

**'Workers', 'clients' and the struggle over needs:
Understanding encounters between service providers and injecting drug
users in an Australian city**

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Abstract

A feature of contemporary Western, neo-liberal democracies is the frequent interaction between representatives of health and social services and the members of stigmatised and ‘unruly’ populations, such as injecting drug users. Previous research on drugs has tended to ignore the power relations and cultural dynamics at work in these encounters, and the ways in which they are framed by the wider neo-liberal context. Drawing on an ethnography of street-based heroin use in Melbourne, Australia’s second largest city, I show how the discourses of both service providers and injecting drug users draw on wider neo-liberal values of independence, autonomy, rationality and responsibility. Service providers negotiate a framework of needs interpretation that creates and reproduces professional identities, and maintains boundaries between ‘workers’ and ‘clients’. It also includes tensions around the definition of injecting drug users as ‘chaotic’ (ie, failed neo-liberal) subjects, and slippage between service philosophies that emphasise a social model of health and forms of service delivery that emphasise the production of responsibilised subjects. For their part, street-based injectors construct an alternative framework of needs interpretation that emphasises their self-reliance, autonomy and independence, attributes and capacities largely denied them in service provider discourse. In encounters with service providers, street-based injectors respond in various ways that include elements of resistance, strategic accommodation and the incorporation of therapeutic discourse. I conclude by considering the implications of my analysis for the future development of drug policy and practice.

Introduction

A feature of contemporary Western, neo-liberal democracies is the frequent interaction between representatives of health and social services and the members of stigmatised and ‘unruly’ populations, such as injecting drug users. Studies of service utilisation by injecting drug users typically focus on a range of policy and practice questions such as how to ‘improve service outcomes’, increase ‘client engagement and retention’, address ‘non-compliance’, reduce ‘barriers to service utilisation’ and better target services to ‘vulnerable’ or ‘at-risk’ populations (eg, Semple, Grant & Patterson, 2005; Treloar, Abelson, Cao, Brener, Kippax, Schultz, et al., 2004; Wright, Klee & Reid, 1999). While providing information relevant to the redesign of health services, this work tends to ignore the power relations and discourses (ie, the ideas and practices) shaping encounters between service providers and injecting drug users, and ways in which they are framed by the wider neo-liberal context. In this article, I offer a way of understanding such encounters and their context through an analysis of those I recorded during a two-year ethnographic study of street-based heroin use and service provision in the St Kilda area of Melbourne, Australia’s second largest city.

In seeking to understand these encounters, I draw on recent poststructuralist work on ‘bio-power’ or the ways in which ‘historically entrenched institutionalized forms of social control discipline bodies’ through ‘laws, medical interventions, social institutions, ideologies and even structures of feeling’ (Bourgois, 2000, p.167). This work has identified shifts in the ways in which health and social services are conceptualised and delivered under the institutions, ideas and practices of ‘advanced’ or neo-liberalism. In classical liberalism, a ‘welfarist’ political rationality emphasised State

and expert responsibility for the care of individual citizens. In neo-liberalism, there has evolved a political rationality in which rational, independent and entrepreneurial citizens are increasingly responsible for the 'care of the self' (Petersen, 1997). There has been a move to non-collective, low-cost solutions to growing welfare budgets, a de-institutionalisation of health care, privatisation of services, adoption of user-pays models and promotion of more active forms of citizenship (Nettleton & Bunton, 1995).

There has also been a marked rise in preventative medicine and health promotion (Burrows, Nettleton & Bunton, 1995). Citizens are urged to stop smoking, to eat less fat, to exercise more and to monitor their alcohol intake, and thus risk is redistributed from the state to individuals. The 'patient' is no longer a passive recipient of expert care but a 'client' with the capacity for healthy choice, and 'choosing' health becomes the duty of modern citizens (Henderson & Petersen, 2002). Health promotion, it is argued, becomes a 'technology of the self', a mode of self-regulation and self-care that is central to the government of conduct in neo-liberal societies.

However, as a number of studies of neo-liberal governmentality have argued, the adoption of technologies of self-regulation and self-care is by no means universal. Writing about public health, Lupton (1995, p.156) has argued that people may negotiate, resist or ignore health promotion strategies because they derive greater pleasure from other practices or because these strategies 'chafe upon cherished notions of autonomy'. In relation to the provision of services for drug users in Denmark, Asmussen (2003) has similarly argued that the ideas, practices and structures governing recipients of such services as particular kinds of subjects may meet with 'resistance,

dissidence or absence' on the part of the 'governed'. Likewise, Fraser (1989), in her essay 'Struggle over needs', argues that clients of services may practice various forms of resistance that undermine, exploit or explicitly challenge the ways in which they, and their needs, are defined by service frameworks.

An interest in understanding struggles over the definition of drug user needs and their consequences for service provision and utilisation informs the following analysis. I show how the discourses of both St Kilda service providers and injecting drug users draw on wider neo-liberal values of independence, autonomy, rationality and responsibility. Service providers negotiate a framework of needs interpretation that creates and reproduces professional identities, and maintains boundaries between 'workers' (ie, service providers) and 'clients'. This framework also includes tensions around the definition of injecting drug users as 'chaotic' (ie, as failed neo-liberal) subjects, and slippage between service philosophies that emphasise a social model of health and service delivery that emphasises the production of responsibilised subjects. Street-based injectors are not, of course, passive participants in this process. They also draw on neo-liberal discourses to construct an alternative framework of needs interpretation in which they struggle to claim possession of the very capacities and attributes largely denied to them in service provider discourse, and in wider public imaginings of injecting drug users as irrational and irresponsible (Keane, 2002). In response to social, cultural and economic marginalisation, street-based injectors enact a 'survivalist' cultural form that articulates a set of needs deriving from participation in a street drug market. In their encounters with service providers, street-based injectors respond in various ways that include elements of resistance, strategic accommodation

and the incorporation of therapeutic discourse. I conclude by considering the implications of my analysis for future reformulations of drug policy and practice.

Research methods

I conducted ethnographic research with street-based injecting drug users and service providers in St Kilda from August 2000 to June 2002, with follow-up research undertaken in September and December 2002 and May and August 2003. The research focused on the social contexts of heroin overdose and service provision. St Kilda, a bayside suburb located approximately 6kms south of central Melbourne, was chosen as the research site because of its high rates of non-fatal overdose, its long association with both street-based drug use and sex work, and its hosting of several drug, health and welfare services. The research was funded by the Victorian Health Promotion Foundation and ethical approval was granted by the Victorian Department of Human Services Ethics Committee and the Human Research Ethics Committee at Deakin University (where I was based at the time).

To begin the research, I met with staff from a range of services in order to: (1) make contact with various 'stakeholders', (2) gain some initial understanding of local drug-related issues and (3) investigate opportunities for accessing social networks of street-based injectors through participation in outreach work and through the conduct of initial interviews at a local crisis centre. Following these introductions, I participated fortnightly in evening outreach work to street-based injectors and sex workers, and observed office-based service provision and client/provider interaction on a weekly

basis. Detailed fieldnotes were made following each episode of outreach work and office-based observation.

Evening outreach services – via car, bus and on foot – extended into the early hours of the morning in order to reach the maximum number of street sex workers and their associates. Staffed by nurses, welfare workers, peer workers (ie, former or current drug users) and counsellors, outreach services provided clean injecting equipment, condoms and lubricant, and referral to other services. Bus-based outreach offered basic medical care and advice, in-bus testing for sexually transmitted infections, and drinks and light snacks; in the case of the car-based service, street outreach or home delivery of telephoned orders for injecting equipment. As the outreach staff drove or, less frequently, walked around St Kilda, they would ‘engage with clients’ by asking ‘Do you need anything?’ or, approaching a group of people, by stopping to offer their services. Alternatively, sex workers, injectors and other street participants would hail outreach staff or use more discreet ways of indicating their wish to ‘engage’ (eg, a simple nod of the head). Brief conversations and provision of equipment sometimes occurred through an open car or bus window or on a footpath outside vehicles, with longer, sometimes more intimate conversations possible when on foot, inside the bus or in more secluded car parks away from main streets.

St Kilda also included a needle and syringe program (NSP), which was housed in the crisis centre referred to above. In addition to the provision of clean injecting equipment, NSP workers sometimes took the opportunity to disseminate harm reduction

information and education, and to provide referrals to health, housing, legal and welfare services.

I also interviewed a purposive sample of 56 practitioners drawn to cover the main types of service provision in the area. They included general medical practitioners, nurses, peer workers, community developers, youth and social workers, welfare workers and counsellors. The interviews covered professional background and experience; current duties; guiding philosophies and professional models; understandings of drug use and dependence; and definitions of effective service provision. Interviews were tape-recorded and transcribed or handwritten notes were made during or immediately following interviews.

Building relationships with people participating in the local street drug market began with initial interviews at the NSP, and through conversations arising during outreach work and pedestrian sweeps of the area. From these starting points, I developed sufficient familiarity and trust with nine members of street-based networks to observe them, and their larger groups of associates, in street settings several times per week. Detailed notes were made following episodes of fieldwork.

In addition to fieldwork and multiple interviews with the nine members of street-based networks, I also conducted in-depth interviews with a convenience sample of 58 people recruited through the NSP, 33 of whom also participated in the street drug market (ie, total street sample = 42). These interviews focused on sociodemographic characteristics; education, employment and drug histories; social contexts of current drug use; patterns

of service utilisation; and circumstances of overdose. Interviews were tape-recorded and transcribed or handwritten notes were made during or immediately following interviews. Interviewees received AUS\$20 for their time and out-of-pocket expenses.

In collaboration with an epidemiologist and NSP staff, I also designed a series of snapshot surveys of NSP clients conducted on a weekly basis over a six-week period in 2002. These surveys allowed me to compare the sociodemographic profiles of the street-based sample and a larger sample of injecting drug users. In Table 1, a profile of the 42 street-based research participants is compared with data gathered in the snapshot surveys of NSP clients.

Table 1: Comparison of street and NSP samples

	Street sample % (n=42)	NSP sample % (n's)
Age <30	62	47 (600)
Female	43	35 (625)
Anglo-Australian	83	NA
Homeless/squat/refuge/hostel/shelter/boarding	52	22 (484)
Secondary schooling incomplete	85	59 (497)
Employment status:		
Not in full-time work	98	85 (730)
Unemployed	69	18 (730)
Major source of income = sex work	74	10 (477)
Living outside St Kilda	52	60 (550)
'Main drug' = heroin	76	NA
Polydrug use (≥ 2 illicit drugs)	95	NA
Drug conviction	40	NA
Ever in treatment	80	NA
Overdose	71	NA
HCV+	59	NA
Shared injecting equipment – ever	50	NA
Shared injecting equipment – last year	38	NA

As the shaded rows in Table 1 indicate, street-based injectors are much more likely to be involved in illegal street sex work (either as a sex worker or partner of a sex worker), to be unemployed, to be homeless or insecurely housed, and to have lower levels of education. Most are Anglo-Australian heroin users with experience of drug treatment and the legal system. The majority believe that they are infected with hepatitis C, more than one-third reports sharing injecting equipment in the last year, all but two report polydrug use and more than two-thirds report experiencing a drug overdose. Those who do not live in St Kilda (roughly one in two) are drawn there by the economic imperatives of heroin dependence and participation in an underground economy that includes street sex work and drug dealing.

Data analysis was inductive and iterative in that it involved the ongoing collection of data, identification of emerging themes and generation of plausible hypotheses to guide further data collection. Hardcopies of fieldnotes and interview transcripts were coded for cultural categories expressed in key words and phrases, events and practices.

Neo-liberalism and Australian public policy

Since the 1980s, alongside developments in other Western countries, neo-liberal ideas, practices and approaches have increasingly informed Australian public policy in finance, education, industrial relations, public administration, and health and social services (Henderson, 2005; Mendes, 2003; Newman et al, 2007; Petersen, 1997; Western et al, 2007). According to Beeson & Firth (1998, p.221): ‘The image of the market [...] becomes the ideal to which schooling, education, health services, welfare and the agencies of the state which provide these services are encouraged to conform in

order to ensure national economic survival'. Australian public health policy and practice in relation to drugs has also been influenced by neo-liberalism in such areas as heroin overdose (Moore, 2004), hepatitis C infection (Fraser, 2004) and methadone maintenance therapy (Fraser and Valentine, 2008). Neo-liberal ideas have also informed the development of harm reduction in Australia and elsewhere (Keane, 2003; Miller, 2001).

In the state of Victoria, services underwent profound changes as a result of neo-liberal government policies introduced in the 1990s. These included a move to a market model which saw government as a purchaser rather than provider of services; the introduction of widespread competitive tendering for service funding; an emphasis on productivity, outputs, goals and targets; and restructuring of agencies and community services to make them 'more autonomous and accountable, oriented to cost-cutting efficiencies, technical rationality and values of competitiveness' (Reiger & Keleher, 2004, p.31-32).

Many of St Kilda's social, health and drug services had experienced the 1990s neo-liberal reforms. These had generated a structural tension whereby agencies delivering services to marginalised populations were often competitors for funding. However, agencies were also linked by personal relationships between staff who had collaborated on previous programs. The relationships included management as well as direct-service workers – 'street bureaucrats' (Lipsky 1980) – who dealt directly with clients in the provision of social services and who had considerable power to make decisions that impacted on client lives.

Subjects and environments in service discourse

Across diverse agencies, the framework of needs interpretation constructed by service providers in St Kilda had several common features, even if the specific rules and regulations by which these were instituted differed in each service setting. In-depth interviews and fieldwork revealed that the field is conceptualised as consisting of professional ‘workers’ and the ‘clients’ of service provision. Workers are invested with considerable authority by the state through ‘mandatory reporting’ (ie, the legal requirement to report cases of child physical or sexual abuse or neglect) and ‘duty of care’ regulations (eg, to provide a reasonable standard of care whilst undertaking acts that could potentially harm others).

In addition to professional knowledge and skills, ‘good workers’ need ‘empathy’, a ‘non-judgmental attitude’, ‘good social skills’ and to be ‘client-centred’. However, codes of professional conduct also caution workers to ‘establish boundaries’ with their clients so as not to create unreal expectations for them or complicate the professional/client relationship, to be vigilant on safety issues and to ‘debrief’ regularly to colleagues so as to reduce work-related stress. From time to time, services also conduct ‘needs assessments’ in order to redesign existing programs to better meet the perceived requirements of clients, plan new programs or support funding applications.

Alongside these common elements of service provision, tensions existed between neo-liberal and critical readings of clients and service delivery. The first tension concerns the cultural construction of ‘clients’, who are defined in agency policy documents as ‘drug dependent’, ‘vulnerable’, ‘marginalised’, ‘hard-to-reach’, having ‘complex needs’

or 'at-risk'. When asked in interviews to describe a 'typical client', workers tended to answer in one of two ways. First, clients consisted of 'all sorts' or 'all types'. For example:

There are certain people that, particularly guys living on the street, that hang around and take up a lot more visual space, head space, time-wise space, so that you get the impression that there is a typical client but [...] if I had to really think past that immediate first thought I would have to say that there is no typical client in St Kilda.

(Interview: October 2001)

The decontextualisation of drug use individualises 'drug problems' and ignores the well-established relationship between political economy and drug-related harm (Baer, Singer & Susser, 2003). Although middle-class access to greater resources is acknowledged, orthodox explanations for drug problems continued to emphasise childhood abuse, personality disorders or other forms of psychological or social dysfunction. In the words of one service manager, drug users are 'damaged' individuals. Consider also the following examples:

I really do believe when one is beaten and violated and raped at an early age or brought up by bullying, that one's connections, one's receptors or whatever they are, do not reach full maturity. And I think those people have less resources. I heard one psychologist say in a lecture that these people don't need rehabilitation because they've never been habilitated.

(Interview: September 2001)

Why are some people heroin addicts and [...] some people able to use every blue moon [ie, very occasionally]? I think there's something beneath that [...] mental health, trauma, [lack of] acceptance. [Addiction is] 'pain relief, either mental or physical'. (Interview: October 2001)

A second way in which workers describe their clients is as 'chaotic', as in the following examples:

Sometimes I think people may be very chaotic; they just see you as a calm place and just try and get to you. It's like a bit of a lifeline, I actually think that happens quite a lot and [they] might just rock up because they need practical help and know that you are probably good at trying to [...] figure your way through some of that stuff. (Interview: October 2001)

Fairly chaotic [...] Some [have] really quite severe borderline personality disorder to the extent where they can't really sort of function at a GP clinic. I mean we try and stabilise people and refer them back, but we have a sort of core group of 25 or maybe even 50 that are so sort of, just in and out, and so chaotic, that they are sort of regulars [...]. The rest of the people actually have had some crisis or something, and usually stabilised, and then can be moved back.

(Interview: October 2001)

There is much that could be said about these quotations but here I highlight their role in establishing drug users as failed neo-liberal subjects. In the quotations, in which 'chaotic' is an intrinsic quality of the subject, what is meant by 'chaotic' is not defined.

In the first, its negative status is established through comparison with the qualities assumed by the service provider – she is calm, is a lifeline, has organisational skills and can provide practical assistance. In the second quotation, its negative status is firmly established through its linking to mental illness and dysfunction. As I have argued elsewhere (Fraser & Moore, 2008), references to ‘chaotic’ drug users and lifestyles in public discourse on drugs are poorly defined, and uncritically promote neo-liberal norms (often through their implied absence in the lives of drug users). They serve mainly to affirm the illegitimacy of illicit drug use by establishing and policing boundaries between the ostensibly disorderly lives of illicit drug users and the ‘normal’, orderly lives of non-illicit drug users.

The categorisation of injecting drug users as ‘chaotic’ did not go unchallenged, however. During interviews, several service providers offered more critical readings when discussing ‘chaotic’ clients. Consider the following reflexive statements, both of which redefine ‘chaotic’ as an entirely understandable response to the withdrawal or absence of material resources rather than as an intrinsic quality of a (flawed) subject:

I think it [using ‘chaotic’ to describe clients] has everything to do with our lifestyle as the baseline [...] We have stable accommodation, we have an income coming in, and we go to the supermarket, we can buy food, we can budget, they don’t have those basic things so therefore I think we just embellish it with that word, it must be ‘chaotic’ because I know whenever I’ve been without any one of those things it’s felt chaotic.

(Interview: November 2001)

They have to go out each day to get [money and drugs]. So it's actually quite structured, in some ways, *but* ... it's liable to change at the drop of a hat and that might be 'chaotic'. Being 'chaotic' for someone ... [...] it's not about spontaneity, it's about doing what has to be done to get through and [...] I don't know if that represents 'chaos'. To me, that's just more of doing what has to be done to get through.

(Interview: November 2001)

The second tension between neo-liberal and critical readings of clients and service delivery relates to the slippage between service philosophies that emphasise a social model of health and forms of service delivery that emphasise the production of responsabilised subjects. Agency policy documents often cited the 1986 Ottawa Charter for Health Promotion and the 1978 Alma-Ata Declaration on Primary Health Care, both of which draw attention to the social determinants of health, as guiding the design and delivery of services. An underlying principle of the social model of health is that clients face considerable material, social and discursive barriers to addressing drug-related risk and accessing quality healthcare, issues which needed to be addressed in critical policy and practice. Several agencies lobbied for the introduction of a supervised injecting facility and safer working conditions for street sex workers, drew attention to the decline in affordable housing, argued for social inclusion as a guiding principle in urban planning, and engaged in community development and advocacy on drug issues. Several years after the conclusion of fieldwork, the manager of one service was elected to the local government council on a platform that included social justice and improved services for people who use drugs and sex workers.

The contribution of services to wider political and community debates on drug use was therefore substantial, and self-critical, reflexive and politicised service narratives were articulated by many workers in describing their guiding philosophies. Concerns with ‘social justice’, structural inequalities and ‘equal access to healthcare’ were cited as primary motivations in their work. For example:

I just started to upgrade my nursing training and I got exposed to the World Health Organization, ‘primary health care’ and all those concepts.

(Interview: November 2001)

A commitment to health and everyone’s right to access health care and to access information [...] particularly groups at-risk or who are marginalised from access to health care, [and] a focus on empowerment and inclusion.

(Interview: November 2001)

However, a different set of concerns was dominant in relation to service delivery: a practical focus on ‘meeting client needs’ through ‘opportunistic healthcare’, of providing ‘immediate’, ‘practical’ resources when the opportunity arises in the lives of clients unlikely to seek ‘mainstream services’. For example:

We took the attitude that it was opportunistic so give it the best you can because you may not see them [the clients] again.

(Interview: November 2001)

Just to facilitate everyone that comes in, really, just to be open to what they want and to give it to them as best and as easiest as we can.

(Interview: December 2001)

In describing everyday service encounters, street bureaucrats tended to fall back on neo-liberal articulations that emphasised the production of responsabilised subjects. They were 'helping [drug users] to help themselves' and assisting them to understand and navigate through the service system. Chaotic clients must 'take responsibility' through learning to plan their affairs:

[I]t can be difficult if they come to rely on the service and for whatever reason it's not there. So it's about that, encouraging people to take responsibility to do some planning ... and to be prepared, and also to say, you know, there are a number of other spots that you can get [injecting] equipment and things like that, so ... I think, you know, it can be that danger of falling into the handout mentality.

(Interview: September 2001)

We've got a limit on condoms and the girls [female sex workers] will come in and we'll go 'Sorry mate, you've been in today, I can't give you any more', and they go, 'Oh, because of you I'm going to get HIV/AIDS' and [...] it's like 'Well actually, if you use [drugs] you've got enough money to buy your own'. Trying to [make them] take a bit of responsibility for what they're doing.

(Interview: December 2001)

Ascribing to drug users the status of rational, autonomous, neo-liberal subjects may confer obvious benefits. Notions such as 'responsibility' and 'competence' are highly

regarded in Western, neo-liberal societies, and it is important to understand the productive sense of personal empowerment and resilience that adopting a neo-liberal view may confer upon drug users, thus enabling them to counter marginalisation and deal with drug-related problems and services more effectively. At the same time, however, the neo-liberal approach may also be disempowering in that it may detract from a focus on the material and other disadvantages experienced by people who use drugs. It may also prevent them from seeking support and advice from others and from developing a more politicised view of their life situation.

Thus, the framework constructed by service providers defines several needs. First, service providers need to possess particular professional and personal skills and attributes. Services also need to be responsive to their clients and to seek ongoing funding (often in competition with other services). Service providers also debate whether to define clients as lacking a range of neo-liberal capacities and attributes or to see them as competent citizens struggling to cope with material disadvantage. In relation to service delivery, they tend to adopt and promote neo-liberal understandings that may be potentially empowering for clients but which may also de-emphasise the role of environment in shaping practice. Acknowledging these tensions provides a more nuanced empirical reading of the complex processes constituting contemporary neo-liberalism, which complements and extends the frameworks offered by Lupton, Asmussen and Fraser cited earlier.

Street-based survivalists

Street-based injectors in St Kilda construct an alternative framework of needs interpretation. Their ‘survivalist’ cultural form (Nayak, 2003) emerges in response to heroin dependence, ill-health, unstable housing, long-term unemployment and stigmatisation. A primary need is the ability to finance daily heroin injecting, with street sex work being a main source of income. Women solicited potential customers, known as ‘mugs’, through the open windows of their vehicles. They would negotiate price before providing the ‘[sexual] service’ in the mug’s vehicle or in a public toilet, park, flat, boarding house or motel. Although occasionally lucrative, street sex work is extremely hazardous. Street sex workers are regularly physically and sexually assaulted, robbed and, on occasions, murdered. There is also the high probability of arrest and sexually transmitted infection. Some of these women, and many of their male partners, are also involved in various ‘rorts’ (eg, ‘burgs’ [burglaries] and the sale of stolen goods). In addition to their fluctuating involvement in rorts and also street dealing in heroin and methamphetamine, some of the men also act as ‘spotters’ for their sex-working female partners. This involves noting the registration number of a mug’s vehicle, to be reported to police in the event of an assault or a sex worker failing to return from a ‘job’.

Another feature of the survivalist framework of needs interpretation is the requirement for detailed knowledge of the St Kilda streetscape. Typical topics of conversation documented during ethnographic fieldwork included:

- the price, quality and size of heroin deals;

- the availability, ethics and business practices of dealers, particularly with regard to giving ‘credit’;
- recent trends in sex work, including assaults, descriptions of aggressive mugs and the actions of hostile (as well as supportive) residents;
- activities relating to income generation or ‘rorts’;
- police activities;
- recent dealings with service providers; and
- the (mis)fortunes of other street participants.

In constructing key aspects of their lifeworld, street-based injectors draw on the linguistic traditions of the Australian, working-class ‘underworld’ (see Baker, 1970; Simes, 1993; Wilkes, 1990). Not surprisingly, given their extensive involvement in illegal activities, a key figure is the ‘jack’ (1919; date refers to year of first use as recorded in the studies cited above) – originally an English word for ‘police’. To ‘word’ (1915) means to warn others of impending police action or other potential threats. A ‘dog’ (1864) is an informer and/or a coward. As already noted, income for drugs derives from ‘rorts’ (1936) – deceptions, rackets or dodges, usually involving money – and the target of a rort may be a ‘mug’ (1857), particularly if a member of the middle class. As we have already seen, ‘mugs’ in the St Kilda context are the clients of sex workers. ‘Sweet’ (1898), meaning ‘all right’ or ‘in order’, is a positive evaluation of situations or events. ‘Grouse’ (1924) means ‘extra special’, ‘first rate’ or ‘excellent’, as in high-quality heroin being described as ‘grouse gear’ or simply ‘the grouse’. The Australian linguistic tendency to use the suffixes ‘ie’ or ‘o’, as in ‘hottie’ (from ‘hot [stolen] car’) and ‘benzos’ (benzodiazepines), is also much in evidence.

These terms are part of an Australian variant of liberal discourse that valorises independence, autonomy and self-reliance within egalitarian social relationships:

Intrinsic to the individual in [Australian] egalitarianism are the integrity and coherence of the individual, the autonomy of the individual, and the capacity to act as a free, self-determining, and moral unit or agent (Kapferer, 1988, p.15).

These 'natural', 'intrinsic' qualities of individuals stand in opposition to the social conventions of artificially created and externally imposed social and political orders, and are threatened by the unwelcome attention of representatives of the state such as the police.

In the context of the moral economy of street-based injecting drug use, these values are expressed in the notion of 'doing the right thing'. This involves keeping one's word, respecting one's self, paying one's debts and 'helping out' other injectors during withdrawal or overdose. A key element is maintaining control over one's drug use so that personally defined boundaries are not crossed (eg, 'I don't rob old ladies'). These values provide the framework for the commonly-made cultural distinction between the 'responsible user' (self) and 'junkies' (other). 'Responsible users' dispose of used injecting equipment with appropriate regard for other members of the community whereas 'junkies' allegedly show no such altruism. In contrast to those service-provider representations of drug users that emphasise disorder, drug users re-assert their possession of attributes such as rationality, autonomy and independence, and articulate a set of needs around income-generation, access to heroin, respect, safety and the knowledge relevant to participation in the street drug economy.

Resistance, strategic accommodation and incorporation

In the accounts cited earlier, Lupton, Asmussen and Fraser note that, in addition to engaging with services, clients may also resist or undermine them. Recent anthropological work, however, has problematised binary oppositions between conformity and resistance (eg, Campbell & Heyman, 2007; Ning, 2005). I draw on this work in what follows but also note a third element in the range of responses to services – the inconsistent and partial incorporation of therapeutic discourse by drug users. I treat these themes not as describing types of encounter but as co-existing elements of many encounters.

Resistance takes the form of ‘everyday tactics’ (Scott, 1985) such as verbal abuse, avoidance, false compliance, feigned ignorance and lying. In St Kilda, some drug users refuse to engage with service providers. They avoid contact with services altogether, enter into brief encounters in order to obtain injecting equipment or condoms, refuse to conduct themselves in ‘appropriate’ ways (eg, by verbally abusing workers or damaging service property) or challenge service-provider interpretations of their needs. They frequently articulate a desire to be treated respectfully and display acute sensitivity to perceived slights from service providers, which can result in verbal abuse and abrupt disengagement from the encounter. They employ what is widely seen by service providers as the aggressive tone of street speech, which some service providers find ‘difficult’ and ‘challenging’. Female service providers, in particular, frequently remarked on their discomfort when dealing with ‘the blokes’ – male spotters and other male street participants – particularly if they had been using the stimulant

methamphetamine rather than heroin. Service providers saw their ‘need’ to engage with female clients as being obstructed by male street practices.

In the following interview extract, ‘Jackie’ (names and other identifying details have been altered to preserve confidentiality) challenges the exclusive right to interpretation of a housing service and explicitly compares my freedom of movement and association with her own more limited version:

I had a flat through [housing service]. There was no visitors’ period, you had to be back by a certain time and you had to rock back, I think it was every 48 hours, or they’d threaten you with [...] kicking you out of the flat, you know it was like a prison camp, it was ... worse! [...] I mean, you [referring to me] go home, you’ve got a place, you don’t have restrictions [...] a certain time you must be home otherwise you cannot get back into your house [...] You don’t have restrictions that you can only have female visitors between the hours of 9 and 9 or in your case male. It’s fucking ridiculous, it’s absurd.

(Interview: May 2002)

If clients of social services sometimes deploy everyday tactics of resistance in their encounters with service providers, they also choose more strategic modes of accommodation. In order to gain and preserve access to services, they must be willing and able to submit to, and comply with, service provider demands, at least in a strategic sense. Ning (2005, p.351), writing of interactions between staff and clients in a Canadian methadone clinic, also focuses on this strategic accommodation but calls it

‘complicity’: a ‘duplicitous act with the appearance of conformity [...] that actually subverts ends as defined by decision-making powers and attempts to convert them to the needs of the disenfranchised’. While acknowledging Ning’s recognition of the agency of drug users in her formulation of ‘complicity’, the term risks reinforcing popular stereotypes of drug users as deceitful. I prefer ‘strategic accommodation’ – by which I mean purposive action in pursuit of defined needs – because it more accurately describes culturally approved modes of instrumental practice (eg, in areas such as business negotiations).

Strategic accommodation takes several forms. For example, street-based injectors remarked to me on several occasions that, when being case-managed by several workers, they struggled to remember what information they had provided to which service provider, in order to ensure a coherent form of strategic self-presentation in their dealings with them. Another common strategic claim of street-based injectors (referred to earlier) is that they always dispose of their used ‘fits’ (needles and syringes) safely – by returning them to NSPs or by disposing of them in specially designed steel bins placed in various public locations. Such practice can be seen as one strategy for gaining credit with service providers, of establishing one’s credentials as responsible and rational (see also Bourgois, 2002, p.262).

Another example of strategic accommodation is provided by the sometimes abrupt switches in the linguistic codes of street-based injectors when they contact services – shifts from street slang and demeanour to more polite and courteous modes of communication (eg, apologising to service providers after swearing). For example,

Angela and Jim were a couple who regularly engaged in various rorts in order to supplement the money Angela earned from sex work. These included selling goods stolen from cars or houses and gaining money through deception. In their dealings with various service providers, Angela and Jim were invariably polite and friendly. This led several workers, who were unaware of the rorts, to comment that Angela seemed 'sweet' and 'too fragile' and 'vulnerable' to participate in the street economy. Through their strategic self-presentation, Angela and Jim attempted to manage the way service providers perceived them, and to establish good relationships with them, so as to ensure access to services. Their efforts were rewarded several months later when they were able to secure access to a range of scarce resources including court support and housing.

A third theme evident in encounters between street-based survivalists and service providers is 'incorporation' – the adoption of service provider discourse by survivalists. My first example comes from a shift on the bus-based outreach service. During the course of the evening, my co-worker and I made contact with two female sex workers aged in their late teens. We fell into conversation about an incident earlier in the day when they had been, in their words, 'treated like junkies' at a local supermarket. One of the women, Deb, had become angry and had abused the supermarket staff. She said she probably would not have reacted so aggressively had she not already suffered what she perceived to be discriminatory treatment earlier in the day at a medical service. Deb said that, as a result of the counselling she had received in juvenile justice and prison, she knew that she had 'anger management issues' that she needed to address.

A second example of incorporation is provided by my interview with Mick. After a discussion of his most recent experience of heroin overdose, he said:

I'm into risk-taking behaviour, you know what I mean, and I do tend to, I do tend to do quite a bit of risk-taking behaviour, whether it'd be crossing the road when there's a car so far from me [he indicates the distance], or just shooting up the whole lot [of heroin] or whatever, that's just me, risk-taking behaviour.

(Interview: February 2001)

In these two examples, survivalists appear to be producing themselves and their practices through elements of service provider discourse – Deb as needing to control her impulses through self-management; Mick in identifying himself as a risk-taker. They read education pamphlets, they talk to other drug users involved with service providers, they interact with different types of workers. They become familiar with narratives of self-knowledge and self-care and may come to understand themselves, at least partially and inconsistently, as 'deep selves to be unravelled therapeutically' (Fraser, 1989, p.175).

But these two examples are also open to alternative interpretations. Deb's deployment of the term 'anger management' could also be read as an example of strategic accommodation – as a way of reinforcing her relationship with a particular service provider so as to improve access to scarce services at some future date, of demonstrating the progress she has made in taking control of her life. Likewise, Mick's references to risk-taking behaviour could be an instance of incorporation but they could

also be read as a form of strategic accommodation and even of resistance. He casually drops the term into the conversation, all the while eyeing the clock and giving ever-briefer answers to my queries. We are sitting in the nurse's room at the crisis centre – perhaps he feels it is an appropriate place to use such a term? Is it a kind of shorthand – an economical way of encapsulating a set of varying practices? While I agree with Ning when she argues that dissolving the binary opposition between resistance and conformity provides a more nuanced understanding of client responses to the disciplinary power of the clinic, she seems to underplay the potential incorporation of therapeutic discourse into the self-understanding of service recipients.

Conclusion

In this paper, I have focused on the power relations and discourses operating in encounters between service providers and their drug-using clients. The needs interpretation of service providers includes tensions around the definition of injecting drug users as chaotic (ie, failed) subjects and slippage between service philosophies that emphasise a social model of health and forms of service delivery that emphasise a responsibilised subject. For their part, injecting drug users practice a survivalist cultural form that emphasises self-reliance, autonomy and independence, attributes and capacities denied them in service provider discourse. Their responses to disciplinary power are varied and include, in addition to everyday acts of resistance, elements of strategic accommodation and the inconsistent and partial incorporation of therapeutic discourse. In this sense, both service providers and drug users take up neo-liberal values in constructing their discourses, but deploy them to promote different interests.

How, then, to move beyond these complex and contested frameworks of needs interpretation? One possible starting point would be to begin to reconsider several key aspects of the service-provider framework of needs interpretation. First, the initial training and ongoing professional development of service providers should emphasise, as a matter of priority, an understanding of the politics and ethics of service provision. What are the strengths and drawbacks of adopting particular policy and practice models of the drug-using subject? How do these shape funding and service philosophy, design, delivery and outcomes? How best to understand drug-using subjects? As chaotic subjects or as competent but under-resourced citizens struggling to cope? How to reconcile commitments to social justice and ‘health for all’ with the limitations inherent in service delivery?

Second, should drug users have to accept service-provider definitions of them as chaotic and damaged subjects in order to transform their lives? Do such definitions rob drug users of one potentially empowering discursive resource, which offers political benefits in terms of recognition, trust and legitimation (Moore & Fraser, 2006)? If drug users were not required to adopt the subject positions made available to them in the service-provider framework of needs interpretation, were not expected to relinquish their claims to autonomy and independence, would this enable them to counter marginalisation and deal with drug-related problems and services more effectively? Finally, to what extent do the needs of service providers and of services themselves conflict or compete with those of clients? For example, does the need to ensure worker safety hamper the ability to provide outreach services in street settings? In other words, how do the needs of service providers limit the efficacy of their professional interactions with clients?

More broadly, drug-related service systems might consider reviewing the widespread changes that have occurred in the transition from a welfarist to a neo-liberal political rationality. What benefits have accrued? Would a focus on ‘risk environments’ (Rhodes, 2002) and subjects produce better service responses? Would these simply be another form, albeit more politically and ethically acceptable, of the social control of ‘unruly’ populations? As I and others have argued elsewhere (Moore, 2004; Keane 2003), seeing any form of service provision as merely a technology of self sidesteps the ethical responsibility to produce forms of governmentality that arguably produce less social suffering. These are undoubtedly challenging questions but their discussion should be central to future reformulations of drug policy and practice.

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