chapter three, Foucault (1991) describes governmentality as an assemblage of institutions, procedures, reflections and calculations that form a system of population management. A way of thinking or mentality (Miller and Rose 1990) that allows complex forms of power to be exercised by social authorities in the management of populations and the regulation of conduct. Following Foucault, Bacchi and Goodwin (2016) note that this form of government constitutes a 'biopower with populations as its target, political economy as its major form of knowledge and apparatuses of security as its essential technical instrument' and

are characteristic of contemporary democracies in 'which the security, reproduction, productivity, and stability of the population are concerns of the state' (Bacchi and Goodwin 2016:41). As Gastaldo (1997) notes, Foucault refers to biopower as the power over life. Biological processes associated with economic and social issues. Gastaldo notes for example that while 'social policy is a visible strategy' for managing the health and wellbeing of a population, 'invisible power techniques' which extend the gaze of health care into private lives, conspire to collect information on individuals and populations 'to establish what is normal and pathological' (Gastaldo 1997:116). Moreover, Gastaldo (1997) notes that Foucault spoke of how biopolitics, through a process of anatomo-politics, focused on the body as a 'machine' seeking to maximise 'usefulness', human capacity and capabilities as ways to integrate the body into social and economic life. Foucault (1991) asserts that the history of governmentality, a collaboration of biopolitics 'which has dominated political power since the eighteenth century' (Lupton 1995:9) 'was without question an indispensable element in the development of capitalism' (Foucault 1990:140) the integration of human labour into the machinery of production and the transition to a politics of population economics. As Foucault notes:

> The development of the great instruments of the state, as *institutions* of power, ensured the maintenance of production relations, the rudiments of anatomo and bio-politics, created in the eighteenth century as *techniques* of power present at every level of the social body and utilised by very diverse institutions (the family and the army, schools and the police, individual medicine and the administration of collective bodies) operated in the sphere of economic processes, their development, and their forces working to sustain them. They also acted as factors of segregation and social hierarchisation, exerting their influence on the respective forces of both these movements, guaranteeing relations of domination and the effects of hegemony (Foucault 1990:141).

The role of professionals and professional discourse has, as Cohen (1985) points out, been central in the process of 'labelling' and the creation of new categories of deviance. Through the mechanisms of classification, 'professional discourse has a critical part to play in determining the boundaries of the category  and then ruling on who belongs in it' (Cohen 1985:196).

For Lupton (1995) the notion of governmentality has a particular relevance for a theory of biopolitics – the mechanisms, regulatory controls and interventions employed to manage populations and discipline individuals:

> As the concept of governmentality incorporates as analysis of both the coercive and the non-coercive strategies which the state and other institutions urge on individuals for the sake of their own interests, it provides a means of understanding the social and political role of public health and health promotional discourses and practices (Lupton 1995:9).

Importantly, following Foucault, governmental power is not located within the state as an overarching repressive force. Foucault's analysis of power, as has been observed elsewhere, conceives power as productive and flowing from multiple sources in social life. In keeping with Bacchi and Bonham's PIA (2016) the question asked of governmentality should be, as McKinlay and Pezet have posed:

> How are claims to govern made? How did these claims gain coherence and legitimacy? How do these claims reflect – and make – intellectual and practical authority? How are the intellectual, moral and administrative connections between abstract programmes of government and mundane life made and sustained? What are the effects of these systems of governing on ourselves and others? (McKinlay and Pezet 2017:27).

Governmentality and poststructural policy analysis are conceptually close and share ontological and epistemological assumptions. Both perspectives share a conception of power as productive and relational, emphasise the centrality of knowledges (discourses) in governing practices and both conceive of subjects as being constituted in practices (Bacchi and Goodwin 2016). In this sense PWID, through the processes of subjectification discussed in the previous chapter, become objects of knowledge and suitable subjects for treatment. Considering the imperatives of biopolitics, Jöhncke (2009) cites Foucault's 1963 and 1975 discussions of the clinic and the prison as highly relevant to an analysis of drug treatment institutions as sites for the

construction, exploration and regulation of treatable bodies. As Cohen (1985) reminds us, the ability to classify is one of the purest forms of professional power.

### 7.4 Treatmentality and governing PWID

> Drug treatment has an importance and status that far outweighs what it actually produces in terms of cures or the improvement of drug users' situations (Jöhncke 2009:14).

Jöhncke (2009) coined the phrase 'treatmentality' to describe the cultural value and governing function of drug treatment. Jöhncke (2009) notes how drug treatment discourses often centres on a clinical choice between a limited range of treatment options; opiate substitution treatment (OST) with either methadone or buprenorphine, almost always consumed orally, but rarely extend to any consideration of whether drug treatment can actually make matters worse through its harm producing policies and practices. Testimony from PWID confirms the presence of punitive responses and harm producing policies with several reporting negative consequences to disclosing infrequent sporadic or one-off instances of injecting drug use. The following interview extracts consider some reflection on posing the question 'do you think drug treatment services can ever make things worse for PWID?'

> Yes I do. So, at the moment I see my drugs worker here at this GP practice – I'm in shared care (a collaborative arrangement between a specialist drug treatment provider and GP practice where people assessed as being 'relatively stable' will have their drug treatment managed by the GP practice with the support of drugs worker and overseen by the specialist treatment service). It's really good for me because I live close and the chemist where I pick up my script is only around the corner. It's taken ages to get back into shared care though because last time I mentioned to my drugs worker that I had used heroin occasionally and that I had injected. Well, that was it. A couple of days later I got a letter from the clinic to say that I was being transferred back to the main clinic in town and would be on daily supervised (consuming any prescribed medication on-site under the observed supervision of a pharmacist) from a chemist in town. Apparently that was the policy and it can't be changed. I was having to get a bus into town every day to pick up. After a couple of weeks, I just sacked it off. But then I was having to buy methadone and gear and before long I was injecting more and more. Things got pretty bad before I ended up going back to treatment and then finally getting back here (Mark, PWID).

In this extract of testimony, the governmental practices of treatment discourse are clearly visible with the application of sanctions for transgressing ‘policy’ while re-engaging with the shared care practice required a demonstration of subjectivity – a ‘suitable’ and ‘compliant’ case for treatment. The notion of becoming a subject of treatment is further identifiable in the following two contrasting testimonies from PWID:

> Well, it is true that services use prescribing and supervised consumption as a punitive thing – as a disciplinary function that shouldn’t be there at all. So, yeah I agree treatment could make things worse but you can see the reason or some of the reasons why they might want to do that. I don’t think it’s right that they use medication as a way to get people to comply to certain behaviour, but in certain circumstances it would be easy to understand why they did it. I guess it’s the only threat that they have, or feel that they have in their repertoire. I don’t condone it. Obviously it would be better it they could persuade people, but some people don’t want to be persuaded. It’s a tough one, I’m totally against using prescribing as a weapon but you can see why they do it. Sometimes it’s the only way that they’re going to see some of their clients – by making them come into the clinic to pick up a script (Donna, PWID).

> Yeah, people have often asked if I can point to any benefits from drug treatment. Other than the provision of drugs, I’ve never been able to point to any benefit that it provides. I have been able to point to things, certainly from my point of view, where treatment has made things worse. There have definitely been times when changes in the treatment system has made things worse for me and other PWID. Like when, as a PWID, you don’t fit with the new treatment model so they either try to stop you injecting or bump you out of treatment (Phil PWID).

These extracts invite us to consider not only the discursive practices in relation to governing PWID, but also to consider the broader political implications of treatmentality (Jöhncke 2009) and which forms of treatment deserve to be labelled as ‘proper treatment’. For (Jöhncke 2009) ‘proper treatment’ is viewed both politically and morally as that which is orientated towards abstinence while treatment orientated towards PWID through the discursive practices of harm reduction is generally more concerned with reducing the risks associated with injecting practices and PWID. Holt and Treloar for example have noted that while harm reduction advocates distance themselves from the moralistic position of prohibitionist drug policies they

do 'share with anti-drugs campaigners an almost overwhelming focus on the risks and harms associated with substance use' (Holt and Treloar 2008:349).

As previously observed, following Foucault, discourses are understood as 'socially produced forms of knowledge that set limits upon what it is possible to write or speak about a given social object or practice' (Bacchi and Goodwin 2016:35). For Jöhncke:

> A pivotal point in this argument is that the idea and practice of treatment govern what it is possible for all of us to think and say about drug use, so those also governed are treatment staff, policy makers, researchers, journalists and the general public. Treatment is such a brilliant idea and such and attractive promise that we can no longer imagine the world without it – regardless of what it actually does and the (good and bad) consequences it has in reals people's lives (Jöhncke 2009:15).

The consequences that treatment produces, the harms reduced or harms produced, is central to the question of governmentality and regulating the conduct of PWID. Positioning 'treatment' in drug policy in a way that it becomes viewed, not only as a solution to the 'drug problem', but an inevitable and restrictive response to the 'drug problem' through the discourse of 'treatmentality', becomes part of the assemblage of governmental practices targeted at PWID. Professionals exercise power through discursive practices while simultaneously being subject to the restrictions inherent within the hegemonic views and expected outcomes of drug treatment.

One drug treatment professional reflected the inevitability of treatment when they commented that:

> I can't imagine there ever not being a need for this kind of service because human nature is that we are pleasure seekers so I don't think people are ever going to stop seeking substances of some sort (Jamie, AOD treatment professional).

The introduction of a possible pleasure seeking dynamic into the narrative opens up an analytic opportunity to consider some important motivating factors for individuals engaging in drug use

and subsequent drug treatment. Moreover, it reveals further the techniques within an assemblage of governing practices. Access to opiate substitution treatment (OST) programmes is reserved for people with ‘problematic’ substance use, ‘dependency’ or a ‘diagnosed addiction’ as described in the previous chapter. Treatment is transformative in that it confirms all of the negative effects of drug use through reinforcing the notion of addiction. In their analysis of methadone maintenance treatment, valentine and Fraser note that the meaning given to drug use in treatment discourse is fairly limited:

> Pleasurable drug use is sanctioned only as a retrospective or historical experience. Using drugs (mainly heroin) may have been pleasurable once, but it must be problematic now, because recreational use is not a reason to enter treatment. Methadone itself, while holding almost all the same properties as heroin, is not prescribed for pleasure, but for stasis: avoiding withdrawal, obviating the need for heroin (valentine and Fraser 2008:414).

valentine and Fraser (2008) note that while policy makers and treatment practitioners are clearly aware of the pleasurable effects of heroin and other substances, pleasure is suppressed, subjugated or absented in policy and discursive practices. Moore (2008) argues that the absenting of pleasure from treatment discourses can best be understood within the context of prohibition and governmental controls. Bull (2008) notes how the daily application of drug treatment reinforces practices techniques of ‘surveillance, regulation, examination, standardisation and normalising discipline’. Moreover, Moore (2008) suggests that public health policies and funding tend to favour approaches that emphasise the harmful effects of substance use, a trend that is evident in a critical analysis of contemporary drug policy up to and including the UK governments 2022 10-year plan.

### 7.5 Subjugated knowledges: Absenting pleasure and governing practices

Like valentine and Frasers 2008 research, interview testimony from this study reflected several drug treatment providers acknowledging pleasure as a motivating factor for people using drugs,

while PWID cited the highly intense and pleasurable experience associated with injecting drugs as their main reason for choosing that particular method of administration. Most spoke of the effects from OST (methadone or buprenorphine) as fairly mundane or boring, limiting their reference to any positive factors to the stability derived from treatment. Only a limited number of interviewees, those who were receiving prescriptions for injectable methadone, could draw any parallels with the experience of injecting other opioids.

> Injecting? Yeah, pure pleasure when you're doing it, well it feels like that at the time. When I do it all my anxiety just goes. I get that relaxed feeling like you've had a drink but you're in control and that's what appeals to me (Julie, PWID).

> The benefits of injecting are like the intensity of the effect – it's more euphoric. Injecting gives you a heightened euphoric effect that you don't get using any other way basically. That's why people do it and that's why they struggle to stop doing it. It's also more cost-effective but I think the economic factors are less important than the pleasure aspects. It's pleasure that's really at the centre of it (Phil, PWID).

In their 2008 study, valentine and Fraser quote from an interview with a medic who also works in drug policy:

> It's the one thing that, to my knowledge very rarely enters into the patient-doctor discourse, is the issue of prescribing for pleasure […] morally, doctors have got a problem prescribing for pleasure […] And likewise, patients would never say, "yeah, look, I am on eighty [milligrams], I'm not using, (whispers) but I'd really like to get a bit more stoned, can I have an extra twenty milligrams?" (Cited in valentine and Fraser 2008:414).

This study revealed a similar moral dilemma in the testimony from one prescribing doctor:

> I think there's a couple of factors at play in viewing potential treatments as pleasurable. Generally, you know the saying "you need to learn how to take your medicine", it's built into our history and our culture that actually medicine is not going to be nice – it shouldn't be pleasurable. It should be uncomfortable, you know, being ill is not a nice place to be and treatments are going to bring with them risks and all the rest of it. Having a drug problem is seen as some sort of moral failing, a moral issue that is linked with incredibly emotive language which is not used to describe other health conditions. I think that's why addiction is so interesting in many respects because why should treatment be unpleasant? It's

> about moral judgements – societal and political pressure (Aiden, Consultant Psychiatrist).

As noted at the beginning of this chapter, problematising policy representations can reveal how drugs and people who use them are positioned within a political and moral context. That moral and political context was powerfully illustrated when, in 2022 the now UK Prime Minister commented that:

> Drugs are horrific. There is nothing recreational about them. I have never taken them and will be incredibly tough on anyone who does (Rishi Sunak Conservative Party Leadership Hustings, Darlington 2022).

A clear indication that whatever the future of drugs policy and drug treatment was in the UK it certainly wasn't going to be pleasurable.

Testimony from this research confirms multiple reasons for people engaging in drug use. However, failure to acknowledge pleasure as a motivating factor contributes to the idea that those who continue using are irrational and lacking in self-control. Drug treatment orientated towards abstinence-base recovery can be characterised by its 'prescriptive focus on identity transformation via participation in 'normal' relationships and responsibilities' (Fomiatti, Moore and Fraser 2017:181) that reject the primacy of 'addicted' behaviour. Emphasising the 'non-addicted normal' reproduces a 'series of binary opposites between addiction and free will, independence, self-control, responsibility, productivity and autonomy' (Moore, Pienaar, Dilkes-Frayne and Fraser 2017:155). Fomiatti *et al.* (2017) adopt the notion of interpellation to describe how discourses of treatment produce the 'recovering addict identity' within which exists the potential to reproduce stigmatising and pathologising ideas about people who continue to use drugs. Like Jöhncke (2009) who has argued that 'proper treatment' is orientated towards abstinence, Fomiatti *et al.* (2017) point out that recovery-based treatment, the dominant treatment discourse in the UK since 2010, has emphasised a normative commitment to

abstinence confirming in professional discourse a persistence of a binary opposite between addiction and health. Fomiatti *et al.* (2017) describe how abstinence-based recovery discourse effectively forecloses treatment choices informed by and appealing to a more diverse treatment population including PWID:

> If recovery-focused treatment currently relies on a 'recovering addict identity' in which the drug using subject is poorly placed to articulate agency and which eclipses the political, economic and social challenges of life outside the treatment setting, what are the alternatives? (Fomiatti, Moore and Fraser 2017:181).

Feelings of exclusion and alienation were prominent across interview accounts in this study from both PWID and professionals providing treatment services:

> Why would you go to an abstinence-based recovery service if you didn't want to stop using? You just wouldn't would you. Honestly, I think the bottom line is that some people might not want to stop. Treatment shouldn't be just about getting people to stop using (Jamie, AOD treatment professional).

> I think you need to separate the provision of drugs from the provision of treatment. Let people just buy their opiates from the chemist over the counter (laughs) I know it's not going to happen any time soon, but then if people want or need treatment, they get it on a voluntary basis. They're going to treatment for something other than just the supply of drugs. They're going for some kind of therapeutic engagement basically – and I do think that there would be a demand for that but it would probably be a different population you know. It would be a population that wants what you provide rather than a population of people who are like having it [treatment] imposed on them whether they want it or not (Phil, PWID).

> There are so many people who might benefit from treatment but are not engaging with the service. In part I think that's because what we are offering isn't what people want or they think it isn't going to work for them. If you you're an injecting drug user and you know what the treatment offer is – that you're going to come in and be started on 30mls of daily supervised oral methadone – perhaps it's just that we're not offering people what they want. The treatment service that I worked at in London had an injectable clinic and through that were able to very successfully engage a cohort of people who traditionally didn't engage in generic OST treatment. If you offer people a broader range of treatments – offer people what they want – what might actually work for them – I suppose you're going to increase the numbers of people who access the service (Joe, AOD treatment professional).

The choice limiting nature of drug treatment again brings into question the mechanisms by which expert knowledge – (professional discourses) conspire to regulate and position PWID in relation to drug treatment services characterised by neoliberal notions of resilience, individual responsibility and self-governing practices.

A prominent theme discussed by public health treatment commissioners in this study was that of 'managing expectations'. In the context of more varied treatment options, managing expectations was variously used by commissioners citing a lack of evidence-base and cost as a justification for excluding the seemingly preferable option of providing diamorphine (heroin) prescriptions for PWID. As one public health treatment commissioner noted:

> I was dealing with a question from the media about local attitudes to heroin assisted treatment programmes and you've got be aware of the of the politics of that and the clinical intervention – is it a real option? My service are looking at injectable buprenorphine as a treatment option which is something we haven't done in area in recent years. We have a legacy of innovative prescribing shall we say from some of our doctors in this area historically. This isn't going back to those days – this is a relatively new treatment approach that staff are really excited to be able to offer as they know it works for some people (George, AOD treatment commissioner).

The legacy of innovative prescribing mentioned here refers to the work of a local Consultant Physiatrist Dr John Marks who ran heroin prescribing clinics in line with the previously described British system of drug treatment. Seddon (2020) provides account of Marks' work and beneficial effects that heroin prescribing had for PWID and for the local communities. Marks' clinic in Widnes has been operating as a 'Rolleston Clinic' (Seddon 2020) for several years prescribing opiates, including injectable heroin, on a maintenance basis. Seddon notes how Marks juxtaposed:

> The nearby town of Bootle had adopted a different approach which emphasised withdrawal and detox, rather than maintenance. Given this 'natural experiment' Marks decided to make some comparisons between Widnes and Bootle and, somewhat to his surprise, found that Widnes had strikingly lower prevalence and mortality rates and that patients at the Widnes Clinic were healthier and less likely

> to be criminally active than their Bootle counterparts (Marks 1991 cited in Seddon 2020:3).

Seddon (2020) goes on to note how Marks and the Rolleston type prescribing clinics became increasingly out of step with the political ideology of the day and with the discursive practices dominating addiction psychiatry. Heroin and cocaine prescriptions, sometimes in a smokable preparation, being given out by a health service doctor became an increasing embarrassment for the Thatcher government while the dominant professional discourses of the London-based psychiatric hospitals, instrumental in producing new clinical prescribing guidelines in 1984, effectively brought an end to Marks' work and the British System of Rolleston Clinics by ushering in a treatment system based predominantly of prescribing oral methadone (Seddon 2020). This new treatment system, outline in the Guidelines on Clinical Management (Department of Health 1991) further illuminates the governmentality inherent in drug treatment and the capacity of professional discourses for governing the conduct PWID:

> Prescribing a substitute drug where appropriate can be a useful tool in helping to change the behaviour of some drug misusers either towards abstinence or towards intermediate goals such as a reduction in injecting or sharing of injecting equipment. If opioid drugs are prescribed, liquid oral preparations (eg Methadone Mixture 1mg / 1ml) are preferable, to avoid the risks associated with injecting crushed tablets or melted suppositories for example, and to reduce the potential for sale on the black market (Department of Health Scottish Office Home and Health Department Welsh Office 1991:20).

Following Bacchi and Bonham's (2016) PIA line of enquiry on 'things said' it is clear that the testimony provided by the public health commissioner above has not only been influenced by historical discourse, but also has the capacity to influence present and future discursive practices. One of the aims of this research is to consider how problematisations (problem representations) in policy set limits (through narrative and meaning) on the direction of public health commissioning and the construction of discourse and practices that limit treatment options, manages and regulates the lives of PWID.

To be clear, the buprenorphine prolonged-release injection (Buvidal) is not a treatment offer specifically for PWID, or for that matter, a medication designed for those seeking to experience any sense of pleasure from their treatment. It is administered by a health care worker as a subcutaneous (under the skin) injection. The contents of the injection form a deposit or 'depot' of buprenorphine which is slowly absorbed into the body over a specific time (usually 1-week or 1-month) depending on the dose administered. According to the National Institute for Health and Care Excellence (NICE) buprenorphine prolonged-release injection:

> May be an option where there is risk of diversion of opioid substitution medicines or concerns about the safety of medicines stored at home. It may also be an option for people who have difficulties adhering to daily supervised opioid substitution medication. Buprenorphine prolonged-release injection may have a place in treating opioid dependence in people in custodial settings, where the risk of diversion and the time needed for supervised consumption currently leads to challenges in supplying supervised medicines safely (National Institute for Health and Care Excellence 2019:2)

The pharmacological properties of Buvidal make it a particularly suitable technology in the regulation and governing practices of drug treatment. Moreover, because Buvidal is a partial opioid antagonist (meaning that the medication blocks the effects of heroin and other opioids) once the 'treatment' is administered, the recipient will not be able to experience the effects of heroin, should they change their mind about this treatment, for the duration of the dose. This can result in the person turning to non-opioid drug use such as cocaine, including crack cocaine or amphetamine, to overcome antagonist effects, potentially increasing rather than reducing the risk associated drug use.

Parker, Aldridge and Measham (1998) have argued that the imperatives of public health reinforce a disassociation with any notion of intoxicated pleasure in part through its historical positioning of alcohol and other drugs as harmful and dangerous (Holt and Treloar 2008). Holt and Treloar (2008) have noted that positioning certain drugs as harmful and dangerous can have

the unintended consequence of making those drugs appear more attractive and intensify the pleasure derived from using them. Moreover, reducing pleasure effects solely to the pharmacological properties of the substance neglects any consideration of the pleasures derived from the way in drugs are used, 'the activities associated with their use' (Holt and Treloar 2008) and the context or 'set and setting' (Zinberg 1984) in which they are experienced and understood. Through the productive power/knowledge relations of discourse, risk is no longer associated with illicit drug use alone but with pleasure more generally (Netherland 2012) as the disciplinary practices of governmentality seek to regulate behaviour:

> The careful regulation of pleasure to encourage consumption but avoid becoming 'addicted' or 'sick' becomes a powerful tool in promoting self-governance. Individuals, with the help of public health messaging, medicine and cultural representations are encouraged to police themselves and control their appetites in order to preserve their own and the public's health (Netherland 2012:xv).

Following Foucault, the problematisation of pleasure and risk discourses in relation to health, and public health in particular, illuminates the binary opposites of addiction and health and pleasure and freedom. Representing addiction within professional discourses as encompassing the notion of pleasure as a binary opposite shifts addiction discourse in a way that reinforces a neoliberal public health ideal of healthism and wellbeing (Netherland 2012).

> In its attempt to transform pleasures, public health always run the risk of introducing new and unanticipated elements that may run counter to goals of health enhancement. In part, this is because it has not been able to theorise the place of pleasure in health and well-being (Coveney and Bunton 2003:174).

Pleasure becomes a subjugated knowledge with the discursive practices of addiction professionals. Where it is mentioned at all, it is in relation to legally sanctioned drugs such as alcohol within a narrative of social or sensible drinking rather than in relation to it being motivating factor for engaging with drug use more generally. As O'Malley and Valverde (2004)

have noted, notions of harm reduction discourse adopts a 'neoliberal twist' where PWUD are regarded as consumers, capable of making rational choices in a consumerist world:

> Risks appear as probabilistic events triggered by the failure of the user to take necessary avoiding steps. The governmental presentation of risk information is presented as no more than a service provided to enable individuals to chart their own chosen course through the probabilistic course of health, pleasure and social risks presented by drug use (O'Malley 2018:204).

Holt and Treloar note that without acknowledging pleasure seeking as a motivating factor for drug use public health and harm reduction messaging assumes that:

> Rationale users of drugs perform a simple calculus and limit or stop their use once they have been informed of drug risks (Holt and Treloar 2008:349).

**7.6 We've told you it's risky so don't fucking do it.**

Designating the label 'at risk' confirms the status of an individual or social group as powerless, marginalised and vulnerable. The label is often applied to individuals and groups including, but not limited to, people with mental ill health, homeless people, commercial sex workers and PWID (Lupton (2013).

Lupton has noted how:

> The 'at risk' label tends either to position members of these social groups as particularly vulnerable, passive, powerless or weak, or as particularly dangerous to themselves or others. In both cases, special attention is directed to these social groups, positioning them in a network of surveillance, monitoring and intervention (Lupton 2013:156).

As previously observed, harm reduction responses to HIV situated PWID as being simultaneously at risk of acquiring and transmitting infection while subjecting individuals to a network of public health monitoring and surveillance. Lupton (2013) refers to 'constellations of risk' or 'risk assemblages' which are configured using data derived from these surveillance

technologies and managed through various professional practices. Lupton has argued that from this perspective:

> Risk may be understood as a governmental strategy of regulatory power by which populations and individuals are monitored and managed through the goals of neoliberalism. Risk is governed via a heterogeneous network of interactive actors, institutions, knowledges and practices (Lupton 2013:116).

Notions of risk, it's avoidance, reduction and management have become key justifications in the discursive practices that impose restrictions on PWID through a rationale of normalising harm reduction policies.

Realist accounts of risk, for example Beck (1986) situate the emergence of risk language as a consequence of scientific and industrial development. Risk is something that is real and requires individuals to successfully navigate around it. In contrast, Rose (1999), refers to a process of 'risk thinking' that materialised in the nineteenth century and like Lupton, sees risk as a governmental strategy. Risk thinking 'brought the future into the present and made it more calculable' (Rose 1999:246).

Risk identification, calculation, management and reduction, are conceptualised within the principles of harm reduction, and described by both treatment commissioners and treatment providers in this study as service priorities. A number of service commissioners referred to 'safety' as being an overarching priority:

> The first priority is to keep somebody alive, keep them well, enable them to have the best life they can, keep their families together, keep their children safe. Then you follow up the hierarchy of needs basically. How far up that hierarchy you get depends on a number of things, but if you can start getting them to self-fulfilment, self-reliance, then that's great. Your first priority though is keeping somebody alive and well, keeping their families safe and not affected by the drug use (Peter, AOD treatment commissioner).

> Keeping people safe. In general, harm reduction – reducing the risks to self and others. It should be individualised, some people might want to stop using now,

> others might not. The important thing is reducing harm – reducing risk to self and others. Keeping people safe (Laura, AOD treatment commissioner).

> Keeping people safe I think is the main thing as a commissioner. I think you've got to have a safe harm reduction strategy to keep people safe. I don't necessarily just mean safer injecting and all that, but really understanding the health impact that drug use is having. Keeping people safe. I think that is critical (Carol, AOD treatment commissioner).

Following Bacchi and Bonham's (2016) PIA line of questioning, it is clear that 'ways of thinking' or 'risk thinking' (Rose 1999) as well as the 'responsibilisation of individuals' (Osborne 1997) are significant influences in professional discourse, the 'expert' knowledge of alcohol and other drug treatment commissioners and treatment providers:

> The idea that someone is going to come into treatment and stop using overnight or within a month is not feasible. Drug use is a chronic relapsing disorder. The idea is to reduce the amount of harm that they're doing and encourage them to stop (Trevor, AOD treatment professional).

> I think treatment should be focused on reducing harm. The biggest risk is a person dying. Their life ending and their family being affected. I think the priority should be preventing death, reducing harm and promoting health for the individual. Naloxone has been a game changer in reducing, in terms of reducing drug related deaths and needle exchange is brilliant for people to reduce the risks from injecting (Natalie AOD treatment provider).

For Dean (2010) representations of risk are a means by which events are characterised as governable through particular techniques and practices:

> What is important about risk is not risk itself. Rather it is: the forms of knowledge that make it thinkable, such as statistics, sociology, epidemiology, management and accounting; the techniques that discover it, from the calculus of probabilities to the interview; the technologies that seek to govern it, including risk screening, case management, social insurance and situational crime prevention; and the political rationalities and programmes that deploy it, from those who dreamt of a welfare state to those that imagine an advanced liberal society of prudential individuals and communities (Dean 2010:206).

An emphasis on self-care and self-management of risk has, as Peterson (1997) points out, became increasingly evident within the new public health and aligns to the rationality and basic premise of neoliberalism. McLean (2013) notes that Peterson and Lupton (1996) assert that harm reduction discourses are intrinsically linked with the rise of the new public health and a turn to neoliberal governance in general. For Peterson and Lupton (1996) the language of the new public health masks a shift in the power/knowledge relations concerned with redefining citizenship, rights and responsibilities. They note that:

> The new public health is, if nothing else, a set of discourses focusing on bodies, and on the regulation of ways in which those bodies interact within particular arrangements of time and space. Perhaps less obviously, the discourses of the new public health also seek to transform the awareness of individuals in such a way that they become more self-regulating and productive both in serving their own interests and those of society at large (Peterson and Lupton 1996:11).

The extent to which harm reduction policy and practice has embraced neoliberal discourse is a contested area of debate. In her study of injecting drug use, Vitellone (2017) has described the distinctiveness of harm reduction as transforming PWID from pathological deviants to public health citizens who promote self-care and wellbeing for themselves and for others. While McLean has noted that poststructural analysis calls for more 'reflexivity around the implementation and underlying theory of harm reduction technologies' (McLean 2013:423). In contrast, Moore and Fraser (2006) have argued that in embracing the neoliberal notion of a responsibleised drug consumer, harm reduction risks overlooking the material constraints on health care experienced by significant numbers of PWUD and the inequalities that arise through political, economic and social structures. Rhodes (2002) has also pointed out some of limiting factors of individualised harm reduction risk discourses noting that while the rhetoric of the new public health claims to alleviate health inequalities through environmental and structural change, harm reduction interventions tend still to focus on individual risk and behaviour change. Rhodes *et al.* for example, have argued for a shift in the analysis of risk relating to

PWID towards the 'connections between risk practices and environments' (Rhodes 2006:1390) and suggest that harm can be better understood, and therefore reduced, through the notion of 'risk environments' (Rhodes 2002). For Rhodes, the notion of a risk environment provides an opportunity to reorientate risk away from individual responsibility towards an understanding of the social and structural determinants of risk. Here, the focus of risk opens up a more useful discussion for a poststructural analysis allowing for a consideration of a constructionist perspective of harm and an analysis of the harm producing policies and the 'material inequalities in the production of harm associated with drug injecting' (Rhodes *et al.* 2006:1390). Moore (2004) has also pointed out that injecting practices among PWID are shaped by social, cultural and economic contexts that might undermine individualistic forms of harm reduction interventions.

Commenting on the regulatory capacity of professional discourses Keane (2003) argues that a critical analysis of the underlying theory and practices of harm reduction reveals a 'surveillance medicine' that reproduces the 'prescriptive moralism' embedded in the notion of a health seeking citizen:

> Notions of 'agency', 'empowerment', and 'responsible drug use' may have little impact if they are not accompanied by policy and practice that attempts to address the political – economic conditions that contribute to the marginalisation of drug users. [Attributing blame] to individual injecting drug users for a crisis that is better understood as a product of a network of interlocking individual, social, political and medical responsibilities (Moore and Fraser 2006:3041).

Also drawing on Foucault's notion of governing subjects, Nettleton (1997) notes how risks are constituted within professional discourses and presented to individuals by 'experts' it is then the responsibility of the individual to calculate the likely consequences of certain actions for themselves (Nettleton 1997:208). The section heading, taken from the testimony of a PWID in this study reflects that displacement of responsibility unequivocally:

> Harm reduction used to be like getting practical help to avoid harm, safer injecting advice, even how to inject more safely in your groin. Now it's just like we've told you risky so don't fuckin do it (Giles, PWID).

### 7.7 Conclusion

This chapter started with what might be described as a populist account of risk and harms associated with unrestricted access to illicit drugs. A policy narrative derived from and constituted in a particular problem representation of illicit drugs and people who use them. While chapter five considered in more depth, how governments have controlled the risk associated with the production and availability of drugs, this chapter has attempted to illuminate how controlling consumption has, as Alaszewski (2011) has noted, depended more on public health messaging and the communication of risk. Following Foucault's concept of governmentality, this chapter has described risk as part of a regulating and disciplinary discourse. As Rose (1999), Rhodes (2002), Moore and Fraser (2006), Dean (2010), and other critical commentators have noted, harm reduction principles, once concerned with bringing about structural change, have been appropriated by a governmental treatment system and have been reduced to a series of target driven transactional arrangements. Needle and syringe programmes (NSP), originally enacted as 'grass roots activism' (Shaw 2012) have been recast within professional discourse as part of a broader surveillance and monitoring of PWID while heroin assisted treatment programmes (Poulter *et al.* 2023) and overdose prevention centres (Holland *et al.* 2022), when discussed at all, are promoted as a part of engagement with a treatment system whose disciplinary and regulatory discursive practices are largely responsible for their proscription in the first place.

# Chapter Eight

## From hopeless to harmful: Responding to injecting drug use

### 8.1 Introduction

> Ghouls with dirty hypodermic syringes and morphine solution made with any water are to be seen in the teashops (or restaurants) in Soochow giving injections at the low rate of seven cash (one-fifth of a penny) each. As the victims pass before them each gets his allowance in succession without the needle even being wiped after the previous one (Anonymous, cited in Zule *et al.* 1997:199).

Zule *et al.* cite the anonymous quote above as evidence of 'the existence of shooting gallery conditions and needle sharing among drug abusers (sic) in China as early as 1902' (Zule *et al.* 1997:199). Framing the 'problem' as one of hopelessly addicted victims of morphine use engaged in the practice of needle sharing, Zule *et al.* (1997) narrate the origins of illicit injecting and provide a historical perspective of needle sharing based on representations of chaotic, irresponsible and pathological drug use. They note that in the United States, an awareness of widespread needle sharing followed reports of malaria transmission among PWID between 1929 and 1932. For Zule *et al.* (1997) factors influencing an increase in injecting drug use and consequent needle sharing included laws in 1909 banning the importation of opium resulting in a shift away from opium smoking to the more expensive option of smoking heroin, as well as the increased therapeutic use of intravenous injections. They point out that between 1903 and 1925 over 300,000 therapeutic injections had been administered in the United States for the treatment of over 130 diseases noting that:

> With intravenous injections being given with such frequency for such a wide variety of diseases, at least some drug abusers (sic) must have been exposed to intravenous injections in the course of medical treatment (Zule *et al.* 1997:202).

Zule *et al.* (1997) conclude that knowledge shared among drug using social networks probably contributed to the spread of the 'intravenous technique', increased needle sharing and increased

risk of transmissible infections. However, as McBride and Wichter (2005) have noted, the addition of quinine, with its antimalarial properties, as a dilutant or 'cutting agent' to illicit heroin may have ironically contributed to the end of the 1930s malaria outbreak in the United States by 'rendering ineffective the malarial parasites in contaminated syringes' (McBride and Wichter 2005:113). Whether or not this was a contributory factor, the Malaria epidemic in New York, as McBride and Witcher have noted, was over by 1943. The 'problem' of the syringe however was not. As Hickman (2004) notes, many commentators believed that the new medical technology exacerbated the emerging drug problem and consequently, as Walmsley points out:

> The relation between individual, physician and syringe had to be reconstituted through medical power and in terms of medical knowledge. Representing this modern instrument as a medical and social problem, restrictions were, in part, characteristic of a preventative logic in circulation in the 19th century which governed dangerous individuals unable to govern themselves (Walmsley 2012:94)

The 'problem' of injecting drug use and the focus on 'contaminated syringes' has been a key feature of public health policy and responses to PWID since the early 1970s. Referring to PWID as 'shooters' Howard and Borges (1970) reported that in a sample of 77 PWID infected with hepatitis, 60% 'had shared a needle', while 27% had 'shared a needle' with someone who they knew to have hepatitis or who they believed might have hepatitis. They suggest that the 'ritual' of sharing was regarded as a 'means of socialising the newcomer to ways of the shooting subculture', while 'mastering the techniques of needle sharing is a means of achieving status' amongst peers (Howard and Borges 1970:229). Howard and Borges conclude that in the 'social control of illness-producing behaviour, needle sharing is related to hepatis as smoking is related to cancer and sexual promiscuity to gonorrhoea' (Howard and Borges 1970:230). Interest in PWID, particularly in the way that they administered their drugs, was re-awakened and intensified, as Murphy (1987) reminds us, with growing public concern

around HIV/AIDS and with the identification of injecting drugs as ‘something unusual’, pathological and requiring treatment.

### 8.2 Pathologising injecting drug use

Previous chapters have discussed how drug policy situates PWUD through the processes of subjectification and the discourses of criminalisation and pathologisation into adopting stigmatising and socially isolating subject positions. Fraser (2004) reminds us, that PWID are uniquely stigmatised, not only in relation to the legal status of their substances of choice and the medicalisation of ‘legitimate supply’ but through the responsibilising practices and discourses that position PWID as the ‘problem’ in relation to infection control.

Carlson (2000) reminds us that public health research has historically described the locations where PWID use drugs as ‘shooting galleries’. Portraying them as:

> The kavas of drug injectors, places where people rent and ritually share needles and syringes to create symbolically a bond of intimacy (Carlson 2000:327).

Carlson (2000) points out that ethnographic observations and studies reveal this to be a somewhat myopic impression of injecting spaces and a perceptual expectation that is incorrect and offers little or no insights into the contextual aspects of communal drug use. Rhodes *et al.* have noted that while the notion of the ‘shooting gallery’ ‘conjures up an image of high-risk injecting in public or semi-public places’ the spaces that constitute a shooting gallery are less well determined and often subject to local and cultural variation (Rhodes *et al.* 2006:1385). Offering an alternative view to that constructed through the lens of public health epidemiology, Rhodes *et al.* point out that:

> One interesting variant on dominant scientific constructions of the crack house and shooting gallery, for example, is such locales as ‘safe havens’; as places offering some perception of safety or protection from a hostile risk environment, for instance by enabling off-street injection where the risk of arrect or public disturbance is reduced (Rhodes *et al.* 2006:1385).

Moreover, Murphy (1987) notes that PWID are both economically and ethnically diverse, with motivations and drivers for engaging with injecting drug use ranging from resistance to authority, through economic necessity and efficiency to heightened euphoria and pleasure. The argument here, as Fraser *et al.* (2004) point out, is that essentialising injecting as irrational and pathological increases the risk of overlooking or 'obscuring the effective harm reduction mechanisms' that PWID might employ while reducing the practice of injecting to an intractable behaviour.

Following Bacchi and Goodwin (2016) discursive, subjectification and the lived effects of problem representations are further revealed through problematising the notion of 'needle fixation' and the discursive practices that render it meaningful. Pates *et al.* describe 'Needle fixation' as the:

> Repetitive puncturing of the skin with or without the injection of psychoactive drugs via intravenous, subcutaneous or intramuscular routes, irrespective of the drug or drugs anticipated effects of the drug (Pates *et al.* 2001:15).

Following Foucault, Fraser *et al.* (2004) have argued that 'needle fixation' can be seen as a discursive construction in which the privileged discursive practices of mental health and medicine make available the existence and more importantly, the meaning of a particular phenomenon. In chapter six, Hall (2013) reminds us that Foucault's emphasis on discourse as knowledge and meaning is not to deny that things can have a material existence in the world. The argument here, as Mills (2004) notes, is that things do not have meaning outside of the discursive practices that define them. Importantly for Fraser *et al.* (2004) is a consideration, not only of how the term 'needle fixation' enters discourse, but how it becomes part of a 'regime of truth' in which PWID come to recognise themselves. Fraser *et al.* further illuminate this by drawing our attention to Foucault's notion of 'technologies of the self' pointing out that Foucault 'argues that discourse can provide 'technologies of the self': the means through which

individuals can understand and act upon themselves ethically' (Fraser *et al.* 2004:68). The notion of technologies of the self is discussed further later on in this chapter in relation to the responsibilisation of PWID and self-governing practices. For now, it is useful to note that for Fraser et al:

> Needle fixation can be understood as a technology of the self that offers injecting drug users a means of understanding themselves, and of producing themselves in relation to ethics (such as the ethics of drug use and injecting) Thus, in thinking about the category of needle fixation, it is important to consider not only the ways in which the term enters discourse, but how it can become, both intentionally and otherwise, the truth of individual existence – part and parcel of a regime of truth in which injecting drug users come to recognise themselves (Fraser *et al.* 2004:68).

**8.3 Interpellating injecting drug use and the politics of 'identity'**

Aston (2009) draws our attention to the complex power relations at work in the processes of identity formation. Aston reminds us that it was Althusser in 1971 who first introduced the concept of interpellation to explain the process by which individuals come to recognise themselves as belonging to particular subject positions, or identities' (Aston 2009:613). She notes how in illuminating how identities, roles and activities are conferred through established discourse and social practices, Althusser offers the example of 'hailing':

> A policeman on the street shouting, 'Hey you there!' to a passerby. In this this commonplace exchange, an ideology (represented by the policeman) recruits and transforms an individual (the passerby) into a particular identity (Althusser 1971 cited in Aston 2009:614).

Aston (2009) notes how, following Althusser, Butler (1995; 1997) has argued that the process of interpellation is more complex and subtle than the act of 'hailing' as described by Althusser. Aston (2009) has noted that importantly for Butler there must be a degree of 'openness' or receptiveness to the identity and subject positions made available through the particular discourses operating within a given social context (Baxter 2016). Fomiatti *et al.* (2017) support

this more nuanced conception of interpellation noting that subjects are produced through iterative socio-material practices that can be characterised by the dynamics of inclusion and exclusion. For Fomiatti *et al.* 'interpellation is not a single performative act but rather a socio-material circuit of recognition' (Fomiatti *et al.* 2017:176). In this sense, Fomiatti *et al's.* position aligns with Bacchi and Goodwin's assertion that policies, or rather discourses, produce subjects as well as restricting the type of subject positions available. As previously discussed, for Bacchi and Goodwin (2016:30) 'a performative is that which enacts or brings about what it names'. People's identities do not preceded their performances, neither as Fomiatti *et al.* have pointed out above, are they constructed in a single performative act. Rather they are constituted in and through them. Bacchi and Goodwin (2016) note that Mol (2002) has asserted that:

> Identity is not something that is given; it is something that is practiced: The passive and mundane acts in which this is done make people what they are (Mol 2002 cited in Bacchi and Goodwin 2016:30).

Again, we are reminded of the pervasive and productive nature of the power/knowledge relations in the constitution of political subjects – the processes by which subjects are made or are becoming. As with Becker's 1953 account of becoming a marihuana user, Hanoa *et al.* (2022:668) note that the 'identity transition' associated with injecting drugs involves a process of becoming that constitutes a 'transition to a new symbolic identity'. For Hanoa (2022) that transition involves 'learning how to value injecting' highlighting the importance of learning how to navigate an assemblage of social and peer influences in the perception of both pleasure and risk. In her autoethnographic study of heroin use in the North West of England, Stewart (1987) describes exactly those competing peer influences as she gives an account of becoming a heroin injector.

> Cranking [injecting] is the most exciting, enjoyable and dangerous way to take heroin. It feeds the human capacity and need for ritual. The dangers are many and varied. At first you may worry about things like getting sterile water to be safe,

> and then someone reminds you that the gear itself may well have spent some time in a set of smelly underpants or in a dirty sock. It will have been heaped up and shovelled about on dirty floors; packed and shipped in dirty conditions; chopped up and mauled around countless tables and tiles; spilt on the carpet and scaped up. You disguise the fact that you are a bit nervous, your mates are abundantly confident. They assure you all is well. At least that is how it is the first time (Stewart 1987:21).

In a similar way to Stewart's account, interviewees in Hanoa et al's (2022) study described having feelings of anxiety and negative beliefs associated with injecting for the first time. And like Stewarts descriptions they increasingly came to perceive injecting as constructive and valued:

> While most of the interviewees acknowledged the dangers associated with their injecting practices, they were still heavily influenced by peers when addressing their initial trajectories and describing the pleasures they associated with injecting. As such, they had learned how to value injecting, despite their initial fears, and their interactions with drug using peers enabled the acquisition of both technical skills and a more embodied knowledge that influenced their perceptions of risk and pleasure (Hanoa *et al.* 2022:672).

The point here is that the transition from a non-injecting identity to one were injecting is perceived as constructive and valued is a process of interpellating the 'the injecting drug user identity' through 'hailing' normative injecting practices that are bound within a socially, culturally and economically determined context. The politics of identity that belie the subject positions available within the power/knowledge relations of discursive practices are evident in the testimony of PWID interviewed in this study:

> I had spent years smoking heroin and got to the point where it was costing me a lot of money. I decided that if I injected I would get more off it for less money. I knew people who were injecting and they talked me through it and explained it all. It was someone I knew really well that first injected me (Keith, PWID).

> I was looking for it. I was seeking it out rather than having it pressed upon me. I'd always been interested in drugs. I'd run the gamut of all the other drugs by the time I started injecting. Injecting was just a box that needed to be ticked off basically (Phil, PWID)

> At the time I had just finished at art school. There were a group of us living in a squat, I was in a band and some of my friends from the squat were involved in various arts projects. All our heroes were heroin addicts and I think we definitely thought we were the cool ones because we injected. The immediacy of the quality of the hit was like a greater experience than snorting it which would have been the only other option back then (Donna, PWID).

In their analysis of rational for selecting administration methods in heroin use, Bravo *et al.* (2003) identified the main reasons for transitioning from smoking or snorting heroin to injecting as 'superior effectiveness (better or greater effect) and efficiency (same effect for less money)'. Other influences included having a partner who injected and the social environment (Bravo *et al.* 2003:752).

Importantly, testimony from interviewees in this and other studies suggests a willingness, as Aston (2009) noted, to 'turn to the hail' of injecting subject position and a seemingly rational logic in practicing it. Testimony from PWID consistently points to the intense experience associated with injecting that is not rivalled by other methods of consumption. These insights raise questions about the way that injecting has been problematised as a technique of drug consumption and the likely effects of interventions to discourage it based on policy discourse and the problem representations of injecting drug use and PWID. The intensity, the uniqueness and pleasurable effects described by PWID as part of their identity is captured well in Stewart's account of injecting heroin:

> The rush is so hard to describe. It's like waiting for a distant thunderstorm to move overhead. A strange foreboding. A bizarre, awesome calm. It's in your blood, moving towards your brain, relentlessly; unstoppable, inevitable. A feeling starts to grow like a rumble from the horizon. The feeling swells, surging, soaring, crashing screaming to a devastating crescendo. The gear smashes against the top of your skull with the power of an uncapped oil well. You won't be able to bear the intense ecstasy. It is all too much. Your body may fall apart. The rock that is your head shatters harmlessly into a million sparkling, tinkling smithereens. They tumble at a thousand miles an hour straight back down over your body, warming, insulating, tingling, denying all pain, fear and sadness. You are stoned, you are high. You are above and below reality and law (Stewart 1987:29).

The argument here is not to deny the material realities of risk associated with injecting drug but to re-problematise the problematisations and trouble the assumptions and policy representations that are the basis of hopelessly ineffective harm reduction strategies based on mainstream public health paradigms that as Bourgois points out:

> Ignore power – whether it be the criminal justice system and laws governing controlled substances and paraphernalia; the ideological and social structural enforcement of social marginalisation by institutions and mainstream discourses; or the structuring of networks and identities / practices of risk by race, class, gender, sexuality, and geography. By focusing on changing individual behaviour in a vacuum, public health researchers obscure and ultimately reinforce the power dynamics that shape risk. They defer to biomedical statistical paradigms and psychological behaviourist-applied intervention models that fail to analyse the prolonged everyday suffering and ecstasy of PWID (Bourgois 1998:2344).

### 8.4 A Blueprint for harm reduction

In its 2023 *European Drug Report* the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) note that despite a decline in injecting use over the past decade 'this behaviour is still responsible for a disproportionate level of health harms' pointing out that PWID 'are at greater risk of contracting blood borne viruses or dying from a drug overdose' and stating that 'reducing the harm associated with injecting drug use still remains an important priority for protecting public health (EMCDDA 2023:5).

As noted earlier, the 1988 report from the ACMD, *Aids and Drug Misuse* was regarded by many as a blueprint for harm reduction (Ashton and Seymore 2010) with calls for services to minimise risk by any available means. However, when it came to PWID, those means, the policies and population health interventions, fell short of recognising the complexity of injecting drugs and failed to adequately address the broader health and social risks faced by PWID. A re-reading of ACMD recommendation in 1988 through a WPR lens reveals injecting drug use and PWID as being represented as a particular kind of problem with policy responses being typically restrictive and hopelessly limited:

> Misuse of drugs by injection is particularly dangerous. It carries many risks in addition to that of acquiring and spreading HIV. Even where a drug injector regularly uses sterile equipment he or she may well share equipment on occasions when clean needles and syringes are not immediately to hand. A move from injecting drug use to oral use is therefore very desirable in cases where abstinence is not, for the time being, achievable (ACMD 1988:51).

While the availability of an oral substitution treatment might be appropriate for PWUD who have not yet been initiated into injecting practices the policy fails to recognise the complexity of injecting drug use and the politics of identity discussed above. The move from injecting drug use might well be desirable in terms of governing 'risk practices', but as is still the case now, the offer of oral-based medicine assisted treatment to PWID is only likely to appeal to those who actively want to stop injecting and/or engage in a programme of 'abstinence-based recovery'. For those who don't, injecting becomes an 'invisible risk' with PWID concealing their practices from treatment providers for fear of negative repercussions. From a WPR perspective the ACMD in 1988 had represented the problem as one of injecting drug use and the solution is to change or eliminate it.

When in 1993 the ACMD updated its report on Aids and Drug Misuse the clamp down on PWID was ratcheted up further with its position on prescribing injectable drugs being unequivocal:

> We are concerned that recommendations in our previous reports on the use of injectable drugs as an intermediate treatment stage have been converted in some treatment settings to a pattern of maintenance treatment with injectable methadone (ACMD 1993:49).

> Drug use can itself pose a significant threat to health; injecting drug use represents an even greater threat. It is vital that all relevant agencies work together to act upon drug use in all its manifestations. Action must be directed towards encouraging cessation of drug use (ACMD 1993:64).

The 1993 report from the ACMD looked less like a blueprint for harm reduction and more like a declaration for abstinence-based treatment, encouraging the cessation of drug use and

exposing a misplaced belief, that persists to the present day – that efforts to reduce drug use through disruptions to the supply chain will result in a reduction of harm.

The ACMD reports of 1988 and 1993 target individual behaviour change rather than the structural and material conditions of inequality in their efforts to reduce the harms associated with drugs and the people who use them. Harms that impact on the individual, the family and the wider community (ACMD 1988). Some of these harms are confirmed in the influential and credible information source, *The Safer Injecting Handbook* (Preston and Derricott 2017) which lists the top five risks associated with injecting drugs as; catching viral infections; overdose, vein damage; infection from bacteria that gets into the blood; and passing any infection you may have to others. The handbook notes that 'people who inject also tend to be more dependent on drugs than people who don't' encouraging a switch away from injecting and notes that:

> Getting into treatment makes a big difference. People who get prescribed drugs usually find they are able to greatly reduce or stop injecting (Preston and Derricott 1017:8).

Through the lens of critical poststructural research on the disciplinary nature of treatment, and following testimony from the PWID in this study the idea that treatment helps people to stop injecting is questionable. Research suggests that around 50% of people who die from drug related causes, many of them PWID have either never engaged with structured drug treatment or have dropped out of treatment and not re-engaged (Public Health Matters Blog 2017:3). NSP monitoring data in the North West of England (Whitfield and Reed 2024:9) shows as few as 18% of PWID attending community pharmacy-based NSPs are known to treatment services, while re-infection rates for hepatis C among PWID previously treated for the virus continue to present a challenge for National hepatitis C elimination programme (UKHSA 2023). For many PWID engaging with structured drug treatment with its limited offer of options is characteristic

of a disciplinary regime and a logic of governmentality underpinned by harm producing policies and neoliberal discourses of responsibilisation.

### 8.5 Responsibilising PWID

In connecting this back to the theoretical framework outlined in previous chapters, Smart (1988) reminds us that for Foucault, resposibilisation can be best understood through the logic of governmentality, subjectification and self-governing practices. Foucault refers to technologies of the self as those:

> Which permit individuals to effect *by their own means or with the help of others* a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection or immortality (Smart 1988:81).

Following Foucault, Gastaldo (1997) argues that 'norms' of healthy behaviours promotes discipline for the achievement of good health. For Gasteldo health education with its involvement in prevention and health promotion 'enhance the set of power techniques that come into play in the management of individual and social bodies' (Gastaldo 1997:114). Importantly here, as Fraser (2004) reminds us, within these power relations the logic of governmentality that operates through processes of subjectification appear to be voluntary and self-defined. Echoing Gasteldo (1997) and Adkins (2001) Fraser notes that:

> Health education functions through the production of identity – it provides individuals with elements to produce selves which are then managed through processes of reward and punishment. A 'choosing, self-monitoring, self-regulating, self-forming subject' is fostered in health policy, one who can be enjoined to enact appropriate health behaviour designed to minimise illness and the public burden of care (Fraser 2004:200).

For Fraser (2004) the critical point is that health education materials are produced in a way that identifies individual rather than social or political structures as problems and therefore the target for intervention. Identifying and targeting individual behaviour in this way creates a discursive

space where, according to Fraser (2004) subjects are not only responsible for improving their own (as well as others) health, but also culpable for misfortune, illness or other crisis. The logic of governmentality that operates through the effects of technologies of the self – the processes of self-discipline that ensure the management of populations with minimal coercion are consistent with the notion of problem representations that Bacchi and Goodwin (2016) alert us to in the analysis of drug policy and the implications of problematisations that can be unpicked through a consideration of their discursive, subjectification and lived effects. In this sense Fraser (2004) is drawing our attention to the effects of individualised harm reduction messages that link safer injecting interventions to the main causes of HIV, hepatitis C and other blood borne viruses while failing to address the broader structural responses to the problems of risk, health protection and safer injecting.

In 1993, the ACMD proclaimed that:

> Lower levels of injecting risk behaviour and the presently low HIV prevalence among drug injectors provide solid grounds to affirm the success to date of the strategy adopted in the UK (ACMD 1993:2).

Discussing the efficacy of NSP programmes in reducing blood borne viruses, Levy (2018:68) asserts that NSP have demonstrated substantial changes in risk behaviour decreasing the risk of and transmission of blood borne viruses amongst PWID. While presenting a compelling argument for the benefits of a harm reduction approach, Levy acknowledges that the efficacy of NSP has been contested by some commentators. He draws our attention to commentators who have both suggested that 'syringe programmes have no empirically demonstrable impact in preventing transmissible blood borne infections or improving the health of people who use drugs', and quotes one addictions psychiatrist commenting on NSP as saying 'I don't think it does much harm, I don't think it does much good either' (Levy 2018:69). The contestation that Levy is highlighting here is largely related to the challenges that NSP have faced in evidencing

any sustainable reduction in hepatitis C infections among PWID since the virus was identified in 1989 and tests to determine infection became widely available in the early 1990s.

Palmateer *et al.* (2014) draw our attention to the significance of items of equipment (paraphernalia) used in the preparation of drugs for injection. The term paraphernalia is used here to describe utensils such as spoons for mixing up an injectable solution; water and acidifiers necessary to render powders or solids soluble and filters used to filter any non-soluble material as the solution is drawn up into the syringe. These items of 'injecting paraphernalia' can, as Gossop *et al.* (1997) and Palmateer *et al.* (2014) become contaminated during the preparation process and act as a source of viral transmission when shared or re-used among PWID. For hepatitis C, a virus believed to be more easily transmitted through contaminated injecting equipment than HIV (Rhodes and Treloar 2008) injecting paraphernalia is a critical consideration for blood borne virus prevention initiatives and a potential limiting factor in the efficacy of NSP. Commenting on its efforts to eliminate hepatitis C as a public health threat, the UK Health Security Agency (UKHSA) noted in 2023 that:

> while 'the number of people living with chronic hepatitis C infection in the UK has fallen dramatically by over 47% from 2015 to 92,900 in 2021, almost three-quarters of those still living with chronic hepatitis C remain unaware of their infection (UKHSA 2023:3).

Moreover, UKHSA go on to note that any reduction in chronic infections have been mainly due to people receiving treatment for the virus and not as a result of primary prevention interventions stating that:

> Data suggests that prevention has failed to keep pace with gains made in other areas; the number of new infections and re-infections poses a threat to England meeting WHO incidence targets. Injecting drug use remains the main driver for HCV transmission in England and needle and syringe provision has remained suboptimal across all UK nations (UKHSA 2023:4)

The 2023 report from UKHSA reveals why commentators might question the efficacy of NSP in relation to blood borne virus prevention, but again responsibilises PWID through the conflation of HCV transmission and injecting drug use. The irony seems lost in the commentary of the HCV Action report (2023) who note on page 10 that 'PWID make up more than 90% of those affected by HCV and face stigma and intersecting layers of discrimination'. Moreover, as Fraser (2010) points out, the causation chain implied through these interpretations can be misleading and avoids a more critical questioning of structural arrangements:

> Injecting substances does not in itself cause hepatitis C. Only the presence of the hepatitis C virus in the equipment used to inject, or in substance injected, can cause transmission (Fraser 2010:241).

In this sense the transmission of hepatis C is not reducible to the act of injecting. As Fraser (2010) reminds us, 'the presence of the virus in the population of PWID at a sufficiently high level of prevalence is also necessary'. The prevalence of HCV soared undetected among PWID while delays in the identification of screening and treatment for the disease and barriers to accessing sterile paraphernalia contributed to the proliferation of infections. In 1986, needles and syringes had been made legally available to PWID in the wake of the HIV / Aids crisis. Injecting paraphernalia including sterile water, mixing utensils, acidifiers and filters remained prohibited under section 9a of the Misuse of Drugs Act 1971 for a further seventeen years. On 8th July 2003 the ACMD announced that The Government will be laying a negative resolution statutory instrument to implement changes to section 9A of the Misuse of Drugs Act 1971 with effect from 01/08/2003 (cited at www.exchangesupplies.org Drug Paraphernalia and the UK law).

PWID would have to wait a further two years until June 2005 for legislation permitting the provision of sterile water, confirming the Misuse of Drugs Act 1971 the discursive practices it produces and the strategies and policies that follow it, as harm producing policies.

### 8.6 Prescribing injectable drugs: A medical dilemma?

Commenting on the harms associated with drug use, Scott (2005:34) reminds us that when injecting substances, it is clearly preferable to use a 'medical product that has been manufactured by a pharmaceutical company in a ready to use form'. Scott (2005) notes that in the quest to reduce injecting related harms, ready-to-use products, in other words prescribed injectable drugs, limit exposure to the environments where they can become contaminated with bacteria or viruses and undergo rigorous testing to ensure a sterile and measured dose. The prescription of injectable drugs, as previously mentioned, has been part of a UK treatment response from the 1920s, since when the policy has experienced varying degrees of support and criticism. In a randomised control study contrasting the usefulness of prescribing heroin compared to oral methadone Mitcheson and Hartnoll (1978), concluded that:

> While heroin prescribed patients attended the clinic more regularly and showed some reduction in the extent of their criminal activity, nevertheless they showed no change in their other social activities, such as work, stable accommodation or diet, nor did they differ significantly in the physical complications of drug use from those denied such a prescription (Mitcheson 2005:45).

For Mitcheson these were all areas of concern that proponents of prescribed heroin for self-injection believe that there should be a harm reducing effect. However, while there was no observed difference in a range of health and social measures, Mitcheson did note a difference between the groups in relation to crime and criminal activity. Approximately two thirds of both the heroin prescribed and the methadone prescribed groups continued to engage with some criminal activity with the group refused heroin prescriptions being arrested more frequently and spending longer periods in custody (Mitcheson 2005). In spite of these observations and the conclusions drawn by the study, that the results were not a clear indication of one treatment being substantially better than the other, Mitcheson (2005) notes that the findings confirmed for clinicians in the influential London-based drug dependency clinics that the policy of

prescribing injectable drugs was unhelpful to the patient and indefensible therapeutically. Prescribing injectable drugs was not achieving significant change or a reduction in harm. However, as Metrebian *et al.* have noted, much of the debate centred around the drug - diamorphine rather than on the injectable route of administration', pointing out that 'injectable methadone ampoules are more readily prescribed and have attracted far less controversy' (Metrebian *et al.* 2010:101). This is a point echoed by Spear who notes that 'generous prescribing of methadone ampoules rather than heroin was clear evidence that it was the drug and not the method of administration at which many of the objections were directed' (Spear 2002:254). For Metrebian *et al.* (2010) a clinical preference for methadone was underlined by the Department of Health when clinical guidelines published in 1999 noted that even where there might be some benefit to the individual from an injectable prescription the availability of injectable methadone means that there is little clinical indication for prescribing diamorphine.

In contrast, trials outside of the UK had concluded positive outcomes from prescribing injectable heroin. Bourgois (2000:186) notes the findings from the Swiss heroin trials of Uchtenhagen (1997):

> Compared to addicts placed on methadone or morphine maintenance, those who consumed medically prescribed heroin were healthier, 'less depressed'; 'less anxious'; and 'less prone to delirium'. They were also 'better housed', 'more employed'; used 'less welfare'; and 'decreased their street contacts more' as well as their 'sensations of automatism'. Those prescribed heroin also used less illegal heroin and cocaine. Most dramatically, medically-stabilised heroin addicts decreased their participation in crime sevenfold"

Moreover, Bourgois (2000) draws our attention to the unpleasant side effects associated with methadone consumption. Bourgois cites one example of a study in which 80% of a random sample of 246 PWUD complained of complications related to methadone ingestion. Reported side effects included; sexual dysfunction, psychological distress, constipation, nausea, vomiting and appetite abnormalities (Bourgois 2000:185). 'Given that the side effects of methadone are

dramatically more unpleasant than those of heroin one wonders why methadone 'cures' and heroin 'sickens'' (Bourgois 2000:186).

Methadone ampoules were first prescribed in the UK in the 1970s, 'in part as a way of moving patients away from heroin' (Metrebian *et al.* 2010:101). Prescribing injectable methadone was back on the agenda in the 1980s as a way of attracting PWID into treatment and as a means of reducing the harms associated with injecting drug use. For the majority of clinicians, faced with the dilemma of prescribing an injectable opiate, methadone was the drug of choice due to its longer duration of action and its more accepted medical status. However, as Sell *et al.* (2001, 2004) point out, given the option to choose between methadone and diamorphine most PWID would prefer diamorphine. In a sample of 125 individuals prescribed injectable opiates at a clinic in the North West of England, none of the individuals receiving diamorphine wanted an alternative treatment whereas 107 (44.9%) of those receiving methadone ampoules currently wanted diamorphine (Sell *et al.* 2001:62). Commenting on the above study, Sell and Zador (2004) have noted that contrary to the irresponsible, hopelessly addicted heroin users depicted in policy representations of PWID, one of the most striking findings was that:

> Procuring a drug supply of known dose and purity, improving family relationships and avoiding trouble with police were the most frequently nominated reasons for seeking a prescription for injectable opiates. For only a minority of subjects was a desire to stop using drugs or to reduce or cease injecting behaviour a factor in their decision to seek treatment. These motivations for injectable opiate treatment (IOT) would suggest that most of the subjects in this study did not perceive their opiate injecting behaviour as a problem *per se,* but sought to reduce the attendant risks and complications of illicit street heroin use. IOT was perceived as a means of continuing the injection of opiate albeit in a safer, less risky way (Sell and Zador 2004:446).

The findings of Sell *et al.* (2001) have a relevance for current drug policy and ways in which discourses represent the problem of PWID. Given the stated aim of the 2021 UK drug strategy to increase the numbers of people accessing drug treatment, drug treatment commissioners and

service providers should be mindful of the motivating factors and the reasons outlined above for PWID seeking treatment. According to that view, increasing the number of treatment places in abstinence-based recovery services is hardly likely to provide the appeal or the incentive for PWID to engage with them.

Most of the treatment commissioners interviewed for this research showed a reluctance to comment when asked about the possible advantages of diamorphine prescribing while those who did express a view framed the 'challenges associated with prescribing heroin' in terms of neoliberal managerialism – ensuring financial prudentialism, managing individual expectations and not wanting to be seen as 'condoning high risk practices'.

> I think it's about the political perception of heroin. Can you imagine the uproar if you were to say that treatment services were prescribing heroin? (Richard, AOD treatment commissioner).

> For me the jury is still out on heroin assisted treatment to be honest. I don't know, but I haven't heard our commissioned service provider ever saying that it would help clients. It would be perceived as a backwards step. Getting [them] off injecting and into methadone or buprenorphine programmes is part of the harm reduction journey that they're on (George, AOD treatment commissioner).

Following the assertions of Fraser (2004) and others outlined above, the idea of condoning high-risk practices positions the PWID at the centre of responsibility while the reference to managing the expectations of PWID – many of whom have remarkably low expectations of support services to start with, might align with the discursive practice of governing the conduct of conduct but offers little harm reducing potential. The harm reducing potential of prescribing injectable drugs is captured by Sell when she notes that:

> Few doctors would want to continue prescribing injectable methadone for a patient who had had a deep vein thrombosis while injecting prescribed drugs, but the risk of further medical problems may remain higher without the prescribed drug than with it (Sell 2003:112).

In the UK injectable opiate treatment, dispensed for unsupervised consumption at home is available to a vanishingly small number of PWID. Concerns over the lack of supervision reflect an anxiety associated with regulating heroin use that are rooted in the governmental discourse of the second Brain Report of 1965. The 'risk' potential for diversion of heroin prescriptions onto the illicit street markets gives doctors 'good reason' not to prescribe it (Metrebian *et al.* 2010) and affirms heroin's political and 'problem' status as one of the most dangerous of dangerous drugs. The social construction of dangerousness, risk and criminality surrounding the non-medical use of heroin is intimately linked to its consumption via injection and the mystification surrounding the syringe. Walmsley reminds us of the symbolic power/knowledge relations of this particular medical technology:

> The syringe is only safe in the hands of medical men who appreciate its dangers, and abuse almost certainly follows if its administration be left to patients themselves. Patients, all patients that is to say, when confronted with the syringe are subordinated by a type of power-knowledge arrangement within which the individual is placed on the 'right' side of the syringe through taking the position of a 'medical subject' (Walmsley 2012:95).

As previously discussed, subject positions made available and constituted in discourse are always in process. The subject is an effect of politics and a product of power/knowledge relations (Bacchi and Goodwin 2016). The 'subject' attracted into treatment by appeal of an injectable prescription becomes embroiled in that power/knowledge relationship and the governing practices of medical discourse. The 'harm reduction' incentive of injectable opiates is gradually replaced, as noted earlier and outlined on page 51 of the 1988 ACMD report, by 'a move from injecting drug use to oral use in cases where abstinence is not, for the time being, achievable'. While this was expressed as a desirable harm reduction measure in the 1988 report, the switch to oral methadone and the turn against maintenance treatment had as Seddon (2020) points out, already been consolidated with the first edition of the Department of Health *Clinical Guidelines* published in 1984.

## 8.7 Critical perspectives of heroin prescribing

The lack of critical research into prescribing heroin to PWID has been a limiting factor in our understanding of it as a harm reducing response. As Seddon reminds us, drug policy responses on 'managing problems and harms' from the mid-1980s were 'partly connected with the broader rise of risk-based forms of governance in the last quarter of the twentieth century' (Seddon 2020:6). The idea of long-term self-administered heroin maintenance was entirely out of step with the discursive practices (knowledge-power relations) of the addiction psychiatry establishment. When in 2003, the NHS, National Treatment Agency for Substance Misuse published its guidance *Injectable heroin (and injectable methadone) potential roles in drug treatment* it recommended that such treatments should only be delivered under supervision.

A body of evidence now exists for a highly regulated and supervised form of injectable heroin prescribing for PWID. Heroin Assisted Treatment (HAT) has been described by Strang *et al.* as 'a feasible and effective treatment for a particularly difficult-to-treat group of heroin dependent patients' (Strang *et al.* 2015:11). However, Strang *et al.* acknowledge that:

> for many marginalised heroin users, the attraction of prescribed diamorphine is rarely sufficient to promote engagement in highly structured treatment (Strang *et al.* 2015:12).

Strang *et al.* (2015) refer to the possible consideration of 'contingency management' as an incentive reinforcement presumably to increase the potential for treatment engagement. For Wakeman (2015) the randomised controlled trials and clinical context which constitute the evidence for HAT renders it of questionable value outside of those clinical settings. This point is particularly well made by MacCoun and Reuter when they describe the Swiss HAT programme and its operators 'efforts to reduce this experience to medicine rather than recreation':

> Patients must turn up on time, take the drug promptly, and leave the premises. There is to be no congregating or socialising. For example, in one facility there are few chairs in the waiting room; the aim is to move patients on as soon as they have recovered from their dose. They are expected, here and elsewhere, to leave within 20 minutes of taking their heroin (MacCoun and Reuter 2011:71).

PWID could be expected to engage with this de-personalising and alienating experience two or three times every day. Little wonder that, as MacCoun and Reuter (2011) point out, for some PWID HAT is not an attractive option due to the overly restrictive arrangements under which it is delivered. Problem representations underpinning the epidemiological construction of risk groups essentialise entire populations of PWID and obscure the complex realities for understanding how social conditions shape individual lives, neglecting as Wakeman (2015) points out, heroin's role in the construction and maintenance of individually meaningful identities. Perhaps, as MacCoun and Reuter (2011:72) have concluded, 'there is more to heroin addiction than a craving for the drug'.

PWID cannot escape the risk status conferred upon them even with the most progressive and reflexive of service providers (Fraser and valentine 2008). Poulter *et al.* (2023) describe how discourses of 'risk management' and governance presented a barrier to engagement in the delivery of a diamorphine assisted treatment service in the North East of England confirming some of the problems highlighted earlier in this chapter. In addition to the 'intensive supervised delivery model' typically associated with HAT type services, restrictions were imposed on PWID injecting a variety of sedative drug and crushed tablets while 'femoral and jugular injecting are prohibited in the service due to perception of enhanced injecting related risk (Poulter *et al.* 2023:3). They report the discursive practices of media and local commissioning bodies as 'fostering a hostile operating environment' and 'exacerbating the sense of surveillance experienced by clients' (Poulter *et al.* 2023:7) supporting the view that PWID engaged with treatment services are subject to a constant and multidimensional professional

gaze creating what Foucault describes as the ‘drug using subject’. Moreover, discourses on PWID play into policy and funding structures contributing to and reinforcing the ‘problem of addiction’ (Moore and Fraser 2013). Poulter *et al.* conclude that:

> Benefits reported extend beyond the pharmaceutical provision of diamorphine to impact care provision for acute physical health concerns, the quality of social relationships and individual self-esteem. Yet, multiple layers of avoidable constraint were experienced by providers, much of which could be reduced with appropriate policy level intervention (Poulter *et al.* 2023:8).

**8.8 Producing social stigma**

Chapter six argued that discourse and discursive practices can ‘rule in’ and ‘rule out’ the terms of reference (Hall 2013) around particular topics, meaning and understanding through which people speak about and know their worlds. The argument presented in chapter six was not to deny that ‘addiction’ is experienced as a ‘real’ effect, but that the discursive effects produce ‘real’ world experiences of risk, stigma and harm. Lancaster *et al.* (2015) draw our attention to ways in which the experience of discrimination and stigma for PWID causes a tension between what they might theoretically know to be effective interventions for reducing harm and their experiences of how policies, programmes and interventions are delivered in real life settings. PWID interviewed in this study for example described how disclosing their injecting practices to doctors or key workers would often result in negative responses and/or repressive consequences.

> People are scared to be honest now. You used to be able to say yeah, I’m still using a bit on top of my script, or yeah, I had a slip and ended up injecting – you could be straight with your worker but now people are scared, they don’t trust their worker not to put them on supervised consumption or something. Even if it doesn’t always happen there’s a worry that it might so you don’t mention it (Julie, PWID).

> If you’re injecting you should get an injectable prescription and if you’re not injecting you should get a non-injectable prescription. But that’s not how it works. If you go in the clinic and say that you’re injecting, they just say tough, you’re

> getting oral methadone. People either leave and don't go back or take the oral methadone and continue to inject. All they are doing is increasing people's habits. You don't tell anyone that you're still injecting because you don't want to lose your script (Giles, PWID).

Simmonds and Coomber (2009) describe a hierarchy of oppression and discrimination in which PWID are a stigmatised and stigmatising population. Stigmatised through the discursive practices of harm producing policies and stigmatising as an effect of the responsibilisation internalised through particular subject positions. Hierarchies of stigma operate within layers of oppression depending on the degree to which the health seeking rational and responsible PWID has been 'successfully' incorporated within the adopted subject position – the responsible vs the irresponsible PWID. In the hierarchies of oppression and stigma those who experience the strongest forms of discrimination and derision will often be those who are most visible – PWID who are homeless, sleeping rough and cut off from safer conditions, structures and support, and forced to use drugs in 'risk environments' (Rhodes 2002) that increase social harm, the risk for sharing injecting equipment and vulnerability to injecting related infections.

Simmonds and Coomber (2009) remind us that drug use among individuals who experience lower socio-economic status is likely to be more stigmatised than that of their more affluent peers. An established body of knowledge exists which supports claims that the material conditions of inequality are socially determining factors for ill health and are compounded by the burden of stigma and discrimination, Wilkinson and Pickett (2010), Marmott, (2015), Lansley (2022). While all causes of ill health and mortality fall most heavily on the poorest in society, Stevens (2011) has noted that the harms associated with drug use fall especially heavily on poor drug users with deaths among PWUD being disproportionality high.

### 8.9 Combating Drugs Partnerships: Talking tough on drug related deaths

In its 2000 Report, Reducing Drug Related Deaths, the Advisory Council on the Misuse of Drugs (ACMD) stated that:

> Deaths due to drug misuse in this country are currently at the highest level ever recorded and rising. The problem lies not only with overdoses and other acute causes of death but also with fatal long-term consequences of HIV and hepatitis. We outline the contents of a report which identifies a range of actions to reduce these deaths" (ACMD 2000:1).

Official statistics suggest that there were between 1076 and 2997 deaths identified in England and Wales in 1998. Some of those deaths were intentional overdoses but the majority were accidental (ACMD 2000:1) The report concluded that:

> The unequivocal view is that the incidence of drug-related deaths in this country can, will and must, in the very near future be substantially reduced". (ACMD 2000: xxxiv 10.21 – 10.22)

In 2001 the Government produced a 3-year *Action Plan* to reduce drug-related deaths following which the numbers of recorded deaths associated with the use of drugs began to fall. However, by 2003 the trend in drug related deaths was yet again on an upward trajectory (Public Health England (PHE) 2016 a:8). Moreover, due to the reports reflecting deaths recorded in previous years, it is difficult to determine with any accuracy if the temporary downturn was in fact as a result of measures taken in the Action Plan. In 2007 the publication of *Reducing Drug Related Harm: An Action Plan* (Department of Health (DoH); National Treatment Agency for Substance Misuse (NTA) 2007) sets out the:

> Broad streams of action to be taken in England to enhance harm reduction activities within the drug treatment sector. The aim is to progressively bear down on the drug misusers either dying through a drug-related death or contracting blood-borne virus infections (DoH; NTA 2007:1).

Office for National Statistics (ONS) annual data records four successive decreases in numbers of drug related deaths between 2008 and 2012. That would be the last time to date that ONS would report any reductions in drug related deaths.

The turn to recovery orientated treatment in 2010 prioritised 'drug-free' outcomes and wrote abstinence-based approaches into the National drug strategy. Harm producing practices and process-driven targets described in chapter five underpinned a combative response to drug use which, according the Government strategy would bring about permanent change and see individuals 'cease offending' and 'stop harming themselves' (MH Government 2010:18).

When in August 2019, ONS released data on drug related deaths for England and Wales there were 4,359 deaths related to drug poisoning recorded in England and Wales in 2018, the highest number and the highest annual increase (16%) since records began in 1993 (ONS 2019). Ben Humberstone, ONS Deputy Director for Health Analysis and Life Events stated, 'We produce these figures to help inform decision makers working towards protecting those at risk of dying from drug poisoning (ONS 2019:3). Decision makers like the UK Home Office for example, who in spite of calls from the ACMD for harm reduction measures to reduce the scale of drug related deaths (ACMD 2016), ruled out medically supervised drug consumption clinics stating that, 'there is no legal framework for the provision of Drug Consumption Rooms (DCRs) in the UK and we have no plans to introduce them' (Fortson and McCulloch 2018:5).

The UK accounted for around on third (34%) of the 8,238 overdose deaths in the European Union in 2017, European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2019). In January 2020 the UK left the European Union effectively losing its ability to monitor trends of drug use comparatively, including deaths arising from the increase in strong synthetic opioids such as fentanyl and nitazene-type-drugs, which have become more prevalent in some European countries since 2020.

In its 2019 report on Drug Policy, the House of Commons Health and Social Care Committee echoed the view of the ACMD in 2000 when it stated (on page 3) that every drug death is avoidable and concluded that the increase in drug related deaths was a sign that UK drugs policy is failing. Two years on and the 2021 data from the ONS reported that drug related deaths had reached yet another all-time high and a government commissioned independent review described the UK drug treatment system as 'broken and wanting' (Finch 2021:1). The number of people accessing drug treatment and support continued to fall (Black 2021) while surveys of PWID (UKHSA 2022, 2023) indicates an increase in needle sharing between 2012 and 2021 confirming that PWID remain vulnerable to harm and stigma.

Combating Drugs Partnerships where established under the UK Government's 2021 drug strategy with a view to 'overseeing and monitoring' local progress. At a Ministerial level, the Central Combating Drugs Unit would be responsible for ensuring that ' a range of organisations work together to achieve the ambition for change outlined in the 10-year drug strategy' (HM Government 2022:9). Two years after the government introduced its latest strategy, and with only eighteen months left of the £900 millions of funding to build a 'world-class treatment system, the National Audit Office in its report *Reducing the harm from illegal drugs* stated on page 6, 'that is too early to conclude whether the strategy will reduce the harm from illegal drugs'. The report went on to state on page 37 that, 'the Joint Combating Drugs Unit (JCDU) faces significant challenges in demonstrating progress against some of the strategy outcomes'. Outcomes like the commitment to prevent 1000 drug related deaths by 2024. These 'significant challenges' where made clear when late in December 2023, when the ONS published a delayed report on drug poisoning for England and Wales that revealed there were 4,907 deaths relating to drug poisoning registered in 2022, 1.0% higher than before the *Harm to Hope* strategy was introduced in 2021 and again the highest number registered since records began in 1993.

## 8.10 Conclusion

Following Bacchi (2009) and Bacchi and Goodwin (2016) this research has argued that 'problems' are constituted and given meaning within policy and rejects claims that policy has problem solving capacity. This chapter has discussed a history of responses to injecting drug use within that policy context, from those representing PWID as hopelessly addicted subjects to those that reproduce and reinforce the harm producing policies and practices of neoliberal forms of governmentality. Following a poststructural analysis of policy as discourse, any 'appropriate level policy interventions' that Poulter *et al.* call for would require a re-problematisation of injecting drug use and PWID and a different representation of the 'problem' of drugs. Policy level interventions that leave PWID at 'the centre of the professional gaze' (Sim 1990) will only reinforce the stigmatised and stigmatising subject positions available to PWID through problem representations and the harm producing discursive practices of responsibilisation, criminalisation and pathologisation.

The comprehensive review of drug treatment (Black 2020, 2021) made thirty-two recommendations for improving treatment and reducing harm, calling for a cultural change in the way that drug treatment was delivered. Recommendation eleven called on local authorities to 'commission a full range of evidence-based harm reduction and treatment services to meet the needs of their local populations' (Black 2021:11) yet as the drug charity Transform (2021) have noted, the land mark review ruled out of the terms of reference the 'role of the legal framework in creating, exacerbating or mitigating the harms her reports address' Black's review and the subsequent UK Government strategy *Harm to Hope* avoided any meaningful discussion of safer injecting spaces or heroin assisted treatment, focusing its attention instead on anti-drugs rhetoric and a tough talking approach to combating illegal drugs including disruption to supply chains and criminalising 'so-called recreational use'. In spite of the stigmatising effects and

harms associated with these approaches, the Government claims that *Harm to Hope* is evidence-led and follows the science.

# Chapter Nine

# Covid-19 and the impact on PWID

## 9.1 Introduction

On the 31st December 2019, Authorities in China notified the World Health Organisation (WHO) of an outbreak of pneumonia in Wuhan City, Chan *et al.* (2020). Two days later the Wuhan Institute of Technology isolated the virus from one of the patients and analysed it using highly sensitive Reverse Transcription Polymerase Chain Reaction (RT-PCR) tests (Honigsbaum 2020). Like Sever Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS) which had been the cause of outbreaks in in 2003 and 2012, the virus belonged to the Coronavirus family. However, it was not SARS and it was not MERS. This was a completely new virus and UK health services, including those for PWID were not sufficiently prepared as it spread around the world unchecked (Horton 2020).

Grebely *et al.* (2020) note that the impact of Covid-19 extends beyond that of a novel pathogen and the illness related to it to include a wider consideration of social, cultural, economic, policy and political effects. Moreover, as Vasylyeva *et al.* (2020) point out, the wider impacts of Covid-19 on PWID could include an increase in homelessness, an increase in unsafe injecting and sexual practices and an increase in drug related deaths. Public health messages to 'stay at home' have been associated with an increase in isolation for PWID and have impacting negatively on mental wellbeing. While those who are most socially and economically disadvantaged have experienced a direct impact on sources of income and face significant challenges in adhering to public health guidance (Keston *et al.* 2021).

### 9.2 Pandemic inequalities: Covid-19 and the impact on PWID

Chang *et al.* (2020) remind us that from around March 2020, PWUD regularly experienced difficulties accessing treatment and harm reduction support as many services adopted business continuity practices and staff were redeployed to support Covid-19 response measures. Restrictions on access to NSP services had a deleterious impact on PWID as NSP coverage halved in some areas in the North West of England (Whitfield *et al.* 2020). Whitfield *et al.* (2020) note that for people injecting psychoactive substances, the provision in those areas dropped from 14 needles per person per week during the 4-weeks to the 15$^{th}$ March 2020 to 7 needles per person per week by mid-April.

The effects of public health policy impacted disproportionately on PWID with one study reporting over a third (35%) of PWID finding it more difficult to access support services, 15% reporting injecting more frequently and 26% reporting difficulty in accessing equipment to enable safer injecting (Croxford *et al.* 2021). The impact on services for PWID from public health restrictions was confirmed by testimony provided in this study:

> Injecting equipment is just left in packs for people to collect. With no face-to-face contact anymore, you don't have the same opportunity to engage with people and give information on harm reduction and safer injecting, etc (Sue, AOD treatment professional).

Further barriers to essential harm reduction facilities were reported by Harris *et al.* (2020) who point out that restrictions to sterile water supplies resulted in PWID resorting to using saliva and other unsafe liquids in order to prepare solutions for injection. The importance of ensuring access to sterile supplies of water and other injecting paraphernalia was underlined by testimony from PWID in this study:

> Yeah, getting clean equipment and access to clean water is really important. That's why I was saying they should put water and Vit C in the packs. If you have nowhere to get clean water you're in a lot of danger. Before you could get Vit C

> I've known people using pickling vinegar and you can have a bad reaction to vinegar. I used vinegar once and I had an allergic reaction to it. My throat swelled up and I almost couldn't breathe. Luckily someone was with me (Des, PWID).

May *et al.* (2022:1) note that while public health mitigation measures were introduced to reduce the risks of contracting and transmitting Covid-19 'they disrupted daily routines and access to health and social care' increasing risk and harm in a population already subject to 'socio-structural inequalities, economic disadvantage, housing instability and stigma'.

Lupton (2021) notes that the harm producing effects of material inequalities often become more visible as governments respond to a crisis in health care:

> When health crises such as pandemics are emerging, aspects of societies that might otherwise be taken for granted or hidden, such as entrenched social inequalities and social marginalisation, often come starkly to the fore Lupton 2021:14).

Bambra *et al.* (2021) argue that the emergence of the Covid-19 pandemic needs to be viewed against a backdrop of social and economic inequality. They point out that inequalities in Covid-19 infection and death rates arise as a result of a syndemic in Covid-19:

> The prevalence and severity of the Covid-19 pandemic is magnified because of the pre-existing epidemics of chronic disease, which are themselves socially patterned and associated with the social and commercial factors that shape health (Bambra *et al.* 2021:7).

For Bambra *et al.* (2021) a syndemic exists when multiple risk factors and causes of ill health including; economic insecurity, discrimination and stigma, homelessness isolation and lack of access to health care services, pile up and reinforce each other in ways that make illness from Covid-19 more common and more damaging. Bambra *et al.* (2021) note that the concept of a syndemic was originally derived from understanding the relationship between HIV/AIDS, substance use and violence. Operario *et al.* (2022) note for example how the social and structural determinants of stigma contribute disproportionately to mental health problems and

HIV transmission for men who have sex with men (MSM) and call for full societal inclusion and rights for MSM worldwide. Lupton (2021) notes that the emergence of HIV in the early 1980 produced an assemblage of public attitudes based on representations of 'risk' and deviancy that produced stigmatising and marginalising social harm experienced by groups including sex workers, gay and bisexual men and PWID in a process of 'othering' and moral judgement. Lupton (2021) points out that regardless of how the virus was contracted, people living with HIV would often be judged as outsiders, ostracised and subject to a degree of stigma that would amount to social and symbolic violence (Parkin and Coomber 2009). It could be argued that the way in which drugs and PWID are represented as particular kinds of problems (Bacchi 2018) are part of those processes of othering and moral judgement – processes that re-emerged during the Covid-19 pandemic.

**9.3 Enacting a 'new normal' for PWUD ?**

Reaction to the risks and inequalities exposed by the Covid-19 pandemic gave rise to a number of policy responses from government and the drug treatment sector. Some people receiving medication assisted treatment experienced a relaxation of restrictions over take-home doses and daily supervised consumption requirements were temporarily suspended (Grebely *et al.* 2020, Figgatt *et al.* 2021, Frank, 2021) leading a number of commentators to talk about opportunities for resistance and the construction of a counter hegemony to coercive and punitive responses towards PWUD (Chang *et al.* 2020). Wisse *et al.* (2021) refer to 'seizing the opportunity' to strengthen community involvement and the decriminalisation of PWUD while Delanty (2021:1) notes that 'Capitalism itself was put on hold, or so it seemed for a brief moment'.

Out of step with public health messages to stay at home and physically distance from other people, drug treatment services came under pressure to move face-to-face clinic appointments to online consultations and implement steps to relax the normalised regulatory practice

requirements of daily supervised drug consumption as part of Covid-19 mitigation measures. Drawing on an established body of literature from the field of harm reduction, Grebely *et al.* (2020) point to the concept of risk environment frameworks (Rhodes 2002, 2009) to emphasise how the bio-social and political-economic elements of Covid-19 create conditions that shape risk as well as the capacities and capabilities to respond to it. In this sense health and harm reduction are contingent effects of discourse; of the discursive, subjectification and lived effects of policy and it's representation of the 'problems'. For Grebely et al, improvements in health are experienced as the effect of 'enabling environments' which accentuate health as 'contingent upon social interventions and structural changes':

> Harm reduction becomes a matter of building and sustaining *safer environments*, be these the spaces and places in which drugs are used and acted upon or the settings in which people who use drugs live or find themselves (Grebely *et al.* 2020:2).

For Grebely *et al.* (2020) risk environment and enabling environment frameworks are particularly useful for mapping the effects of Covid-19 and the health of PWID as complex elements in an emerging and adaptive social system. They point out that:

> Research interventions and policy responses are also *adaptive*, that is, they are situated as emergent responses in relation to localised practices in unfolding situations. This is generally what is invoked by 'practice-based' approaches which emphasise science and policy as 'adaptive'. Covid-19 as with novel viral outbreaks and health emergencies more generally, draws attention to, as well as amplifies, a sense of uncertainty, in which 'knowledge' *emerges* iteratively, and through *negotiation*, in which systems *adapt* accordingly (Grebely *et al.* 2020:2).

Frank (2021) reminds us of the difficulties experienced by many PWUD due to the strict regulations imposed by drug treatment services and the requirements on people to attend crowded clinical spaces on a regular basis. Spaces that would clearly constitute a risk environment for Covid-19 transmission. Frank points out that where PWUD have benefited from extended periods of take-home doses and the suspension of daily supervised consumption,

they will not want to return to pre-Covid restrictions and warns that ‘forcing them to do so would almost certainly lead to increased drop-outs’ (Frank 2021:1).

On the 1st April 2020, then Home Secretary Priti Patel, wrote to the ACMD seeking advice on the risks and harms associated with proposed changes in legislation ‘enabling registered pharmacies to supply controlled drugs without a prescription where the patient has been receiving those controlled drugs as part on on-going treatment’ (ACMD 2020:1). Further measures would include ‘enabling pharmacists to vary the frequency of dispensing of an instalment’ (ibid) removing potential barriers to supply and increasing the quantities of take-home prescription drugs available during a pandemic. While the Advisory Council broadly supported proposals to amend the Misuse of Drugs Act 1971 they cautioned that any amendment should be time-limited and withdrawn as a matter of urgency once the measure was no longer necessary, in other words once the restrictions on face-to-face contacts and mixing in public environments were no longer required as a means of containing the spread of infection.

As Strang (2015) notes, supervised dosing of opioid agonist progressively became routine practice following recommendation set out in the Department of Health Task Force Report in 1996 as part of a concerted effort to reduce drug related deaths and was confirmed as a policy recommendation by the ACMD in their 2000 report *Reducing drug related deaths*. The report stated that:

> In our view the normal practice should be for methadone to be taken under daily supervision for at least 6-months and sometimes longer. The bigger the dose of methadone being prescribed; the greater will be the need for supervision (ACMD 2000:65).

Strang (2015:2) suggests that ‘the introduction of supervision saved an estimated 2,500 lives in England between 2001 and 2008’ and believes that:

> the decision made by policy makers in the 1990s to introduce supervised treatment has proved itself to be the right judgement call. As a result, we now have much safer methadone treatment programmes (Strang 2015:2).

Strang *et al.* have argued that while methadone maintenance treatment significantly reduces mortality among PWUD entering treatment, 'misuse, unsanctioned co-administration, and poorly compliant intake are all associated with risk of death from overdose' (Strang *et al.* 2010:6). This analysis typifies the disciplinary nature of drug treatment outlined in chapter six and the ways in which PWID are governed through professional discourses, discussed in chapter seven. Importantly here from a WPR perspective is that the 'problem' of overdose death is represented as unsupervised dosing of opioid agonist treatment. Moreover, the effects of this particular problematisation, or problem representation, are to increase the perceptions of risk associated with OAT and shift responsibility of that risk onto the individual. The argument here is that discourses of risk act as technologies of neoliberal governmentalism promoting messages of the 'responsible self':

> We believe that the message that drug users have a personal responsibility to avoid overdose and virus infection or risking the lives of their partners or friends, would be a useful corrective to the assumption that they are incapable of exercising responsibility. The message of self-responsibility would, in our view, be empowering (ACMD 2000:99).

However, as noted by Chang *et al.* (2020) and Wisse *et al.* (2021) above, the more empowering option for PWID during the Covid-19 pandemic was a relaxation of restrictions to take-home doses and the requirements for daily supervised consumption, an assertion supported by testimony from this research:

> Removing the requirements for daily supervised consumption and extending the offer of take-home doses has been generally welcomed by people using the services and it has not resulted in an increase in deaths that some people warned it would. Most of my clients have remained stable. In fact, the only concerns that I am aware of are from pharmacies who have said it's affecting their income (Jack, AOD treatment professional).

In the last chapter Fraser (2004) discussed how PWID have been situated at the centre of a hepatitis C crisis and responsibilised for the majority of community infection. Fraser (2004) reminds us that practices which target individual behaviour create a discursive space where PWID are responsible for their wellbeing and the health of others, but also culpable for misfortune, illness and outbreaks of community infection. While not denying its material exist, poststructural analysis looks beyond a realist account of risk to create a better understanding of meaning and the processes by which discursive practices 'turn' structural inequality into individual responsibility. As noted in chapter seven, the notion of a risk environment provides an opportunity to reorientate risk away from individual responsibility towards an understanding of the social and structural determinants of health opening up a useful discussion for a poststructural analysis is which 'discourses of risk are forms of normative regulation' (Rhodes 2009:199).

In a comprehensive review of forty studies (Adams *et al.* 2023) have suggested an association between take-home doses of OAT and increased retention in treatment. Their review found no evidence of an association between take-home doses and illicit substance use or any increase in overdose deaths. Moreover, 'qualitative findings indicated that take-home doses reduced clients exposure to unregulated substances and stigma and minimised work/treatment conflicts' (Adams *et al.* 2023:1). In spite of a body of evidence supporting the social as well as clinical beneficial effects of take-home doses and relaxed daily supervised drug consumption, in October 2023 the UK Government's updated guidance for drug treatment services, *Substance misuse: providing remote and in-person interventions* stated that:

> You should assess the need for supervised consumption of medication at the start of treatment and regularly after that through in-person appointments and drug testing. The orange book [UK Clinical Guidelines] recommends that, in most cases, service users will need supervision for a 'period of time to allow monitoring of progress and on-going risk assessment'. Most people can have supervision relaxed when they can show that they are sticking to their treatment plan and are

> not using other drugs, and if their home environment is suitable for safe storage of medicines (OHID 2023:7).

The optimism of the dawn of a 'new normal' for PWUD appeared to evaporate as practices re-asserted by governmental order. PWID were still, in terms of policy and policy responses represented as 'problem' – a 'problem' to be contained, regulated and 'rehabilitated'.

### 9.4 Responsibilising Covid-19 deaths

Foucauldian theories of governmentality, biopower, and biopolitics discussed in chapters six and seven 'seek to surface the complex relations of power that are inherent in social responses to disease' (Lupton 2021:14). As discussed in chapter seven, for Lupton (2013) risk can be understood as a governmental strategy of regulatory power by which individuals and populations are managed through the responsibilised goals of neoliberalism. Peterson and Lupton (1996) remind us that public health discourses of risk are premised on the expectation that individuals will govern their own risk-taking practices:

> Managing their own relationship to risk has become an important means by which individuals can express their ethical selves and fulfil their responsibilities and obligations as 'good citizens' (Peterson and Lupton 1996:65).

Lupton *et al.* (2021) note how medical and public health discourses on risk started to focus on the role of the face mask in protecting others from the potentially Covid-19 infected wearer. For Lupton *et al.* (2021) wearing face masks demonstrated 'altruism and solidarity'. Crucially here, following a WPR approach there is a need to identify the knowledge practices (discourses) that give meaning to risk and how notions of risk are represented as the 'problem' in particular circumstances and contexts.

> Risk is a way, or rather a set of different ways, of ordering reality, or rendering it into a calculatable form. It is a way of representing events in a certain form so they might be made governable in particular ways, with particular techniques and for particular goals (Dean 2010:206).

Bacchi (2022) reminds us of how regulation also takes place through discourses of risk and risk technologies and draws our attention to the governing effects, including lived and subjectification effects of 'risk categories'. Bacchi (2022) notes how the notion of 'underlying health condition' emerged as a subject position and 'risk category' for 'vulnerable populations', and as an explanation of excessive deaths.

> As the death toll rose, it became important to offer plausible explanations for this rise that did not draw attention to poor pandemic management practice or Covid-19 itself, as these deaths could be anticipated. 'Underlying health conditions' proved to be a useful public health intervention in this regard (Bacchi 2022:9).

By December 2023 there were 233,791 deaths registered in the UK with Covid-19 mentioned on the death certificate as 'one of the causes' (Gov.UK 2023). By the time Government imposed the third National 'lockdown' on 6th January 2021, the shift towards individual responsibility for Covid-19 infections and subsequent deaths had already started with an intensified focus on and reporting of 'lockdown rule breakers'. Sim and Tombs (2022:80) remind us that in what amounted to a 'class-based criminalisation strategy, over 85,000 Fixed Penalty Notices had been issued against individuals who had allegedly broken Covid laws'. They note that according to Harriet Harman, the Chair of Parliament's Joint Committee on Human Rights:

> We've got an unfair system with clear evidence that young people, those from certain ethnic minority backgrounds, men and the most socially deprived are most at risk. Whether people feel the FPN is deserved or not, those who can afford it are likely to pay a penalty to avoid criminality. Those who can't afford to pay face a criminal record along with all the resulting consequences for their future development. The whole process disproportionately hits the less well-off and criminalises the poor over the better off (UK Parliament 2021, cited in Sim and Tombs 2022:80).

Sim and Tombs (2022) point out that non-compliance with 'lockdown' rules was crucial in shifting the political and public gaze away from questions of structural inequality and deprivation to a focus on the individual and failings in morally responsible behaviour.

### 9.5 'Lockdown' and the production of social harm

Green (2021) points out, that for all the talk of unprecedented times surrounding the Covid-19 pandemic, there is nothing unprecedented about pandemics. As noted above, HIV was not the first virus to cause global infection and neither was Covid-19 the first outbreak of a respiratory virus to spread around the world in pandemic proportions. For Green (2021) the unprecedented nature of Covid-19 related almost entirely to government responses to it. Responses such as a series of 'lockdowns' introduced by the UK Government from March 2020 and which it could be argued impacted mostly detrimentally to certain sections of society including PWID.

The language of 'lockdown' as Sim and Tombs (2022) have pointed out conceals a significant degree of variation in terms of its application and effects and the subject positions (Bacchi and Goodwin 2016) that 'lockdown' and Covid-19 make available. In contrast to government rhetoric claiming a precedence for 'lockdown' to 'Save the NHS', Sim and Tombs (2022) draw our attention to the essentially political economic priorities of suppression policy:

> Lockdown involved some businesses – most notably hospitality and leisure, and personal services – being closed by law, with workers and business owners receiving varying levels of Government subsidy to do so – albeit millions were either entirely excluded from or inadequately supported by this. Where work was deemed as 'essential', this had to continue – but which were subject to the various guidelines (which for the most part were not enforced). This meant that the most vulnerable, marginalised and lowest paid workers were those who continued to work through the pandemic: health, social care, emergency services, transport, retail including 'click and collect' services, food supply, cleaners, postal workers, refuse construction, call centre, security, factories, nursery and some school teachers, and many more occupations. Nurseries and schools were crucial to other parts of the economy operating (Sim and Tombs 2022:74).

The Government's insistence on following the science was brought into question when on the 8th July 2020, as part of his 'plan for jobs', then Chancellor, Rishi Sunak announced a package of financial incentives to encourage the public to re-engage with the hospitality sector. Adams (2023) notes that Sunak had already dished out £176 billion in furlough payments, 'bounce-

back' loans and deferred taxes. The headline act of Sunak's summer 2020 budget was his 'restriction busting' policy 'eat out to help out'. At a further cost to taxpayers of £849 million, eat out to help out provided 160 million cut price meals to individuals across 78,116 different outlets (HM Revenue and Customs 2022). As Stevens (2020) has pointed out, ministers get advice through a complex network of scientific advisory committees. To rely on science as the determining influence on policy is to misunderstand what science is or how problems are constituted within policy (Bacchi and Goodwin 2016).

Following Bacchi and Goodwin's (2016) WPR approach it is clear to see how the 'problem' of lockdown is represented in Sunak's eat out to help out policy. In a discourse that produced a false dichotomy between the economy and public health (Horton 2020) the health of economy was the priority. For Giroux (2020) the Covid-19 pandemic 'pulled back the curtains' to reveal the power of neoliberalism its intimate relationship with global financial markets and its ridged belief that individual responsibility is the only way to address social problems.

A report by the Centre for Economic Performance González-Pampillón *et al.* (2021) suggests that the policy failed to encourage people to eat out once the discounts had ended, did little to protect jobs and that any minimal economic gains came at the cost of more infections. One study, Fetzer (2020) suggested that the eat out to help out scheme could have been responsible for around 8 – 17% of all Covid-19 infections during the summer of 2020 and that many more non-detected asymptomatic infections were likely, significantly accelerating a second wave of the pandemic and a further lockdown.

It is difficult to determine with accuracy the effect that eat out to help out had on infection rates. Intersecting social practices and the demands on essential workers to travel would need to be factored in to any calculations. However, as a policy response, eat to help out was at the very least confusing and as Sim and Tombs (2022) point out, contradicted public health

messages to 'Stay Home, Protect the NHS, Save Lives'. Whatever science the Government was following, it wasn't one that the Chief Medical Officer or Government Chief Scientific Advisors claimed they recognised or had even been informed of (Kirby 2023). Walker (2023) notes that John Edmunds, Professor of infectious disease modelling at the London School of Hygiene and Tropical Medicine and scientific advisor to the Johnson Government, told the Covid-19 public inquiry that it:

> Made me very angry, and I'm still angry about it. It was one thing taking our foot off the brake, which is what we'd been doing by easing the restrictions, but to put your foot on the accelerator seemed to me to be perverse. And to spend public money to do that – 45,000 people had just died (Walker 2023 cited in the Guardian 19th October).

Walker (2023) goes to note that Edmunds refers to the scheme as 'prompting the public to take more risks – the optics of it were terrible' while it also emerged that Professor Chris Whitty, Chief Medical Officer, referred to the scheme as 'eat out to help the virus out' and Professor Dame Angela McLean, chief scientific advisor to the Ministry of Defence at the time, had dubbed the Chancellor Sunak 'Dr Death' (Adams 2023).

Briggs *et al.* (2021) remind us that through the lens of a social harm perspective such as those offered by Hillyard *et al.* (2004) and Pemberton (2016) harm, as well as being associated with illegal activity, can be understood as the product of entirely legal activities. Pemberton (2016) for example aligns much social harm with the resurgence of neoliberalism and the erosion of the 'social state'. For Pemberton (2016) harm producing policies are often associated with restructuring the logic of neoliberalism and the governmental practices of responsibilisation. Previous chapters have discussed for example the impact of discursive practices of drug treatment in responsibilising PWID through the governmental constructions of risk.

### 9.6 Covid-19 PWID and governmentality

In April 2020, the UK Government published *Covid-19: guidance for commissioners and providers of services for people who use drugs or alcohol* stating that 'coronavirus (Covid-19) will have specific implications for people experiencing homelessness and rough sleeping, many of whom may also be using drugs or alcohol' and announced that:

> There is a significant work programme underway across government and NHS England to support areas to identify appropriate accommodation and wraparound health services that will enable this group to follow social distancing advice and self-isolate if needed (Gov.UK 2020:6).

The significant work programme that the guidance referred to was the Government's *Rough Sleeping Strategy* published in 2018 that 'committed to end rough sleeping by the end of this parliament (2024)' (Cromarty 2021:8). As Cromarty (2021) points out, a full review of measures to reduce rough sleeping announced in February 2020 as part of the Government strategy was delayed as efforts were pivoted towards pandemic response.

Announcing £3.2 million in emergency funding for local authorities to support rough sleepers during the Covid-19 outbreak the Government reminded us that rough sleepers are vulnerable to coronavirus (Covid-19) and 'more likely to have underlying health conditions' and 'face difficulties in following public health advice on self-isolation, social distancing and hygiene' (Cromarty 2021:8). Robert Jenrick M.P, then Communities Secretary, stated that:

> Public safety and protecting the most vulnerable people in society from coronavirus is this government's top priority. We are working closely with councils and charities to ensure they have the support they need throughout this period. The initial funding that I've announced today will ensure councils are able to put emergency measures in place to help some of the most vulnerable people in our society to successfully self-isolate (Cited in Cromarty 2021:9).

Cromarty notes that:

> On the 26th March 2020 local authorities and homeless charities received an email from Dame Louise (now Baroness) Casey, who was appointed to spearhead the Government's response to rough sleeping, calling on them to ensure rough sleepers were "inside and safe" by the weekend (Cromarty 2021:9).

Again, the move favoured the economic interests of business as empty hotel rooms left vacant by the pandemic restrictions, were commissioned by local authorities to accommodate vulnerable rough sleepers. The notion of 'underlying health condition' surfaced once more in discursive practices both as a calculatable risk factor used to explain excessive deaths and as a way of drawing attention to the risks associated with certain 'people categories' and their role in transmitting infection. As Lupton (2022:63) reminds us, public health responses to infectious and other diseases rely on 'identifying risk behaviours and risky places as well as the social groups who are most vulnerable to contracting and spreading disease'. In this sense the public health discourses of 'at risk groups' used to describe PWID as vulnerable to HIV infection now also applied to Covid-19, while discourses of 'underlying health conditions' play an important role in regulating and governing the conduct of conduct.

**9.7 State talk: Constructing a consensus around Covid-19, the notion of an underlying health condition and technologies of the self**

Sim and Tombs (2022) draw our attention to how, in its attempt to construct a consensus around Covid-19, 'the State never stops talking to us'. Through the operation of what Sim and Tombs (2022) refer to as 'State talk' and 'Silencing' the State builds political and cultural hegemony. They remind us that:

> Persistent and continuous 'talking' has been, and remains, central to the operationalisation of state power – socially constructing, as it does, the discursive parameters through which social issues are defined, discussed, disseminated and responded to (Sim and Tombs 2022:70).

As Giroux (2020) points out, the Covid-19 pandemic was more than a medical crisis. It was a political and ideological crisis. A crisis with its origins rooted in the debris of years of neglect by neoliberal governments defunding welfare services and public health systems. In short, a crisis of hegemony. A crisis that has seen public health responses reduced to a series of implausible claims to be following the 'science' while legitimising government incompetence (Sim and Tombs 2023) and the shifting of responsibility away from structural inequality and an obsession with 'getting Brexit done' to 'risk', underlying health conditions and what Foucault refers to as technologies of the self. Rose (1998) has described technologies of the self as 'self-steering mechanisms' of the means by which individuals experience, understand, judge and conduct themselves:

> They are always practiced under the actual or imagined authority of some system of truth and of some authoritative individual, whether this be theological and priestly, psychological and therapeutic, or disciplinary and tutelary (Rose 1998:29).

On the 19th March 2020, the Advisory Committee of Dangerous Pathogens downgraded the risk status of Covid-19 from 'high consequence infectious diseases' (Scally *et al.* 2020). The decision, as Stevens (2020) points out, was not based on any scientific knowledge of Covid-19 being less consequential, but because the UK was running out of personal protective equipment (PPE). While the multiple effects of inequality and stigma stacked up around PWID and the intensified focus on 'lockdown rule breakers' disproportionately impacted the less well-off, 'the disease had to be downgraded for ministers to escape a legal responsibility to provide high-grade PPE' (Stevens 2020:1). The Covid-19 pandemic would continue to reveal the negative impact of inequality on health and well-being and expose deep-seated flaws in the welfare system.

PWID interviewed as part of this study generally experienced official responses to the Covid-19 pandemic as negative. Harm producing policy responses that increased isolation, disrupted access to trusted drug suppliers and create barriers in accessing essential harm reduction equipment. Relaxation of daily supervised consumption requirements and extended take-home prescriptions where viewed with a degree of cynicism while the offer of emergency hostel or hotel accommodation was only ever seen as temporary and viewed by some as a convenient source of income for hotel owners who had empty rooms  throughout lockdown periods.

> Being stuck at home and not being able to carry on with your day-to-day life is constraining on injecting drug use. I think that's probably true across the patch. People who have managed to secure their own supply are probably still using but with more of an eye on where their next hit is coming from (Donna, PWID).

> I was on supervised consumption for about ten years and they wouldn't take me off it because they kept saying that I needed to provide a 'clean test', then they would take me off it. When we went into 'lockdown' I was just allowed to take it all away unsupervised. Then, when we started coming out of 'lockdown', our prescriber started putting everyone back on supervised consumption – people are not happy (Keith, PWID).

> I suspect that all the people living in hotels throughout 'lockdown' will be moved out once it's over. It's not really dealing with homelessness (Giles, PWID).

In spite of increasing levels of hardship and harm experienced by PWID, for others, the Covid-19 pandemic proved to be an economic bonanza. Wealth producing opportunities enabled by a 'trickle up' capitalist economy ensured large profits for the already rich and affluent. Lansley (2022:251) reminds us that 'vast sums of public money, bypassing usual tendering and procurement arrangements, poured into large private companies and consultancy firms to help manage the state's response' to the pandemic, many with no experience or track-record in this area. The Department of Health and Social Care Public Accounts Committee (2022) note that the Government spent £12 billion on PPE, mostly at grossly over inflated costs, moreover, £4 billion of which was not fit for purpose and would have to be destroyed. Further 'damning

reports' by the Public Accounts Committee are noted by Mahase (2021) where they refer on page 1 to the £37 billion Government flag ship test and trace programme as 'one of the most expensive health programmes delivered during the pandemic, equal to nearly 20% of the entire 2020 – 21 NHS England budget'. Mahase notes that when questioned over the effectiveness of the system, MPs told the Committee that:

> Its outcomes are muddled and a number of its professed aims have been overstated or not achieved (Mahase 2021:1).

Mahase (2021) goes on to note that an earlier report from the Committee found that NHS test and trace could not show it had made a difference to the pandemic. In other words, it didn't work.

Importantly, while the system was referred to as NHS test and trace, it was run by two private companies, Serco and Sitel (Mahase 2021) underlying, as noted by Giroux (2020) earlier, the power of neoliberalism, its intimate relationship with private finance and its ridged belief in individual responsibility. Reducing the number of Covid-19 related deaths would require a responsibilised neoliberal health seeking citizen fully engaged with the public health promoting messages of risk management and self-regulating practices to reduce underlying health conditions.

**9.8 Conclusion**

For PWID the Covid-19 pandemic, like HIV before it, drew attention to the uncertainty of risk and the need to govern, regulate and contain it. In policy responses and guidance PWID were represented as a 'problem', a vulnerable population with underlying health concerns, a population at risk from Covid-19. Yet again, like HIV and Hepatitis C policy responses and guidance, PWID were represented as a 'problem' of risk for Covid-19. A risk to the public

health through unregulated behaviours and injecting practices. A risk that required governmental technologies to manage the conduct of conduct.

The illusion of relaxation of the authoritarian and repressive imperatives of contemporary drug policy fades into the shadows of wishful thinking as the narrative of the 2021 UK drug strategy representing drug use, PWUD and particularly PWID, as the ‘problem’ causing the ills of society, effectively forecloses discussion. Harm reduction interventions become part of those self-governing, self-regulating technologies of the self, situated within a determining context that equates drugs and drug use with crime, social disorder and the exploitation of young people. Once the perceived threat of Covid-19 had passed the rapid introduction of apparently liberal and relaxed treatment measures were withdrawn as rapidly as they were enacted.

# Chapter Ten

# Critical Reflections: Considering contributions to knowledge through self-problematisations

## 10.1 Introduction

This thesis presents an analysis of drug policy over the past decade – and analysis of particular problematisations, their representations of drug 'problems' and their effects on the lives of people who use drugs. Beyond that however it is also an exercise in self-problematisation, a reflection on over thirty-five years of involvement with drug treatment and harm reduction services, a reflection on how that involvement and the experience of personal illicit drug use has shaped beliefs, thoughts and values as well as the taken-for-granted assumptions embedded within the conceptual logics of that time and space.

A key premise of poststructural critique is that as researchers 'we are inside the processes that we are examining' (Eveline and Bacchi 2010:154). Eveline and Bacchi (2010) draw our attention to Law (1994) who notes that the principle of reflexivity reminds us that researchers need to recognise that a relationship exists between our own assumptions and the presumptive statements that we critique:

> There is no reason to suppose we are different from those we study. We too are products. If we make pools of sense or order, then these too are local and recursive effects … our own ordering is a verb. It reminds us that (sense making) is precarious … incomplete … that much escapes us (Law 1994 cited in Eveline and Bacchi 2010:154).

Law (1994:17) notes that researchers engaged in the study of ordering need to be consistent by asking 'how they came to (try to) order in the way they did'. For Law, critical enquiry, 'whatever else it may be, is surely one that accepts uncertainty, one that tries to open itself to

the mystery of other orderings' (Law 1994:18). As Harvey (1990:196) also reminds us 'critical social research is critical because it aims to shatter the illusion of observed reality'.

The WPR approach employed here rejects the claim that knowledge is value-free or value neutral. For Foucault, knowledge is intimately connected to the productive processes of power and the establishment of 'truths'. Foucault uses the term discursive practices to focus on the practices of knowledge and the work that they do. In other words, power is exercised through knowledge – through discourses.

If, as poststructuralism asserts, there is no 'outside' of discourse, no outside of the power/knowledge practices, or the organising ability of discursive practices to shape 'truths' and 'realities', critical research requires a method, a technique, for researchers to identify their own position within those power/knowledge relations and a way to recognise their role and effect in constructing alternative statements of knowledge. Kendall and Wickham (1999) for example remind us that critiques of the 'scientific method' that attempt to falsify knowledge based on assertions of it being socially constructed need to be mindful that the position from which alternative knowledge comes from is also socially constructed. They refer to reflexivity as a means of critically examining one's own assumptions and knowledge claims. Lancaster (2014) for example argues that claims to an 'evidence-based' drug policy are constructed within a framework that privileges certain knowledge claims (or discourses) while silencing alternative discourses and perspectives. Similarly, Lancaster and Rhodes (2020:135) draw our attention to the usefulness of 'making visible the politics of evidence making practices and interventions' rather than 'setting matters of concern aside as troublesome barriers to evidence-based decision making'. Critically here, as Lancaster (2014:949) points out, problematising the construction of evidence making 'challenges the dominant evidence-based paradigm which positions researchers as depoliticised producers of policy relevant knowledge'.

As discussed throughout this research, the turn from problem-solving to problem questioning (Bacchi 2009) challenges the deep-seated presuppositions in evidence-based approaches that problems sit outside of the political process and are 'out there to be solved'. Bacchi and Goodwin (2016) remind us that knowledge made in research is a political act. Bacchi (2009:253) argues that 'by producing knowledge for pre-set questions, researchers become implicated in particular modes of governance'. For Bacchi (2009:253) a WPR approach aims to create space to 'interrogate and challenge representations of problems that have deleterious consequences'.

> The most challenging dimension of the dilemma facing researchers who wish to make such a critical intervention is devising some way to check or examine their own premises – to make us hesitate about our own conditions of thought. To reflect on this issue, I turn to self-problematisation (Bacchi 2021:3).

**10.2 Self-problematisation**

Bacchi (2018a:2) asserts that self-problematisation, as developed in the WPR approach, 'institutes a practice of the self' it involves an 'active practice of critical self-problematisation' (Bacchi 2018b:2) an undertaking that distinguishes it from reflexivity and a recommendation to '(somehow) become reflexive'. For Bacchi (2009) and Bacchi and Goodwin (2016) self-problematisation is important because as researchers we are immersed in the conceptual logics of our time and, in part, who we are is shaped through the problem representations that we are to analyse. The goal, as Bacchi (2021:3) points out, 'is to assist in alerting researchers to the extent to which their own worldviews shape their analysis'. For example, the extent to which analysis in this research could be influenced by the researcher's assumptions and presuppositions following over thirty-five years working in harm reduction services and public health and having personal experience of illicit drug use.

> As researchers, we have work to do in ensuring that we do not simply buy into certain problem representations without reflecting on their origins, purpose and effects (Bacchi 2009:19).

A WPR approach builds self-problematisation into the analysis by 'directing researchers to apply the set of questions in the approach to their own problematisations and the problem representations they contain' (Bacchi 2009:45). Bacchi and Goodwin (2016) note that in practical terms, it is not necessary to subject every problem representation to each and every question. Questions can be applied selectively. For Bacchi and Goodwin (2016) the crucial task of reflexivity in a WPR approach is for researchers to maintain a 'self-problematising ethic' subjecting their own thinking to critical scrutiny in a way that reveals the extent to which they might be 'operating with assumed, unquestioned knowledges or within specific governmental rationalities that may in the researchers judgment, have deleterious consequences' (Bacchi and Goodwin 2016).

During the mid-1980s, the research and author worked with the team that established the first NSP in Merseyside and developed the self-styled 'Mersey Model' of harm reduction. Harm reduction approaches, as discussed in previous chapters, were developed in Merseyside and elsewhere, in response to growing public health concerns relating to injecting drugs and the potential for transmission of HIV from PWID to the general non-drug using population. Public health policy (Ashton and Seymore 2010) like that of the Government's Advisory body (ACMD 1988) was to reduce the potential transmission of HIV from PWID by cessation of injecting practices followed by abstinence from illicit substances. This would be achieved through a 'hierarchy of goals' and an approach to making and maintaining contact with PWID by 'all available means' (ACMD 1988:17). The distinctiveness of the 'Mersey Model' was its partial rejection of the hierarchy of goals placing an emphasis on 'risk minimisation' rather than drug use reduction. A number of those involved in the delivery of harm reduction interventions had

personal experience of drug use and were able to effectively engage PWID in NSP and other practical harm reducing interventions for example instruction on safer injecting techniques and access to prescriptions for injectable drug treatments. The ‘Mersey Model’ of harm reduction provided a credible alternative to abstinence-based models of drug treatment and following the publication of the ground breaking article High Time for Harm Reduction (Newconbe 1987) the Mersey Model gained both National and International acclaim. Staff at the Liverpool-based Maryland Centre, the hub of the ‘Mersey Model’ project (including the researcher and author of this thesis) were committed to the principles of liberal prescribing and safer injection options. The provision of adequate supplies of sterile injecting equipment was key to the project’s success and staff at the Maryland Centre pioneered models of NSP outreach, mobile NSP and peer-based secondary NSP supplies as early as 1988.

Prior to joining the team at the Liverpool-based Maryland Centre, the researcher and author of this thesis had graduated from Lancaster University with a degree in critical sociology and a keen appreciation of Foucauldian concepts of surveillance and governmentality. It was from these early academic readings that suspicions were first aroused over the degree of surveillance that PWID were being subject to through the ever-increasing public health gaze – a suspicion that would in the passage of time see the early principles of the ‘Mersey Model’ be problematised, deleted or subsumed within a neoliberal governmental drug treatment system. That suspicion combined with a thirst for critical thinking and analysis brought about the idea for this project – a project that has been six years in its completion and over thirty-five in its making. A project that has developed to challenge both personally and collectively held beliefs about drug treatment and harm reduction as an understanding of academic literature and vocabulary has grown and a project that has demonstrated the importance of critical self-reflection or self-problematisation.

As noted in chapter four, self-problematisation was maintained throughout this research in a number of ways; through adopting a sceptical approach towards taken-for-granted truths and how ‘problems’ are represented in policy, extending this scepticism towards professional discourses and practices, and avoiding making value judgments. Moreover, an awareness of self was maintained throughout the research through adopting an approach to critical theoretical thinking that reduced possibilities for personal interpretation. In this sense, thinking is informed by theory rather than opinion while a sceptical approach to assumptions outlined above enabled avoidance of conviction to constructed ‘truths’. Here, any personal views and experiences, professional or otherwise, were problematised with the same degree of scrutiny as any other ‘knowledge statements’ or ‘problem representation. In this sense, the WPR questions are embedded in your own critical thinking and considered with every thought process, imagination, proposal and reflection. Adopting a self-problematising ethic through this research has thrown up challenges to numerous previously held assumptions and illuminated the possibilities of alternative problem representations throughout the analysis. These have been both personally and professionally challenging but have been illuminating and transformative in their outcomes.

Following WPR approach the point of self-problematisation is not to avoid influencing the research process but recognising and accounting for when and where it takes place. For example, this research proceeded from the outset with certain assumptions based on the researcher and authors own experiences – namely that drug use was not essentially driven by individual pathology and could be experienced as pleasurable and beneficial; that it was possible to moderate drug usage and abstain voluntarily when the personal circumstances required it and that the notion of addiction was socially constructed without any identifiable biological basis. Moreover, controlled drug use with harm reduction was not only possible but was a policy option preferable to any programme of enforced abstention or criminalising

process. These personal problematisations have, through the process of self-problematisation and re-problematisation, have been conceptualised as different problem representation throughout the course of this research. While a belief in the social construction of addiction still pertains, the unmasking of the effects of certain problematisations – the harm producing effects of drug policy representations and the responsibilising and governmentality potential of harm reduction interventions have been both enlightening and transformative resulting in a re-evaluation and re-positioning of many long-held beliefs and what might well turn out to be constructed 'truths'.

**10.3 Reflections on drug policy**

This research has argued that policy is a discursive practice, not reflected by language but developed within language (Elevine and Bacchi 2010). The research argues that policies give meaning to problems and play a significant role in the processes of subjectification by making particular subject positions available through the representation of problems as particular kinds of problems Bacchi and Goodwin (2016). It highlights the processes by which drug 'problems' are constituted within drug policy, how they are given meaning as particular kinds of problems and reproduced through discursive practices. Through constructed forms of knowledge that is created through the productive processes of power relations and reproduced through professional practices and discourses. Eveline and Bacchi (2010:156) remind us that for Foucault knowledge is more than just technical know-how, it encompasses the 'social, historical and political conditions under which statements come to be seen as true or false'. The conditions that produce social reality. However, as Bacchi and Goodwin (2016:25) point out, Foucault influenced forms of poststructural analysis such as WPR have been questioned in terms of their usefulness, leaving analysis 'mired in a field of competing interpretations with no precise recommendations on ways forward'. In contrast to what he refers to as the 'radical

constructionism' of poststructuralism, Stevens (2024:37) proposes a theoretical framework for understanding the mechanisms that 'generate the actual actions and events that occur in policy making' and calls for a way to 'distinguish between knowledge claims that are based on power and morality from those that have an adequate relationship to reality':

> At some point we need to go beyond self-problematisation and make claims about the world that can be accepted by other people for sound reasons. We cannot expect all of those people – and especially those that have to make policy decisions – to be satisfied with a continual critique of categories and concepts (Stevens 2023:6).

Following a Habermasian conception of power, Stevens (2024:37) argues that:

> Power to affect policy is produced through the actions of people who come together in constellations to which they bring pre-existing resources, capacities and commitments, which are shaped by existing social and cultural hierarchies and cleavages.

For Stevens (2024), the concept of a policy constellation is consistent with a critical realist position, illuminating the generative processes that cause social reality while acknowledging the role that observers play in constructing that reality. Stevens (2020) asserts that in the absence of solid conclusions, poststructural analysis produces a 'flat ontology' where all entities are treated alike.

Lively theoretical debate on the ontological politics of drug policy has been rehearsed elsewhere, Stevens (2020), valentine and Seear (2020), Lancaster and Rhodes (2020), Howarth *et al.* (2021), Bacchi (2021) and there is no reason to revisit that debate in detail here, other than to note, that as Bacchi (2023) reminds us, a WPR approach encourages a way of thinking that challenges realist assumptions and premises. Moreover, the 'actual actions and events that occur in policy making are less of a concern for a WPR approach than the effects of policy representations; the discursive, subjectification and the lived effects that they produce. As

Bacchi and Goodwin (2016:6) remind us, following Mol (1999) 'lived realities are created by, rather than reflected in, social practices, including policy and research practices'.

Engaging with critical reflection through the lens of self-problematisation (applying step seven) it is useful to return to the overarching question in this research, **in what ways have particular problematisations of drugs and their effects since 2010 affected people who use them, with particular reference to people who inject drugs**, the ways in which 'risk' had previously been problematised and understood, and to revisit some of the analytic questions posed by a WPR approach that influenced and shaped analytic thinking here. Question one asked what is the problem represented to be in specific policy while question two asked what deep-seated assumptions underly this representation of the problem? Question three considers the genealogy of the policy representation, asking how the particular representation of the 'problem' came about while question four invites the researcher to think about what is left unproblematic in the particular 'problem representation', explore and reveal where silences exist and consider ways in which the 'problem' can be conceptualised differently (Bacchi and Goodwin 2016:20).

This research draws attention to ways in which particular problematisation of drugs situate PWID as being both vulnerable to 'risk' and the source of 'risk' to others. Conceptualisations that leave the notion of 'risk' as unproblematic. As discussed in chapter seven, Lupton (2013) reminds us that designating the label 'at risk' confirms the status of an individual or social group as powerless, marginalised and vulnerable. Lupton (2013:116) has argued that risk can 'be understood as a governmental strategy of regulatory power by which populations and individuals are monitored and managed through the goals of neoliberalism'. Lupton notes how:

> The 'at risk' label tends either to position members of these social groups as particularly vulnerable, passive, powerless or weak, or as particularly dangerous to themselves or others. In both cases, special attention is directed to these social groups, positioning them in a network of surveillance, monitoring and intervention (Lupton 2013:156).

Through the lens of a WPR approach, constellations of risk or risk assemblages that are constituted in and through surveillance technologies and professional practices become key justifications in the discursive practices that impose restrictions and regulations on PWID through a rationale of normalising harm reduction policies. Practices of 'risk thinking' (Rose 1999) and risk management heighten perceptions of dangerousness and threat and are often the starting point for harm reduction strategies and interventions.

Using critical realist thinking to explain increases in the drug overdose deaths for example, Stevens (2020) argues that different forms of analysis cannot change the amount of a drug consumed or bring back the dead. A poststructural discourse analysis would not disagree. However, his argument does raise an opportunity to further problematise problematisations, or problem representations relating to drug related deaths. In their seminal text, Fraser and Moore (2011:4) ask 'are social constructionist views going too far in emphasising the role of discourse in the production of reality?'. As previously noted, they ask:

> Who would want to dismiss, for example, a fatal overdose as merely a discursive construction, as if a change in ways of talking and thinking about it would alter it or instantly prevent it from happening (Fraser and Moore 2011:4).

Following Fraser and Moore (2011), Hall (2013) and other critical scholars, this research has argued throughout that, poststructural analysis does not deny the material reality of events, it questions the meaning and particular realities that are constructed in policy and practices, including what valentine and Seear (2020:2) refer to as the 'made-in-practice status of realities' that include knowledge, evidence, data and drug effects. In this sense the taken for granted assumptions that a poststructural analysis might question is not the death but the official explanations of its causes. Cruts (2000:381) for example has argued that 'reducing the causes of death to a certain drug as the essential underlying cause of death is a social construction'.

The Office for National Statistics (ONS) classifies deaths where drugs are implicated as either deaths related to drug poisoning where the cause of death is defined using the International Classification of Diseases, Ninth Revision (ICD-9) for the years 1993 to 2000 and Tenth Revision (ICD-10) from 2001 onwards or drug 'misuse' deaths, a sub-set of drug poisonings. Deaths classified as drug 'misuse' must meet either one (or both) of the following conditions: 'the underlying cause is drug abuse or drug dependence, or any of the substances involved are controlled under the Misuse of Drugs Act 1971' (ONS 2022:5).

As discussed in chapter six, poststructural analysis argues that notions of drug addiction, drug 'misuse', or drug dependence are constructed within the discourses that describe them. It argued that drug treatment produces and reproduces notions of addiction while the subject positions available within addiction discourses produce notions of the addicted subject. Subjects who, in some cases go on to reinforce and reproduce notions of addiction and practices of 'risk thinking'. Similarly, it could be argued that the Misuse of Drugs Act 1971 is a technology of governmentality, a stratification system based on constructed notions of risk and harms associated with particular types of drugs while new drugs are added to the classification due to problem representations and political decisions. Versions of the International Classification of Diseases are contingent upon historic, socio-political and knowledge discourses and informed by risk practices. The argument here is that classification systems underlying the causes of drug related death can and do change and are subject to discursive practices. Moreover, as ONS point out themselves (2022:13):

> More than half of all drug poisoning deaths involve more than one drug, and it is not possible in those cases to tell which substance was primarily responsible for the death. There is no Internationally agreed definition of what constitutes a drug-related death; figures cannot be compared with those produced by other organisations.

The point is that drug use as an underlying cause of death is only ever probable and not actual. A category that is contingent, contested and constructed (Howarth *et al.* 2020).

Why does this matter and why is this additional reflection important? Firstly, because WPR exposes the tragic fallacy that policy will provide a solution to the public health crisis of overdose deaths in the UK. Or that the realist calls to increase the number of structured drug treatment places without addressing the power dynamics (the knowledge practices) that operate within drug treatment services producing and reproducing harm. Public health and other neoliberal health systems highlight the centrality of the individual as being responsible for her/his wellbeing. Harm reduction interventions increasingly follow that neoliberal logic (Fraser 2004) reproducing individualised notions of wellbeing that detract from a focus on broader structural problems and health inequalities. The neoliberal logics of care encourage individuals to be responsible for their own wellbeing but also responsible for their own misfortune, illness and death.

It has been suggested that structured drug treatment may no longer provides the 'protective factor' that it once did (Whitfield and Reed 2022). There is evidence that some people are dying at a younger age in treatment than those not in treatment while significant numbers of PWID are not accessing treatment at all. Around 50% of deaths reported by treatment services in some parts of the North West of England are for people who lived alone at the time of death while, 85% of AOD related deaths in that same area died alone (Whitfield and Reed 2022). Moreover, as McPhee *et al.* (2019) remind us, focusing on an aging population of drug users (a 'risk' factor in the discourses of overdose deaths) masks the disproportionate number of deaths in the most deprived areas and downplays the significance of deprivation in explaining increases in drug related deaths. The point here is that underlying causes of death could be just as easily re-cast to include stigma, structural poverty and health inequality along with a constellation of socially

produced harms that result in a compromised quality of health and wellbeing. The argument is not to deny the actual reality of death and loss among PWID but to suggest that it could be understood differently.

### 10.4 Reflections on drug treatment

Chapter six argued how addiction as an object of knowledge was produced through particular problem representations and that drug treatment reproduces those representations through the problems that it describes. Through the processes of subjectification, the discursive practices of drug treatment make available certain subject positions producing and reproducing notions of the addicted subject. As previously noted, the processes of subjectification are central to producing the 'responsibilised subject' the effects of which give rise to notions of a rational treatment compliant subject and increase levels of self-surveillance and self-discipline. By shifting the focus of analysis from 'problem' solving to 'problem' questioning a WPR approach encourages probing into the assumptions and effects of drug policy. This research has argued that through the conceptual logics embedded within an abstinence-based recovery treatment system, practices reinforce and reproduce binary opposites of health and wellbeing and PWUD and addiction. Since 2010, drug treatment policy has embodied what Mol (2008) refers to as 'logic of choice' exemplified through the materialisation of recovery orientated treatment systems. Moreover, responsibilising PWUD within the governing frameworks of treatment, divides subjects themselves, increasing levels of stigma towards the 'non treatment compliant' or 'hard to engage' populations of PWUD by drawing attention to the 'pathological', 'irrational' and deviant behaviours underlying continued use of drugs. Within a logic of choice, the rational, responsible health seeking citizen chooses health. On the surface this appears a reasonable assumption to make. However, critical poststructural policy analysis reveals that the problem representations at play in 'addicting subjects' shifts the dial, not from a logic of choice to a

logic of care but rather from a logic of choice to a logic of control effectively forecloses any alternative narrative on drug use and subjugating the lived experience of pleasure and benefits experienced by many PWUD. Dennis (2019) reminds us of the struggles experienced by PWID discussing pleasure relating to injecting drugs:

> This brings about a tension in which talking about pleasure in this context of addictive drug use becomes very hard, not necessarily because it does not exist (chemically) or does not belong (in a governmentality sense), but because concepts of addiction are always ready to act or rather have already acted in making the conditions that are possible for thought (Dennis 2019:68).

Why does this matter? Acknowledging the benefits and pleasures associated with using drugs moves us closer to an understanding of why people choose to use drugs. And, in spite of deficits and negatives consequences produced through mainstream discourses, choose to continue to use.

Repeated claims of new policy approaches and initiatives have been made in successive drug policies and strategies. Critical policy analysis from a WPR approach reveals that policy has been consistently underpinned by pathologising and criminalising problem representations for decades. It has operated the same disciplinary and regulatory logics and produced the same 'solutions', the same discursive, subjectification and lived effects. Producing the 'problem' of drugs and fixing the gaze of responsibility firmly on people who use them.

Pathologising drugs and people who use them alienates people from the very services supposed to be providing help leaving them cut off from any support and essential harm reducing interventions.

**10.5 Reflections on risk and harm reduction**

Harm reduction has been variously described as 'a non-judgemental approach to drug use grounded in evidence, pragmatism, justice and compassion' (Burke-Shyne and Larasati 2024:

97). A ‘reality-based approach that recognises that drug use and other risky behaviours are a part of our everyday lives’ (Vakharia 2024:43). And as ‘a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use’ (Vakharia 2024:44). Vakharia (2024:44) goes on to note that ‘harm reduction is grounded in the understanding that people can and will make informed choices to keep themselves and their loved ones safe when empowered to do so’ while Burke-Shyne and Larasati (2024:98) states that harm reduction approaches are:

> Programmes and practices that aim to minimise negative health, social and legal impacts associated with drug use, drug policies and drug laws. At a practical level, harm reduction encompasses a range of health and social services which mitigate the harms of drug use

Notwithstanding concerns previously noted about the potentially responsibilising effects of harm reduction approaches, these are completely agreeable aims. Chapters seven and eight discuss the discursive effects of harm reduction policy and practices and argue that harm reduction interventions can have a responsibilising effect, shifting attention away from health inequalities and the social production of harm. Chapter seven particularly notes how a number of commentators following Foucault’s concept of governmentality, describe risk as part of a disciplinary and regulatory practice arguing that harm reduction, once concerned with bringing about structural change has been appropriated by a governmental treatment system, reducing its principles to a series of target driven transactional exchanges (Rose 1999; Rhodes 2020; Moore and Fraser 2006; Dean 2010).

This research draws attention to ways in which harm reduction policy is prefaced on an assumption that harm is an inevitable consequence of drug use and how increasingly, drug services characterised by abstinence-based recovery treatment, have turned to harm reduction as a ‘bolt-on system of corporate risk management’.

These observations raise important questions and challenges to many previously held assumptions and taken for granted 'truths' about harm reduction, including those held by the researcher and formed in their relationship to harm reduction services. As discussed in chapter two harm reduction emerged in the UK as a response to the public health concerns of HIV, a strategy of public health infection control that located PWID, men who have sex with men and sex workers at the centre of the public health gaze. As much as setting a blueprint for harm reduction (Ashton and Seymore 2010) the ACMD 1988 report, *Aids and Drug Misuse* set a blueprint for abstinence-based drug treatment services featuring a hierarchy of goals that emphasised a cessation of injecting drug use and the ultimate realisation of becoming drug-free. Importantly, as Mugford (1993) and Miller (2001) note, it is not problematic in itself to base drug treatment policy on the principles of public health, rather that these principles are not necessarily as empowering and free from moral judgement as advocates of harm reduction claim.

Abstinence-based treatment discourses consistent in UK drug policy dating back over decades reproduce and reinforce the pathology and stigma assembled around the socially, politically and economically constructed representations of risk, harm and addiction identity. Whatever the successes claimed for abstinence-based recovery policy since 2010, reducing harms associated with injecting drugs or the number of deaths among PWID are not amongst them. WPR approaches to probing problem representations, working backward from 'what needs to change' in order to determine 'what the problem is represented to be' confirms the abstinence-based intentions of recovery policy. An intention that, as noted in chapter five, was written into drug treatment commissioning policy in 2011. Testimony from interviews conducted as part of this research confirm a linear process of payment-linked outcomes in which policy expectations informed commissioning practices which in turn informed drug treatment practices. The goal, as Dennis *et al.* (2020:4) point out, was 'movement enacted within the treatment service'.

Treatment success was ‘measured in terms of the months (six required) people stayed out of treatment after discharged’ However, as Dennis *et al.* (2020) point out, little or no support was available for people who wanted to reduce but not necessarily stop their illicit drug use. They note that people disappeared, ‘dropped out (discharged themselves or stopped attending) or were invited to leave due to non-compliance’ (Dennis *et al.* 2020:4) a trend that has continued to date, particularly among PWID. For Dennis *et al.* (2020) while the determining context of commissioning structures ‘mobilised recovery as an evidence-making intervention’ patterns of resistance emerged in what they have referred to as ‘more-than-harm reduction’ giving rise to the possibility of alternatives to popular conceptions of needle and naloxone versions of harm reduction.

Harm reduction, outside of the UK has started to shift it’s gaze towards the ‘problems’ of structured disadvantage, the unhoused populations, race and gender inequalities and the socio-political conditions that diminish the agency of those people caught up in those structures (Levenson *et al.* 2023). These changes have not come about through policy reform, they have come about through the activism of grass-roots organisations and drug user networks. Levenson *et al.* (2023) note how for some activists in America, a turn to abolitionism rather than reform, followed critical problematisation of mainstream narratives and assumptions.

### 10.6 Reflections on injecting drug use

This research draws attention to the particular disadvantages experienced by PWID and suggests that harm producing policies and harm producing practices impact deleteriously on PWID through hierarchies of oppression, stigma and discriminatory practices. Dominant discourses describe injecting drugs directly into the bloodstream as the ‘riskiest’ means of consuming substances. Some commentators, for example, Pates *et al.* (2001), have argued that the process of injecting itself has such compelling force that the ‘hopelessly addicted addict’

will continue to inject her/himself even in the absence of any psychoactive effects. Pates *et al.* (2001) refer to this compulsion as ‘needle fixation’.

Further reflection and problematisation of some of the assumptions underlying the injecting process is necessary here. Injecting drugs directly into the bloodstream is a means by which a concentrated volume of the substance (a relatively high dose of the drug) can cross the blood-brain barrier almost instantaneously. Importantly, it is not only the speed at which the drug crosses the blood-brain barrier that increases the intensity of effects, it is the amount of the drug that crosses the blood-brain barrier almost instantaneously as opposed to other means of consuming the drug, for example, by smoking, swallowing or sniffing the same substance. Moreover, PWID will often describe the practice of injecting drugs as being more ‘economical’, more efficient, and once proficient in the techniques of injecting, quicker and more discrete. Some of the interviewees in this research referred to an ‘injector identity’ a ‘stronger commitment to using’ or injecting being more indicative of longer-term use. Further exploration of ‘injector identities’ may be illuminated by a consideration of the particular subject positions made available in discourses on PWID.

However, injecting is not always the default option for administration of all drugs. Reinarman and Levine (1997) remind us that crack cocaine, for example, is produced in a form that allows for a high concentration or dose of cocaine to be delivered via inhalation, crossing the blood-brain barrier almost instantaneously. Crack cocaine vaporises at high temperature and while the inhalation of hot anesthetising vapor is not without its own risk and health hazards, the argument here is that intravenous injection is not the only means of achieving the effects of a concentrated high-volume dose of a drug and the intensive impact experienced by the person using it. Moreover, modern methods relating to vaping technologies could be explored to reduce the hazards of scorch injury to the upper respiratory tract from inhaling hot fumes, hazards

concerned with drug paraphernalia and the processes involved in preparing drug solutions for injection. Representations of 'problem' drug use draw attention to opiate and crack cocaine use bringing together taken-for-granted assumptions and 'truths' about 'risk', irresponsible behaviour and criminal activity. This research shows that official responses to overdose prevention centres or safer injection facilities defer to a ridged legal framework that prohibits such interventions while abstinence-based recovery orientated discourse silences any alternative consideration of a safe supply of prescribed injectable drugs.

**10.7 Conclusion**

WPR requires those engaged in research to become aware of their own subject positions and to identify their own position within the power-knowledge relations that organise discursive practices and shape 'truths'. Following a WPR approach, this research has applied critical reflection through self-problematisation, alerting the researcher and author to the extent that worldviews influence and shape the analysis. At times this has been personally challenging as one critically examines their own assumptions about knowledge claims. Problematising a sense of 'reality' and 'truth', a personal worldview formed in the experiences of illicit drug use and over four decades of professional practice in public health-based harm reduction services. Yet personal challenge is precisely the point of critical reflection and self-problematisation. A recognition as Bacchi and Goodwin (2016) have noted, that a fundamental premise of a WPR approach is that as researchers we are involved in the conceptual logics of our time – who we are is shaped by the problem representations that we are about to analyse.

Following a Foucault influenced WPR approach, the act of producing knowledge is a political act formed in the relations of power/knowledge and the conceptual logics of the time. Critical reflection through self-problematisation assists researchers in recognising that research too is a political act and that knowledge produced within it is political knowledge, used and acted on

in particular ways and constructed within particular problem representations. WPR and the self-problematising processes that it encourages make visible those political processes and the conceptual logics of our experience. Critical reflection and self-problematisation brings into question claims of neutrality and the value free status of, for example, 'personal experience'. The notion of an 'expert by experience' independent of political forces and selectively called upon to provide 'unique' insights and privileged knowledge.

While these insights and personal experiences can be extremely valuable and useful in policy terms care needs to be exercised here as well. Self-problematisation and critical reflection can be usefully employed to determine the limitations as well as the usefulness of personal experience, its effects and its own problem representations. This research gratefully acknowledges the lived experiences and knowledge contributions of PWID, the professional insights of AOD treatment providers and the commissioners of AOD treatment services. It has also come to recognise that those knowledges and insights, those discourses, are constructed within a particular worldview and expediently privileged or subjugated depending on the particular representations of the 'problem' of drugs. Problematising the problematisations within particular problem representations reveals the assumptions and presuppositions held by others. Critical reflection and self-problematisation helps us to reveal those we hold ourselves.

# Chapter Eleven

# Conclusions

## 11.1 Introduction

This research draws on poststructural approaches to discourse analysis using a WPR critical approach to policy analysis (Bacchi 2009) to consider how drug 'problems' are constituted in policy, given meaning as particular kinds of problems, are reproduced in the power/knowledge relations of professional discourses and are related to technologies for managing and regulating the behaviours of PWID. The research argues that 'problems' represented as objects (addiction) and subjects (the addicted subject) are formed in discourses and have no meaning (reality) outside of those knowledge discourses or practices.

The research is a study of discourse, discourse as knowledge not as language. This is a theoretical view of the world that argues that while physical things and actions exist, they only take on meaning and become objects of knowledge within discourse. Drawing on Foucauldian theory and concepts of archaeology and genealogy, the research emphasises the relationship between power and knowledge and how power is involved in producing knowledge. These are socially constructed forms of knowledge – practices that constitute 'truths'. In this sense, theory provides a window from which to view the world and like windows, if we only ever look through one, we will always see the same thing. Scott and Sim (2023:3) remind us that the American writer and political activist, James Baldwin, once noted that 'the world changes according to the way people see it, and if you alter, even by a millimetre, the way a person looks or people look at reality, then you can change it'. Foucauldian theory of genealogy, integral to a WPR approach, provides an opportunity to look through a different window.

To talk about subjugated knowledges that have been shuttered off from view and to alter, by a millimetre, (or more) the way a person looks at reality. This is, in essence, the aim of poststructural theory and the purpose of this research.

This research offers practitioners and commissioners of drug treatment services a different lens to view drug policy through and to critically consider its effects. It illustrates how drug policy constructs and gives meaning to drug 'problems' and how particular representations of those problems are reproduced as 'truths' through commissioning structures and the discursive practices of drug treatment. Moreover, it opens up a space for contestation – for commissioners and practitioners to consider critically the constructed nature of knowledges and provides a vocabulary for them to challenge the taken-for-granted assumptions that prevail within drug policy and policy responses.

## 11.2 In what ways have particular problematisations of drugs and their effects since 2010 affected people who use them, with particular reference to PWID?

According to ONS data published in 2023 there were 4,907 deaths due to drug poisoning registered in England and Wales in 2022. Of all of those deaths, 3,127 were identified as drug 'misuse' deaths (ONS 2023). In 2021, the UK government published its latest drug strategy, *From Harm to Hope*, announcing a financial package of £900 million to address the 'problem' of drugs, 'change the culture of drug treatment' and 'reduce the number of deaths by 1,000 (HM Government 2023). Deaths registered in England and Wales with drug poisoning or drug 'misuse' as the underlying cause have increased significantly every year since 2012 and are now at the highest level since records began in 1993. However, this research shows that many of the deaths recorded as drug 'misuse' deaths are also associated with chronic ill health and occur while people are using drugs rather than as a result of using drugs. Following Lupton's (2013) analysis of risk and neoliberal governmentality, the epidemiology of drug related deaths

elevates the perceptions of ‘risk’, reinforces the problem representations of dangerousness and justifies further state intervention while policy responses focus on individual responsibility diverting attention from the social determinants of inequality, deprivation and isolation. This research offers an alternative discourse on ‘risk’ and lends support to those working to reduce the harms associated with particular ‘problem’ representations within the field of drug research and treatment.

### 11.3 In what ways have recovery narratives and discourses affected drug user identities?

ONS data does not determine the numbers of PWID among those whose deaths have been attributed to drug use, they do note that just under half, 46% (2,261) of the deaths registered with drug poisoning as the underlying cause involve an opiate while 857 of the registered deaths involve cocaine. However, reports reviewed in local drug related death review panels show a significant number of deaths are among PWID many of which the treatment services are not aware of the individuals injecting status (Whitfield and Reed 2022). This research shows how, through the processes of subjectification, the subject positions (identities) made available within policy representations situate PWID as binary opposites to the ‘responsible’ health seeking individual actively engaged in recovery. It supports the assertions of Fomiatti, Moore and Fraser (2017) in which recovery focused treatment relies on a ‘recovering addict identity’ within which exists the potential to reproduce the stigmatising and pathologising ideas about PWID further alienating PWID from the very support services that could offer help and reduce harm.

### 11.4 To what extent do drug user identities play a role in treatment engagement?

This research has shown how the subject positions available within particular problem representations can influence the ways in which PWID see themselves and how they respond to drug treatment. Data from the OHID’s *Unmet Need Calculator* (NDTMS 2023) suggests

that around 50% of PWUD, many of them as noted above, likely to be PWID, are not engaged with structured drug treatment services. Yet the treatment system, through its discursive practices and the problem representations of drug policy, continues to promote itself as an abstinence-based recovery orientated system with little or nothing to offer PWID. Testimony from this research confirms that PWID avoid contact with treatment services while treatment activity data reports (NDTMS 2023) show that in spite of record levels of investment, the numbers of people who use opiates and crack cocaine engaging with treatment services is falling.

PWID remain vulnerable to a wide range of viral and bacterial infections as well as injecting complications which can result in high levels of illness and death (Hope *et al.* 2015, 2017, UKHSA 2023). A body of literature supports an association between injecting heroin (particularly in combination with other opiates, central nervous system depressants and cocaine) and an increased incidence of overdose and other drug related deaths (Darke and Zander 1996; Oldham and Wright 2003; Sporer 2003; Strang and Fortson 2004; Ward *et al.* 2002; Warner-Smith *et al.* 2001). A key theme emerging from this literature is the centrality of engaging PWID in meaningful 'treatment' and support as a way of minimising or reducing levels of harm associated with injecting drugs. This research, through a critical analysis of UK drug policy and policy responses since 2010, suggests that the effects of problem representations, the discursive, subjectification and lived effects of policy, have been to produce harm rather than reduce it. That harm is compounded by the subjectification of PWID and the construction of subject positions that are increasingly outside of drug treatment systems terms of reference. An important challenge for those wanting to change the effects of drug policy is to re-problematise the problematisations of drug policy and re-set the terms of reference.

## 11.5 To what extent have considerations of benefits and pleasures associated with drug use been 'absented' from harm reduction and recovery discourse?

This research engaged with a critical poststructural policy analysis to illuminate the effects of policy responses in the past decade and their impact on the risk of drug related deaths among people who inject drugs. It is not the intention of the research to undermine harm reduction and public health interventions, but to draw attention to some of the unproblematised problem representations that inform their practices. This research has argued that drug treatment has become a determining context for the 'problem' of addiction. An expression of biopower that situates PWUD within a pathology of consumption and a rejection of disciplined social order while harm reduction practices increasingly individualise risk as an inevitable outcome of drug use. Within this assemblage of knowledge practices and techniques of scientific classification the addicted subject becomes locked into a cycle of repressive, punitive and harm producing policy and practices and a 'truth' about drug use that subjugates, discounts or denies the logic of any benefits or pleasures associated with the use of drugs. The logic of recovery punches down on those who continue to use drugs while public health-based harm reduction interventions coalesce with the disciplinary power of criminal legal discourses – two sides of the same coin – primarily concerned with regulation and governing the conduct of conduct.

## 11.6 To what extent has recovery become narrowly defined around a recovering addict identity alienating PWID who reject or resist that particular identity?

In her review of drug treatment Black (2020) concludes that the drug treatment system is broken. That the system does not achieve its own aims or succeeds on its own terms. This research has shown that the aims of drug treatment are concealed within particular problem representations and a discourse of governmentality and regulatory practices. It shows how drug treatment exercises the technologies of biopower and pathologises the non-medical use of drugs through the construction of addiction and the production of the addicted subject. It shows, in

chapter five, that drug policy, and the problem representations contained within it, situate an estimated 300,000 heroin and crack cocaine 'addicts' in England as being responsible for nearly half of all burglaries, robberies and other acquisitive crime. Following Black's representation of the 'problem' and the terms of reference ruled into her problematisations, her logic is to call, as noted in chapter five, for reinvestment in the treatment system and the creation of more treatment places for people who use opiates and crack cocaine in abstinence-based recovery services. Treatment places that this research shows, significant numbers of PWID are turning away from. This research asserts that the problem with drug treatment is not reducible to a broken system but that it is based on a particular representation of the 'problem'. A treatment system that is narrowly defined around the addicted subject and the problem representations of binary opposites that continue to stigmatise and alienate PWID while promoting the virtues of the responsible neoliberal health seeking citizen in recovery.

### 11.7 Conclusion

By applying a WPR approach, this research brings together a number of Foucauldian modes of enquiry including archaeology, genealogy and problematisation to produce a range of new questions to guide critical thinking and policy analysis. The research uses critical thinking and analysis to interrogate policy representations and to trouble taken for granted 'truths' embedded in drug policy. WPR guides a critical questioning of the deep-seated presuppositions and assumptions that underpin drug policy and the research shows the way in which policies actively produce or constitute 'problems', 'objects', 'subjects' and 'places' in specific contexts (Bacchi and Goodwin 2016:108).

It is not the aim of this research to put forward at a list of recommendations or to proclaim how things should be. Bacchi and Goodwin (2016:25) remind us that Foucault explicitly distanced himself from reformers who declared 'this, then, is what needs to be done'. The uniqueness of

a WPR approach, and of this research, is not what it proscribes but the spaces that it opens up for considering alternative possibilities. The argument, for example, that 'things' have to be made and therefore can be unmade is central to the poststructural thinking that underpins this research. The aim of the research is to show that things could be different.

A poststructural perspective, particularly a Foucault-influenced WPR approach, argues that things taken-for-granted as real are generated in practices and power relations. That 'objects', 'subjects' and places of study are given meaning in discourse and that the 'realities' constructed in discourse are only ever partial. As Hall (2013:29) reminds us in chapter six, discourse:

> Constructs the topic. It defines and produces the objects of our knowledge. It governs the way that a topic can be meaningfully talked about and reasoned about. It also influences how ideas are put into practice and used to regulate the conduct of others.

The research shows how PWID are governed by discourses, by discourses produced in power/knowledge relations. Discourses that are concerned with governing the conduct of conduct. However, the research also shows how the objects constituted in discourse are not fixed. It shows how, through examining and probing problem representations and by conducting a genealogy of those problem representations to determine how they came to be, the research brings to light alternative problem representations challenging the inevitability of drug related harm and revealing how thing could be otherwise. These and other such problematisations do not deny the reality or actuality of phenomena. They seek, as Howarth *et al.* (2021:1) reminds us, 'to disclose the different ways that phenomena are (or may be) constructed in social reality.

This research has questioned taken-for-granted notions of risk and harm. It has questioned the fixed reality of subjects and objects illustrating the partial and transient nature of both. It has questioned the solution providing capacity of drug policy and shown that 'problems' constituted in policy are used as part of a governmental technology. It has questioned the

reliability of epidemiological data and revealed examples of harm producing policies. Mostly it has shown how things could be different. In illuminating the possibilities for change, in showing how things could be otherwise, WPR has been a useful analytic strategy helping to shine the illuminating torch in a different direction. Changing the view from the window and changing an understanding of reality.

This research set out to ask a question, a question that implied that particular problematisations and their effects since 2010 had in some way affected PWID. It considered claims that the treatment system was broken and that it did not succeed in its aims or on its own terms (Black 2021) and it revealed that the aims of drug treatment were concealed within the disciplinary technologies of neoliberal governmentality. It showed that no amount of increased financial investment or an increase in 'quality' treatment places would reduce the harm to PWID while 'treatment' remined based on a particular problematisation and the harm producing policies that followed.

So, what if the treatment system isn't broken? What if, as Robinson (2021:262) suggests, the system demonstrates a 'victorious commitment to maintaining state power, capitalist accumulation and social inequality'. What if a recovery-based treatment system, narrowly defined around the constructed notions of the addicted subject and the promise of liberation, social approval and material success associated with the subject position of a recovering 'addict' is a 'truth' built on a particular economic vision. On a neoliberal problem representation characterised by a framework of governmentality and the disciplinary practices of containment and regulation that underpin the discursive practices of drug treatment and public health-based harm reduction? What if, the 'system itself consistently re-produces harm regardless of who is working it' (Robinson 2021:262). Then the possibilities for transformation come not from

policy and treatment reform but from changing the problem representations that discourse is built on.

This research has turned its gaze away from the problems of policy responses towards problematisations and problem representations. In doing so the research has been able to unpick the implications of problematisations through a consideration of what Brown and Wincup (2020:3) note as three types of effects; discursive effects, including the silencing of alternative views through the adoption of particular problem representations and the discourses that frame them, subjectification effects and the impact of establishing particular social relationships and the lived effects, the material consequences of problem representations.

This research has shown a relationship in the discursive effects on commissioners and providers of drug treatment services in the way that they interpret and navigate policy directives. Finally, it has highlighted the effects of subjectification through a consideration of the subject positions made available within particular problem representations and discourses. The research has questioned the way that PWID see themselves and are seen by others in relation to those who adopt a 'recovering addict' identity and it has considered the effects that particular problem representations have on the lived experience of PWID. For example, experiences of increased levels of social harm, stigma and social isolation and health inequalities. Increased levels of harm to health including, exposure to and infection with blood borne viruses and other injection related infections, increased incidence of chronic illness and avoidable overdose deaths as well as day-to-day criminalisation and pathologising effects of particular problem representations.

This research makes the case for change. Not change based on improving access to treatment and provision of the harm reduction imperatives of needles and naloxone, but change based in deconstruction, in a re-problematisation of problematisations, a rejection of the belief in the solution-based capacity of policy, a critical reflections of practitioners own assumptions and

presuppositions and further critical analysis of the epidemiology of risk and the constructed realities of addiction, harm and recovery.

In calling for a deconstruction of the harm producing policies and practices of drug ‘treatment’ this research invites policy makers, commissioners and partitioners to recognise that practices are always in the making, they never achieve full hegemonic status, ‘there are always cracks, contradictions and therefore opportunities’ (Hall *et al*, 2013:20) to re-problematise, to unmake that which has been socially constructed.

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# Appendix A

## Poststructural Interview Analysis (PIA)

**Process 1: Noting '*What* is said'.**

The emphasis in this first process is examining *precisely what* is said – the things said. For Bacchi and Bonham, this is important as it differentiates the analysis from language studies. They argue that it is important to emphasise that the interest here is not in 'what *people* say' but in '*what* people say, in *exactly* what is said (Bacchi and Bonham in Bacchi and Goodwin 2016:115). Particular attention should be paid to points in the interview where particular ways of thinking, feeling, characterising and doing differentiated from general existence occurs. These are the moments when interviewee speaks of available subject positions. Research questions associated with process one include:

- What 'things said' have been noted?
- On what grounds have they been noted?

**Process 2: Producing genealogies of 'what is said'.**

Process two draws on the theoretical concepts underpinning WPR questions two and three. Researchers are encouraged to reflect on how '*what* is said' *could be* said and how they are considered to be legitimate or 'truthful'. Here it becomes necessary to produce histories or genealogies of 'things said'. Bacchi and Bonham remind us here that in PIA 'things said' are analysed in terms of the practices that give rise to them. Research questions associated with this process include:

- What meanings need to be in place for particular 'things said' to intelligible?
- Where and how has a specific 'thing said' come to be accepted as 'truth'?

**Process 3: Highting key discursive practices.**

For Foucault, discourse refers to knowledge and discourses are described as practices. Discursive practices encapsulate the 'practices', the ways by which they operate to establish their knowledge credentials. It is necessary within process three to consider how the specific discourse relevant the interview topic generate things that can be said 'within the true' (Bacchi and Bonham in Bacchi and Goodwin 2016:117). Research questions associated with this process include:

- Which discursive practices are relevant to the 'things said' that are the focus of the analysis?
- Which subject positions are made available within these discursive practices?

**Process 4: Analysing '*What* is said'**

Process four draws our attention to the centrality of subject positions in forming 'subjects', 'objects' and 'places' and ways in which they give authority to certain discursive practices. The analysis here focuses on productive nature of things said. What they produce or constitute rather than what they mean. Research questions associated with this process include:

- Which norms do the 'things said' invoke?
- Which 'subjects' are produces?
- Which 'objects' do they create?
- Which 'places' are produced as legitimate?

**Process 5: Interrogating the production of 'subjects'**

This process examines the process of subjectification and how individuals are produced as particular subjects. Through an analysis of what exactly what interviewees say ('*what* is said')

it becomes possible to reflect on the processes by which interviewees establish themselves within certain subject positions. Research questions associated with this process include:

- 'What does the individual relate to the self?
- What ways of moving, thinking, characterising and feeling has the interviewee excised and related to the self?
- In which discursive practices have these attributions been, and continue to be, formed?

**Process 6: Exploring transformative potential**

Poststructural interview analysis shifts the focus from the 'subject' being fixed to the process (discursive practices) by which individuals acknowledge themselves as particular types of subjects. By focusing exactly on '*what* is said' it becomes possible to use interview material to explore changes in subject positions. Interview material can therefore serve as a political resource to analyse transformational change (Bacchi and Bonham in Bacchi and Goodwin 2016:119). Research questions associated with this process include:

- Does a particular interviewee comment appear unusual, inappropriate or out of context?
- Does a particular comment offer an alternative to the taken-for-granted 'reality'?

**Process 7: Questioning the politics of distribution**

This process is concerned with the political and ethical implications associated with the production of knowledge. Researchers exercise considerable power in respect of what will be included, what will be excluded, what will be reported and where findings will be reported or disseminated. Qualitative-based interviews such as surveys can operate in limiting '*what* is said' as they will often restrict responses to what a given discipline, or body commissioning

the survey, deems to be appropriate. The following questions address the role of the researcher in producing, analysing and distributing ‘*what* is said’.

- Do particular interviewer comments (‘things said’) challenge or reinforce pervasive ways of thinking?
- Do the questions asked (either in survey or semi-structured interviews) function to reinforce or challenge pervasive ways of thinking?
- Are the sites for distributing research results constrained in ways that reinforce pervasive ways of thinking?

**Interviews as sites of discursive practices**

When turning to interviews the analytic strategy focuses on ‘*what* someone says’ rather than ‘what *someone* says’.

“The task involves taking these ‘things said’ as a point of departure to inquire into the mechanisms, procedures and processes at work in their production – the knowledge that enable them , rather than the language used in their expression. Such an enquiry makes apparent how it has become possible for interviewees to speak of themselves as particular kinds of subjects. It is through the ongoing enactment of relations within a discursive practice that ‘objects’, ‘subjects’, concepts and strategies are continually formed” (Bonham and Bacchi 2017 p: 690).

In their 2016 book, Bacchi and Goodwin move WPR and PIA explicitly towards an ontological politics acknowledging that ‘reality’ is made in and through discursive practices and that, given the plurality and dynamic nature of those practices it can be unmade or changed.

# Appendix B

## LIVERPOOL JOHN MOORES UNIVERSITY
## Participant Information Sheet: People Who Inject Drugs (PWID)

**LJMU's Research Ethics Committee Approval Reference**: **19/PHI/004**

**YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET**

**Title of Study: Producing the 'problem' of drugs: A critical analysis of the effects of drug policy since 2010 with a particular focus on people who inject drugs**

**School/Faculty**: Faculty of Education, Health and Community / Public Health Institute

**Principal Investigator**:
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You are being invited to take part in a research study. Before you decide it is important for you to understand why the study is being done and what participation will involve. Please take time to read the following information carefully. Please ask if there is anything that is not clear or if you would like more information. Thank you for reading this.

1. **What is the purpose of the study?**
   The number of drug related deaths recorded each year is now higher than at any time since official records began. Around half of the people who die from drug related causes have either never received drug treatment or have dropped out of treatment.
   This study hopes to answer the following questions: In what ways have changes in drug treatment in the past ten years affected the risk of drug related deaths among people who inject drugs and what can affect people who use drugs willingness to get into drug treatment.

2. **Why have I been invited to participate?**

   You have been invited to take part in this study because you a person who injects drugs or has injected drugs within the past year and will have experience of drug treatment services and we are interested in hearing your views and experiences.

3. **Do I have to take part?**

   Taking part in the study is entirely voluntary. If you do agree to take part, you will be given this information sheet to keep and be asked to sign a consent form. Signed consent forms will be securely stored in locked cabinets within the University and will only be accessed by the Principle Investigator and University staff who are directly associated with the study. You can withdraw at any time by informing the researcher without giving a reason and without it affecting your rights or any future treatment service that you receive even after you have given consent.

4. **What will happen to me if I take part?**

   You will be asked to take part in the study by being interviewed by a researcher from Liverpool John Moores University. Interviews will take place in your needle and syringe exchange service, via telephone or virtual conference call at a time that is convenient to you. You will be asked a number 'open ended' questions about how drug treatment services are provided and how they could be provided differently. You will be asked to answer in your own words. The interview will be just like a conversation. The researcher may use occasional prompts (extra questions) to keep the conversation going. This type of interview is called a semi-structured interview. Interviews will normally last for between 45 minutes and 1 hour.

5. **Will I be recorded and how will the recorded media be used?**

   Interviews will be audio recorded on a password protected audio recording device and as soon as possible the recording will be transferred to secure storage and deleted from the recording device. Transcripts from audio recordings will be anonymised.

6. **What are the possible disadvantages and risks of taking part?**

   There are no foreseeable risks or disadvantages associated with taking part in this study. If at any time during the interview you feel uncomfortable talking about your experience you can ask for the interview to be stopped and the researcher will advise you to access professional support from the needle and syringe or other support service staff.

7. **What are the possible benefits of taking part?**

   While there may be no direct benefits to you from taking part in this study it is hoped that the work will increase our understanding of why some people who use drugs choose not to engage with drug treatment services.

8. **What will happen to the data provided and how will my taking part in this project be kept confidential?**

   The information you provide as part of the study is the **research study data**. Any research study data from which you can be identified (e.g. from identifiers such as your name, date of birth, audio recording etc.) is known as **personal data**. Personal data does not

include data that cannot be identified to an individual (e.g. data collected anonymously or where identifiers have been removed). If necessary, personal data will be stored confidentially for 5-years. Transcripts will **not** include personal identifiable data. Signed consent forms will be stored in locked cabinets within the University and accessed only by the Principal Investigator and study supervisors.

**9. Limits to confidentiality**

The Investigator will keep confidential anything they learn or observe related to illegal activity unless related to the abuse of children or vulnerable adults, money laundering or acts of terrorism.

In certain exceptional circumstances where you or others may be at significant risk of harm, the investigator may need to report this to an appropriate authority. This would usually be discussed with you first. Examples of those exceptional circumstances when confidential information may have to be disclosed are:

- The investigator believes you are at serious risk of harm, either from yourself or others
- The investigator suspects a child may be at risk of harm
- You pose a serious risk of harm to, or threaten or abuse others
- As a statutory requirement e.g. reporting certain infectious diseases
- Under a court order requiring the University to divulge information
- We are passed information relating to an act of terrorism

**10. What will happen to the results of the research project?**

The investigator intends to complete a dissertation to satisfy their degree programme / publish the results in a PhD thesis / journal article.

**11. Who is organising and the study?**

This study is organised by Liverpool John Moores University.

**12. Who has reviewed this study?**

This study has been reviewed by, and received ethics clearance through, the Liverpool John Moores University Research Ethics Committee (Reference number: 19/PHI/004).

**13. What if something goes wrong?**

If you have a concern about any aspect of this study, please contact the relevant investigator who will do their best to answer your query. The researcher should acknowledge your concern within 10 working days and give you an indication of how they intend to deal with it. If you wish to make a complaint, please contact the chair of the Liverpool John Moores University Research Ethics Committee

(researchethics@ljmu.ac.uk) and your communication will be re-directed to an independent person as appropriate.

**14. Data Protection Notice**

The data controller for this study will be Liverpool John Moores University (LJMU). The LJMU Data Protection Office provides oversight of LJMU activities involving the processing of personal data and can be contacted at secretariat@ljmu.ac.uk. This means that we are responsible for looking after your information and using it properly. LJMU's Data Protection Officer can also be contacted at secretariat@ljmu.ac.uk**.** The University will process your personal data for the purpose of research. Research is a task that we perform in the public interest.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained.
You can find out more about how we use your information by contacting secretariat@ljmu.ac.uk.

If you are concerned about how your personal data is being processed, please contact LJMU in the first instance at secretariat@ljmu.ac.uk. If you remain unsatisfied, you may wish to contact the Information Commissioner's Office (ICO). Contact details, and details of data subject rights, are available on the ICO website at: https://ico.org.uk/for-organisations/data-protection-reform/overview-of-the-gdpr/individuals-rights/

**15. Contact for further information: Alan McGee A.McGee@2018.ljmu.ac.uk**

**Thank you for reading this information sheet and for considering taking part in this study.**

*Note: A copy of the participant information sheet should be retained by the participant with a copy of the signed consent form.*

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# Appendix C

## LIVERPOOL JOHN MOORES UNIVERSITY
## Participant Information Sheet: Alcohol and Drug (AOD) Treatment and Recovery Professionals

**LJMU's Research Ethics Committee Approval Reference**: **19/PHI/004**

**YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET**

**Title of Study: Producing the 'problem' of drugs: A critical analysis of the effects of drug policy since 2010 with a particular focus on people who inject drugs**

**School/Faculty**: Faculty of Education, Health and Community / Public Health Institute

**Principal Investigator**:
Alan McGee PhD Student A.McGee@2018.ljmu.ac.uk

**Study Supervisors:**
Professor Vivian Hope, Professor of Public Health V.D.Hope@ljmu.ac.uk
Dr Conan Leavey, Senior Lecturer in Public Health C.Leavey@ljmu.ac.uk
Dr Steven Wakeman, Senior Lecturer in Criminology S.J.Wakeman@ljmu.ac.uk

You are being invited to take part in a research study. Before you decide it is important for you to understand why the study is being done and what participation will involve. Please take time to read the following information carefully. Please ask if there is anything that is not clear or if you would like more information. Thank you for reading this.

**16. What is the purpose of the study?**

The number of drug related deaths recorded each year is now higher than at any time since official records began. Around half of the people who die from drug related causes have either never engaged with drug treatment or have dropped out and not re-engaged. This study hopes to answer the following questions: 'In what ways have policy responses in the past decade affected the risk of drug related deaths among people who inject drugs' and 'to what extent do drug user identities play a role in treatment engagement'.

**17. Why have I been invited to participate?**

You have been invited because you are a person involved with the delivery of drug treatment, recovery and harm reduction and have valuable insight and experience in providing drug treatment services. You have been selected for inclusion in this study using a process called 'purposive sampling' this is done to produce a sample of people representative of the study population.

**18. Do I have to take part?**

Taking part in the study is entirely voluntary. If you do agree to take part, you will be given this information sheet to keep and will be asked to sign a consent form. Signed consent forms will be securely stored in locked cabinets within the University and will only be accessed by the Principle Investigator and University staff who are directly associated with the study. You can withdraw from the study at any time by informing the investigators without giving a reason or explanation even after you have given consent.

**19. What will happen to me if I take part?**

You will be asked to take part in the study by being interviewed. The interview will comprise of a number 'open ended' questions which you will be asked to answer in your own words. The interview will be just like a conversation. This type of interview is called a semi-structured interview. Interviews will normally last for between 45 minutes and 1 hour.

**20. Will I be recorded and how will the recorded media be used?**

Interviews will be audio recorded on a password protected audio recording device. As soon as is reasonably possible after the interview the recording will be transferred to secure storage and deleted from the recording device. Transcripts from audio recordings and will be anonymised.

**21. What are the possible disadvantages and risks of taking part?**

There are no foreseeable risks or disadvantages associated with taking part in this study. If at any time during the interview you feel uncomfortable talking about your experience you can ask for the interview to be stopped. If necessary, the researcher will signpost you to support services if you are negatively affected by the interview.

**22. What are the possible benefits of taking part?**

While there may be do direct benefits to you from taking part in this study it is hoped that the work will increase our understanding of why some people who use drugs choose not to engage with drug treatment services.

**23. What will happen to the data provided and how will my taking part in this project be kept confidential?**

The information you provide as part of the study is the **research study data**. Any research study data from which you can be identified (e.g. from identifiers such as your name, date of birth, audio recording etc.) is known as **personal data**. Personal data does not include data that cannot be identified to an individual (e.g. data collected anonymously or where identifiers have been removed). If necessary, personal data will be stored confidentially for 5-years.

Transcripts will **not** include personal identifiable data and no reference will be made to your organisation or agency. Signed consent forms will be stored in in locked cabinets within the University and accessed only by the Principal Investigator and study supervisors.

**24. Limits to confidentiality**

The Investigator will keep confidential anything they learn or observe related to illegal activity unless related to the abuse of children or vulnerable adults, money laundering or acts of terrorism.

In certain exceptional circumstances where you or others may be at significant risk of harm, the investigator may need to report this to an appropriate authority. This would usually be discussed with you first. Examples of those exceptional circumstances when confidential information may have to be disclosed are:

- The investigator believes you are at serious risk of harm, either from yourself or others
- The investigator suspects a child may be at risk of harm
- You pose a serious risk of harm to, or threaten or abuse others
- As a statutory requirement e.g. reporting certain infectious diseases
- Under a court order requiring the University to divulge information
- We are passed information relating to an act of terrorism

**25. What will happen to the results of the research project?**

The investigator intends to complete a dissertation to satisfy their degree programme / publish the results in a PhD thesis / journal article.

**26. Who is organising and the study?**

This study is organised by Liverpool John Moores University.

**27. Who has reviewed this study?**

This study has been reviewed by, and received ethics clearance through, the Liverpool John Moores University Research Ethics Committee (Reference number: 19/PHI/004).

**28. What if something goes wrong?**

If you have a concern about any aspect of this study, please contact the relevant investigator who will do their best to answer your query. The researcher should acknowledge your concern within 10 working days and give you an indication of how they intend to deal with it. If you wish to make a complaint, please contact the chair of the Liverpool John Moores University Research Ethics Committee (researchethics@ljmu.ac.uk) and your communication will be re-directed to an independent person as appropriate.

**29. Data Protection Notice**

The data controller for this study will be Liverpool John Moores University (LJMU). The LJMU Data Protection Office provides oversight of LJMU activities involving the processing of personal data, and can be contacted at secretariat@ljmu.ac.uk. This means that we are responsible for looking after your information and using it properly. LJMU's Data Protection Officer can also be contacted at secretariat@ljmu.ac.uk. The University will process your personal data for the purpose of research. Research is a task that we perform in the public interest.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained.
You can find out more about how we use your information by contacting secretariat@ljmu.ac.uk.

If you are concerned about how your personal data is being processed, please contact LJMU in the first instance at secretariat@ljmu.ac.uk. If you remain unsatisfied, you may wish to contact the Information Commissioner's Office (ICO). Contact details, and details of data subject rights, are available on the ICO website at: https://ico.org.uk/for-organisations/data-protection-reform/overview-of-the-gdpr/individuals-rights/

**30. Contact for further information: Alan McGee A.McGee@2018.ljmu.ac.uk**

**Thank you for reading this information sheet and for considering taking part in this study.**

*Note: A copy of the participant information sheet should be retained by the participant with a copy of the signed consent form.*

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# Appendix D

## LIVERPOOL JOHN MOORES UNIVERSITY
## Participant Information Sheet: Alcohol and Other Drug (AOD) Treatment and Recovery Service Commissioners

**LJMU's Research Ethics Committee Approval Reference**: **19/PHI/004**

**YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET**

**Title of Study: Producing the 'problem' of drugs: A critical analysis of the effects of drug policy since 2010 with a particular focus on people who inject drugs**

**School/Faculty**: Faculty of Education, Health and Community / Public Health Institute


**Principal Investigator**:
Alan McGee PhD Student A.McGee@2018.ljmu.ac.uk

**Study Supervisors:**
Professor Vivian Hope, Professor of Public Health V.D.Hope@ljmu.ac.uk
Dr Conan Leavey, Senior Lecturer in Public Health C.Leavey@ljmu.ac.uk
Dr Steven Wakeman, Senior Lecturer in Criminology S.J.Wakeman@ljmu.ac.uk


You are being invited to take part in a research study. Before you decide it is important for you to understand why the study is being done and what participation will involve. Please take time to read the following information carefully. Please ask if there is anything that is not clear or if you would like more information. Thank you for reading this.

**31. What is the purpose of the study?**

The number of drug related deaths recorded each year is now higher than at any time since official records began. Around half of the people who die from drug related causes have either never engaged with drug treatment or have dropped out and not re-engaged. This study hopes to answer the following questions: 'In what ways have policy responses in the past decade affected the risk of drug related deaths among people who inject drugs' and 'to what extent do drug user identities play a role in treatment engagement'.

**32. Why have I been invited to participate?**

You have been invited because you are either a person who injects drugs, a person involved with the delivery of drug treatment or a person who is responsible for commissioning drug treatment services. You have been selected for inclusion in this study

using a process called 'purposive sampling' this is done to produce a sample of people representative of the study population.

**33. Do I have to take part?**

Taking part in the study is entirely voluntary. If you do agree to take part you will be given this information sheet to keep and be asked to sign a consent form. Signed consent forms will be securely stored in locked cabinets within the University and will only be accessed by the Principle Investigator and University staff who are directly associated with the study. You can withdraw at any time by informing the investigators without giving a reason and without it affecting your rights even after consent has been given.

**34. What will happen to me if I take part?**

You will be asked to take part in the study by being interviewed. You will be asked a number 'open ended' questions which you will be asked to answer in your own words. The interview will be just like a conversation. This type of interview is called a semi-structured interview. Interviews will normally last for between 45 minutes and 1 hour.

**35. Will I be recorded and how will the recorded media be used?**

Interviews will be audio recorded on a password protected audio recording device and as soon as possible the recording will be transferred to secure storage and deleted from the recording device. Transcripts from audio recordings will be anonymised.

**36. What are the possible disadvantages and risks of taking part?**

There are no foreseeable risks or disadvantages associated with taking part in this study. If at any time during the interview you feel uncomfortable talking about your experience you can ask for the interview to be stopped. If necessary, the researcher will signpost you to support services if you are negatively affected by the interview.

**37. What are the possible benefits of taking part?**

While there may be do direct benefits to you from taking part in this study it is hoped that the work will increase our understanding of why some people who use drugs choose not to engage with drug treatment services.

**38. What will happen to the data provided and how will my taking part in this project be kept confidential?**

The information you provide as part of the study is the **research study data**. Any research study data from which you can be identified (e.g. from identifiers such as your name, date of birth, audio recording etc.) is known as **personal data**. Personal data does not include data that cannot be identified to an individual (e.g. data collected anonymously or where identifiers have been removed). If necessary, personal data will be stored confidentially for 5-years.

Transcripts will **not** include personal identifiable data and no reference will be made to your agency or organisation. Signed consent forms will be stored in locked cabinets within the University and accessed only by the Principal Investigator and study supervisors.

**39. Limits to confidentiality**

The Investigator will keep confidential anything they learn or observe related to illegal activity unless related to the abuse of children or vulnerable adults, money laundering or acts of terrorism.

In certain exceptional circumstances where you or others may be at significant risk of harm, the investigator may need to report this to an appropriate authority. This would usually be discussed with you first. Examples of those exceptional circumstances when confidential information may have to be disclosed are:

- The investigator believes you are at serious risk of harm, either from yourself or others
- The investigator suspects a child may be at risk of harm
- You pose a serious risk of harm to, or threaten or abuse others
- As a statutory requirement e.g. reporting certain infectious diseases
- Under a court order requiring the University to divulge information
- We are passed information relating to an act of terrorism

**40. What will happen to the results of the research project?**

The investigator intends to complete a dissertation to satisfy their degree programme / publish the results in a PhD thesis / journal article.

**41. Who is organising and the study?**

This study is organised by Liverpool John Moores University.

**42. Who has reviewed this study?**

This study has been reviewed by, and received ethics clearance through, the Liverpool John Moores University Research Ethics Committee (Reference number: 19/PHI/004).

**43. What if something goes wrong?**

If you have a concern about any aspect of this study, please contact the relevant investigator who will do their best to answer your query. The researcher should acknowledge your concern within 10 working days and give you an indication of how they intend to deal with it. If you wish to make a complaint, please contact the chair of the Liverpool John Moores University Research Ethics Committee (researchethics@ljmu.ac.uk) and your communication will be re-directed to an independent person as appropriate.

**44. Data Protection Notice**

The data controller for this study will be Liverpool John Moores University (LJMU). The LJMU Data Protection Office provides oversight of LJMU activities involving the processing of personal data, and can be contacted at secretariat@ljmu.ac.uk. This means that we are responsible for looking after your information and using it properly. LJMU's Data Protection Officer can also be contacted at secretariat@ljmu.ac.uk**.** The University will process your personal data for the purpose of research. Research is a task that we perform in the public interest.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained.
You can find out more about how we use your information by contacting secretariat@ljmu.ac.uk.

If you are concerned about how your personal data is being processed, please contact LJMU in the first instance at secretariat@ljmu.ac.uk. If you remain unsatisfied, you may wish to contact the Information Commissioner's Office (ICO). Contact details, and details of data subject rights, are available on the ICO website at: https://ico.org.uk/for-organisations/data-protection-reform/overview-of-the-gdpr/individuals-rights/

**45. Contact for further information: Alan McGee A.McGee@2018.ljmu.ac.uk**

**Thank you for reading this information sheet and for considering to take part in this study.**

*Note: A copy of the participant information sheet should be retained by the participant with a copy of the signed consent form.*

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# Appendix E

## Producing the ‘problem’ of drugs: A critical analysis of the effects of drug policy since 2010 with a particular focus on people who inject drugs

### Interview Schedule – People who inject drugs (PWID)

### Introduction

Thank you for taking part in this study and for agreeing to be interviewed today. The interview will be based on a number of open-ended questions – there are no right or wrong answers – we are interested in your views and what you think.

The interview will be audio recorded on a password protected recording device. As soon as possible after the interview the recording will be transferred to secure storage and deleted from the recording device. All audio recordings and transcripts will be completely anonymous.

Taking part in this interview is completely voluntary and you can ask to stop the interview at any time.

### Checks

Has interviewee read the relevant information sheet and had time to ask questions

Has the interviewee signed the consent sheet?

Is recording device switched on and positioned close?

| Theme – Context, beliefs, values, benefits | Prompts | Notes |
| --- | --- | --- |
| **Q1 When did you start to inject drugs?** | Did you start to inject drugs with someone else?<br><br>Do people who inject drugs see themselves differently / have different needs to other drug users?<br><br>Are there any benefits for you from injecting drugs? | |
| Theme – Treatment, risk and harm reduction | Prompts | Notes |
| **Q2 What has been your experience of drug treatment as a person who injects drugs?** | What do you think the main aim of drug treatment should be for people who inject drugs?<br><br>What would / has put you off going to drug treatment services | |
| **Q3 How might drug treatment services for people who inject drugs be provided differently?** | Who do you think decides what drug treatment services provide? | |
| Theme – Homelessness, health and drug related harm | Prompts | Notes |
| **Q4 How has the increase in homelessness among people who inject drugs affected health and drug related harm?** | What do you think the main problems are for people who inject drugs and are homeless? | |
| **Q5 Do you think that the government and local councils should provide medically supervised injecting rooms?** | Would you use a medically supervised injecting room? | |

| | | |
|---|---|---|
| **Q6 Do you think that people who inject drugs should be given heroin assisted treatment and should be supervised using that?** | What would put you off using a medically supervised drug consumption room?<br><br>Do you think that the government and councils should focus more on providing homes for people who use drugs? | |
| Theme – Drug policy and policy responses | Prompts | Notes |
| **Q7 What changes have you seen in the way that drug treatment services have been provided over the past ten years?** | What does a recovery orientated drug treatment service mean to you?<br><br>What does harm reduction mean to you?<br><br>Do you think that there is a difference between recovery and harm reduction?<br><br>Do you think that drug treatment services should always be trying to get people to stop taking drugs?<br><br>Do you think drug treatment services can ever make things worse for people who use drugs? | |
| Theme – Crime, harm and the law | Prompts | Notes |
| **Q8 In what ways do the laws controlling drug use and drug possession affect the amount of harm associated with using drugs** | Do you think that drugs need to be controlled and regulated by the law?<br><br>Do you think that drugs could be controlled and regulated differently? | |

# Appendix F

## Producing the ‘problem’ of drugs: A critical analysis of the effects of drug policy since 2010 with a particular focus on people who inject drugs

### Interview Schedule – Alcohol and drug (AOD) treatment and recovery professionals

### Introduction

Thank you for taking part in this study and for agreeing to be interviewed today. The interview will be based on a number of open-ended questions – there are no right or wrong answers – we are interested in your views and what you think.

The interview will be audio recorded on a password protected recording device. As soon as possible after the interview the recording will be transferred to secure storage and deleted from the recording device. All audio recordings and transcripts will be completely anonymous.

Taking part in this interview is completely voluntary and you can ask to stop the interview at any time.

### Checks

Has interviewee read the relevant information sheet and had time to ask questions?

Has the interviewee signed the consent sheet?

Is recording device switched on and positioned close?

| Theme – Context, qualifications, experience, values and beliefs | Prompts | Notes |
| --- | --- | --- |
| **Q1 How did you become interesting in working in drug treatment services?**<br><br>**Q2 What qualification and experience you think people need to work in drug treatment services?**<br>**Q3 Why do you think people use drugs?** | What informs your knowledge, values and beliefs regarding drug use and people who use drugs?<br><br>Do you think it helps to have had personal experience of drug use?<br>Do you think there are ever any benefits for people from using drugs? | |
| Theme – Treatment, risk and harm reduction | Prompts | Notes |
| **Q4 What should the main priorities of drug treatment be?**<br><br>**Q5 Why do you think some people who use drugs do not want to engage with treatment services?**<br><br>**Q6 How might drug treatment services be provided differently?** | What kinds of things work in drug treatment?<br><br>How should the effectiveness of drug treatment be measured?<br><br>What should the main goal of drug treatment be?<br><br>What do you think the main risks for people who inject drugs are?<br><br>Who do you think decides what drug treatment services should provide? | |
| Theme – Homelessness, health and drug related harm | Prompts | Notes |

| | | |
|---|---|---|
| **Q7 In what ways has an increase in homelessness among people who use drugs affected health and drug related harm**<br><br><br><br><br><br><br><br>**Q8 Do you think that the government and local councils should provide medically supervised injecting rooms?** | Do you think that drug treatment services could do anything to help people who use drugs and are homeless?<br>What do you think the biggest problems are for people who inject drugs and are homeless?<br><br>Do you think people would use a medically supervised injecting room?<br>What would put people off using a medically supervised drug consumption room?<br><br>Do you think that people who inject drugs should be offered heroin assisted treatment and be supervised using that?<br><br>Do you think that the government and councils should focus more on providing homes for people who use drugs? | |
| Theme – Drug policy and policy responses | Prompts | Notes |
| **Q9 What have been the main changes in drugs policy and the way that drug treatment services have been delivered over the past ten years?** | What does a recovery orientated drug treatment service mean to you?<br><br>What does harm reduction mean to you?<br><br>Do you think that there is a difference between recovery and harm reduction?<br>Do you think that drug treatment services should always be trying to get people to stop taking drugs? | |

| | | |
|---|---|---|
| | Do you think drug treatment services can ever make things worse for people who use drugs?<br><br>Do you think that language is important in the way that we describe people who use drugs and drug treatment services?<br><br>Who do you think decides on what kind of language is okay and what isn't okay? | |
| Theme – Crime, harm and the law | Prompts | Notes |
| **Q10 In what ways do the laws controlling drug use and drug possession affect the amount of harm associated with using drugs** | Do you think that drugs need to be regulated by the law?<br><br>Do you think that drugs could be regulated differently? | |

# Appendix G

**Producing the 'problem' of drugs: A critical analysis of the effects of drug policy since 2010 with a particular focus of people who inject drugs**

## Interview Schedule – Alcohol and other drug treatment and recovery service commissioners

### Introduction

Thank you for taking part in this study and for agreeing to be interviewed today. The interview will be based on a number of open-ended questions – there are no right or wrong answers – we are interested in your views and what you think.

The interview will be audio recorded on a password protected recording device. As soon as possible after the interview the recording will be transferred to secure storage and deleted from the recording device. All audio recordings and transcripts will be completely anonymous.

Taking part in this interview is completely voluntary and you can ask to stop the interview at any time.

### Checks

Has interviewee read the relevant information sheet and had time to ask questions

Has the interviewee signed the consent sheet?

Is recording device switched on and positioned close?

| Theme – Context, qualifications, experience, values and beliefs | Prompts | Notes |
|---|---|---|
| **Q1 How did you become involved with commissioning drug treatment services?**<br><br>**Q2 What qualification and experience do you think people need to be commissioners of drug treatment services?**<br><br>**Q3 Why do you think people use drugs?** | What informs your knowledge, values and beliefs regarding drug use and people who use drugs?<br><br>Do you think it helps to have had personal experience of drug use?<br><br>Do you think there are ever any benefits for people from using drugs? | |
| Theme – Treatment, risk and harm reduction | Prompts | Notes |
| **Q4 What should the main priorities of drug treatment be?**<br><br>**Q5 Why do you think some people who use drugs do not want to engage with treatment services?**<br><br>**Q6 How might drug treatment services be provided differently?** | What kinds of things work in drug treatment?<br><br>How should the effectiveness of drug treatment be measured?<br><br>What should the main goal of drug treatment be?<br><br>What do you think the main risks for people who use inject drugs are?<br><br>Who do you think decides what drug treatment services should provide? | |

| Theme – Homelessness, health and drug related harm | Prompts | Notes |
| --- | --- | --- |
| **Q7 In what ways has an increase in homelessness among people who use drugs affected health and drug related harm**<br><br><br><br><br>**Q8 Do you think that the government and local councils should provide medically supervised injecting rooms?** | Do you think that drug treatment services could do anything to help people who use drugs and are homeless?<br><br>What do you think the biggest problems are for people who inject drugs and are homeless?<br><br>Do you think people would use a medically supervised injecting room? What would put people off using a medically supervised drug consumption room?<br><br>Do you think that people who inject drugs should be offered heroin treatment and should be supervised using that?<br><br>Do you think that the government and councils should focus more on providing homes for people who use drugs? | |
| Theme – Drug policy and policy responses | Prompts | Notes |
| **Q9 What have been the main changes in drugs policy and the way that drug treatment services have been delivered over the past ten years?** | What does a recovery orientated drug treatment service mean to you?<br><br>What does harm reduction mean to you?<br><br>Do you think that there is a difference between recovery and harm reduction? | |

| | | |
|---|---|---|
| | Do you think that drug treatment services should always be trying to get people to stop taking drugs?<br><br>Do you think drug treatment services can ever make things worse for people who use drugs?<br><br>Do you think that language is important in the way that we describe people who use drugs and drug treatment services?<br><br>Who do you think decides on what kind of language is okay and what isn't okay? | |
| Theme – Crime, harm and the law | Prompts | Notes |
| **Q10 In what ways do the laws controlling drug use and drug possession affect the amount of harm associated with using drugs** | Do you think that drugs need to be regulated by the law?<br><br>Do you think that drugs could be regulated differently? | |