

From Poison to Problem: Governing the Drug Using Population

Ian Richard Walmsley

PhD

University of the West of England

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Abstract

Contemporary approaches to the treatment of problematic drug use situate the individual within a complex system of power-relations. This system of power-relations operates through a wide range of experts, techniques, strategies, institutions and subjectivities. The objective of this PhD research project has been to understand the complexity of these power-relations, how they operate and the effects of their deployment. In many ways, this task has involved problematising some of drug treatment's most basic and taken-for-granted concepts, such as heroin withdrawal. This thesis adopted a Foucauldian genealogical approach. The discourses of natural recovery and recovery capital, needle fixation and withdrawal were identified and then subjected to a genealogical investigation and critique. This historical excavation opened up a wider discursive field and theoretical interest in the productive effects of a poisoning rationality and dividing practice on the body and population. This then informed a second genealogical investigation and critique.

In conclusion, this thesis argues that through subtle and intriguing means, the population, body and subjectivity of the drug user have become the objects of a multifaceted set of discursive and non-discursive practices that extend beyond the institutional boundaries of the drug treatment system and into the life of the individual drug user. These practices have focused upon various domains including health and illness, disease, criminal behaviour, relations with other drug users and non-drug users, education and employment and other behaviours deemed problematic. These practices, and the truths that are dependant upon them, this thesis will argue, have been formed and reconfigured by conditions that are historically contingent and dependent upon various social, scientific, cultural and political influences for their existence.

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Chapter 1

1. Introduction

In this first chapter of this thesis my aim is will provide an overview of drugs policy and the drug treatment system that forms the object of this study. In the final section of this chapter, I will conclude by introducing the research problem, the research questions and then an overview of this thesis.

The following sections, 1.1 and 1.2, have been removed as agreed by the Research Degrees Award Board of the University of the West of England to protect several individuals.

1.3. The problem drug user and drug-related problems

The British Crime Survey, which is a self-completed household survey of a nationally representative sample of 16 to 59 year olds who are resident in England and Wales, has estimated that there are approximately 12 million people in England and Wales that have used at least one illicit drug and 2.9 million that had used an illicit drug in 2010/2011. Although estimating the size of the actual group considered problematic is challenging for many reasons, my intention is to recall the way this group is described and governed. Since the nineteenth century, various labels have been given to this particular individual, such as opium eater, morphinomaniac, inebriate, drug addict or addict, junkie, poly-drug addict, chemically dependent, drug dependant, and more recently, problem drug user. Some of these can still be found in circulation; for some it depends which context you are in. Addicts are the object of the twelve step groups, though, in the main, problem drug users form the object of the drug treatment system.

The current definition of ‘problem drug user’ is provided by the Advisory Council on the Misuse of Drugs (ACMD);

“anyone who experiences social, psychological, physical, or legal problems related to intoxication, and/or excessive consumption, and/or dependence as a consequence of their use of drugs” (1982:34).

The dominant features are problems faced by the individual and society. The health problems concern increased levels of overdoses and blood borne viruses. The circulation of blood borne viruses is also known as the 'hidden epidemic' (Shooting UP, 2006). The social problems include domestic violence, poor and inadequate housing, poor educational attainment, high levels of unemployment and sickness benefits (National Treatment Agency, 2002).

Recent research into the family of the problem drug user have identified what has come to be known as 'hidden harm' where an estimated 205,300 and 298,900 dependent children are living with a parent who uses Class A drugs in England and Wales (Advisory Council on the Misuse of Drugs, 2003). The hidden harm campaign has highlighted the 'problems' (experiences, role models, exposures) and the impact on the well-being, safety, development, and future drug using career of the child. The links between drugs and crime have also been a major force that has shaped drugs policy and treatment in recent years (Gossop, Marsden, Stewart and Kidd, 2002, National Treatment Agency, 2002, 2006, Seddon, 2010).

1.4. The Harm Reduction policy

The philosophy of harm reduction is central to drugs policy and drug treatment. It is concerned with a reduction in harm before a reduction in drug use. Harm reduction is a public health approach that aims to reduce the negative consequences of drug use (Riley and O'Hare, 2000, Stimson, 1994). In "the broadest sense, harm reduction policies, programmes, services and actions work to reduce the health, social and economic harms to individuals, communities and society that are associated with the use of drugs" (National Treatment Agency, 2006:40). The harm reduction policy underpins the delivery of drug treatment and supports the label or identity of the problem drug user.

1.5. The National Treatment Agency and Drug Action Teams

The National Treatment Agency is the agency that has responsibility for tackling the growing drug problem in England and Wales. The National Treatment Agency came into being following the Government's ten-year drug strategy '*Tackling Drugs To Build a Better Britain*' (1998) with the aim of coordinating drug treatment in England and Wales. The National Treatment Agency (NTA)

“is a special health authority, established by the Government in 2001 to improve the availability, capacity and effectiveness of drug treatment in England” (Drugscope, (2004:26).

The objective of the National Treatment Agency is to;

“double the number of people in effective, well managed treatment between 1998 and 2008” and “increase the percentage of those successfully completing or appropriately continuing treatment year on year” (National Treatment Agency, 2006:3).

The National Treatment Agency has been driven by a growing body of evidence that supports the mantra ‘treatment works’ (Gossop, 2005, National Treatment Agency, 2002, 2006). The mantra of ‘treatment works’, according to Gossop (2005), has been informed by various treatment outcome studies from the United Kingdom and the United States. The outcomes studies help identify “*The bigger picture*” (Gossop, 2005:10). The treatment outcome for the ‘problem drug user’ is measured against improvements in the four domains of need: drug and alcohol use; health; social functioning; and criminal activity. These link the individual’s treatment with the wider aims of drugs policy.

The drug treatment system is monitored (apart from treatment in prison) through the National Drug Treatment Monitoring System (NDTMS). The purpose of the NDTMS is to “obtain accurate, good-quality, timely information for reporting structured drug treatment activity” at national and regional level (National Treatment Agency, 2006:38). The NDTMS report on the numbers in treatment, those retained for 12 weeks or more and waiting times – which are the three main targets that treatment services are measured against. In addition, they also affect the local Primary Care Trusts star ratings.

The Drug Action Teams were established by the Government in 1995 to support the strategic co-ordination of local action, in the form of local drug treatment agencies, on the misuse of drugs. Since January 1998 the Drug Action Teams have been engaged with the national ten-year drug strategy that was set out in ‘*Tackling Drugs Together to Build a Better Britain*’. In 2008, a new national drugs strategy, ‘*Drugs: protecting families and communities*’, was introduced by the Government. The responsibility of the

Drug Action Team, therefore, is to reduce the harm caused by drugs, focusing on protecting families and strengthening communities.

1.6. The Drug Treatment System

The life of the problem drug user has become the object of a *historically* constituted, complex system of drug treatment. The Models of Care (National Treatment Agency, 2002) outline a four-tier structure of treatment delivery, which is used for the commissioning and provision of drug treatment. The lower level tiers are designed to improve routes into the system, whilst the higher tiers are designed for work with problem drug users with a higher need and who are currently inside the system. This ‘treatment blueprint’, it is important to point out, is currently being superseded by a ‘recovery-orientated’ system¹. Nevertheless, this ‘treatment blueprint’ advocates an integrated care pathway approach for each local system. By conceptualising this as a ‘treatment journey’, the problem drug user is moved from an initial engagement phase, through to the treatment delivery and then finally into the completion phase. Treatment completion, however, is seen as secondary to the aims of the system. Retention has become a preoccupation as length of time in the system determines treatment outcome. A recent estimate for drug treatment completion rate was 3% (Savage 2007).

The NTA defines drug treatment as “a range of interventions which are intended to remedy an identified drug related problem or condition relating to a person’s physical, psychological and social (including legal) well being” (2002:12). Each intervention targets an aspect of the individual and his/her life through various strategies and mechanisms. Interventions, such as advice and information on safer injecting, can be targeted at those most at-risk from blood borne viruses. Substitute prescribing with methadone, which is an opiate used to prevent withdrawal symptoms, has become extremely important to the drug treatment system over the last two decades (Department of Health, 2007, National Treatment Agency, 2006). Interventions can also be in the form of structured treatment through which psychosocial interventions can target and change thoughts and behaviours thought to be associated with drug taking. These interventions are delivered by practitioners and are normally time limited (National Treatment Agency, 2006). They can, however, be implemented through an aftercare

¹ This ‘recovery oriented system’ is currently unfolding and therefore it would be unrealistic to provide an accurate picture of this recent development at this moment.

package of support aimed at reducing the number of relapses (National Treatment Agency, 2006). The purpose of aftercare is to sustain treatment gains and to further develop community integration.

1.7. Research problem

The main problem investigated in this thesis is an analysis of the influence of historical, political, social and scientific processes on the constitution of the individual and population of problem drug users. The problem is also to analyse their influence on the dominant ways of thinking in drug treatment and how they become realised through its treatment technologies. The concern is that the drug treatment system, which has operated through medical and psychiatric institutions and voluntary sector organisations, has mutated into a complex, multifarious and enveloping approach to the treatment of drug problems. These problems are significant as they have arguably subjected the body and self of the problem drug user to a subtle and dynamic range of strategies of power. These include the methadone maintenance prescribing intervention, outlined above. These processes have enabled areas of the body, self and life become amenable to the power of expert and political discourses. These mutations in the drug treatment system itself and its range of drug treatment interventions have been accompanied by constitution of human categories that have developed an unquestionable sense of ‘reality’ and have ultimately become taken-for-granted. The following research questions have been developed to address this research problem.

1. How is power exercised with respect to problem drug users within the drug treatment system, and with what effects?
2. How has the problem drug using population been produced and reproduced through historical, scientific and political processes?
3. How has drug treatment been shaped by scientific and political rationalities and technologies?

1.8. Overview of thesis

In summary, this Introduction has introduced the reader to the historically constituted complex field of drug treatment, which ultimately forms the research problem. In addition, this chapter has aimed to situate the researcher within the addiction discourses through a reflexive account. The following chapter (chapter 2) will provide a critical discussion of the literature on drug policy and treatment. This research has adopted both a contemporary and historical perspective to understanding the multifarious ways in which power is exercised in the context of drug treatment. As a result of the theoretical and methodological directions of this investigation, contemporary and historical literature has been reviewed. The material is discussed using a historical narrative. The aim of doing so is to introduce the reader to the ‘story so far’ of how drugs policy and practice has developed. In the review, I argue that there are gaps in the historical literature, primarily concerning the influence of poisoning on the object and subject of drug treatment practices. Furthermore, it is argued that historical accounts, which take a sociological perspective, are wanting.

In drawing on a sociological perspective on power, chapter 3 provides a critical discussion of Michel Foucault’s concept of governmentality. The purpose of this theory chapter is to contextualise the concept of governmentality before going on to outline how the governmentality approach will be used to support the analysis. Given the Foucauldian influence, chapter 4 provides an account of the Foucauldian methodological approach, genealogy, which will be used for analysing historical discourses. In chapter 5, the discourses of recovery capital, needle fixation and withdrawal will be interrogated using the genealogical approach. Chapter 6 and 7, build on the discursive strands picked up in the previous chapter and traces the development of the drug treatment system from the nineteenth century to the present.

Chapter 2

Literature Review: historical narrative of drug policy and treatment

2. Introduction

The aim of this chapter is two-fold. First, it will provide a review of the existing academic literature on historical and contemporary research on drugs policy and practice. Second, it will provide a critique of this literature in order to highlight important historical and contemporary problems that have been left unexplored. The literature review will take the form of a historical narrative and will review literature on the same historical periods and problems that have been analysed in the analysis chapters. By using this style of review my aim will be to, in part, introduce the dominant story or narrative so far. The review will now begin in the nineteenth century with early problematisations of opium.

2.1. The opium of the people: self-medication and habitual users

Researchers have generally argued that there was no ‘drug problem’ in nineteenth century Britain (Berridge, 1979, 1999, Bull, 1996, Harding, 1986, 1988, Seddon, 2007, 2010). Opiates were “commonly and unselfconsciously bought and used” and there were no clear boundaries between the medical and social use of opiates (Berridge, 1979, 1999:49, Harding, 1986, 1988, Scott, 1969, Seddon, 2010). Opium-based medications were extremely popular and easily purchased from most pharmacists, apothecaries and general grocers (Berridge, 1999, Harding, 1986, Seddon, 2010). This is not to say these substances were not regulated. It has been pointed out that regulation was “uneven and patchy” and operated through a localised guild system within the police economy (Seddon, 2010:44).

The practice of consuming opium, it has been noted (Berridge 1999, Foxcroft 2007, Harding 1986, 1998, Seddon 2010), was conceptualised through the discursive categories of ‘stimulant use’, ‘self-medication’ and ‘habit’. The habitual use of opiates or, more precisely, the opiate eaters – as they were called – have been categorised by

drug historians according to their social class (Berridge, 1979, 1999, Foxcroft, 2007, Harding, 1986) with Thomas De Quincey and Samuel Taylor Coleridge among the most significant middle class opium eaters (Berridge, 1999, Scott, 1969, Youngquist, 1999). The publication of De Quincey's *Confessions of an English Opium Eater* has been used as a barometer of public attitude towards of the morality of opiate use; Berridge argued that the "reaction was interesting and calm, rather than hysterical" (1979, 1999:53).

Stimulant use was similar to modern forms of recreational drug use (Berridge, 1999, Seddon, 2010). De Quincey distinguished his habitual use of opium from the working class stimulant use by arguing that he used it for its medical properties (Berridge, 1999, Harding, 1986). However, in general, the habitual use of opiates, according to Berridge (1999) and Harding (1986), developed out of the practice of self-medicating. It was not seen as being pathological at this time. It is worth making the point that it was debated in medicine at this time whether opium produced a stimulant effect or narcotic effect (see Berridge, 1999).

It has been reported that there were between 16,000 and 25,000 outlets that sold opium (Berridge, 1999, Harding, 1986, Scott, 1969), with the majority being in working class areas, where agricultural populations congregated and where conditions contributed to high rates of sickness (Berridge, 1979, 1999). It is argued that opium use had existed in the Fenland areas for some time as a "culturally sanctioned practice restricted to self-medication" (Berridge, 1979, 1999, Foxcroft, 2007, Harding, 1986:77). It only came to notice through the increase in social surveys by the public health movement that targeted the giving of opium to children during the teething period (Berridge, 1999). In developing her social control thesis, Berridge argues this particular practice soon attracted attention from public health officials and medical experts (Berridge, 1979, 1999, Harding, 1986).

Before moving onto the public health theme it is important to make the point that the first key problematisation of opium at the beginning of the nineteenth century has been traced back to the needs of the insurance industry and the fraudulent insurance claim of the Earl of Mar (Berridge, 1977, 1979, 1999, Foxcroft, 2007, Harding, 1986, Seddon, 2010). Following a scientific investigation into the excessive habit of the Earl, the insurance company concluded that opium affected health and longevity (Harding, 1986). One argument is that the demands of the life insurance industry pushed opium and the

body into medical (Foxcroft, 2007) and public health discourse (Berridge, 1999). Ultimately, this raised the medical consciousness – *and in turn knowledge* - of opium and the body.

Seddon, in contrast, describes this ‘event’ as “highly significant” in the genealogy of drugs policy and practice (2010:38). He situates this first problematisation of opium by the insurance company within the broader political framework of “liberal understandings of freedom and responsibility” (2010:39). The notions of autonomy and personal responsibility, which are at the heart of liberal forms of government, transformed life insurance from a “speculative to a prudential activity” (2010:39). The habitual use of opium by the Earl forced the insurance company to question the insurability of his body. This interest opened up a space within which to problematise the body-opium relation in terms of health and longevity (Foxcroft, 2007, Seddon, 2010). The use of opium by the Earl was therefore ‘seen’ not as the result of compulsion but as the result of choice. Seddon points out that life insurance companies not only supported the development of epidemiology and public health, but these disciplines also “took on a liberal form” (2010:39). It is worth pointing out that it is at this point Seddon (2010) develops his thesis concerning the affinity between conceptions of freedom within the liberal project and the government of drugs and individuals that use them. Because of the historical trajectory of Seddon’s thesis, which begins with this first problematisation of opium and concludes with the criminal justice turn in the present, his work will be returned to at various points in this review.

2.1.1. Poisoning and public health: the regulation of opium

The mid-nineteenth century public health campaigns concentrated their efforts on the practice of child-doping by working class mothers, despite the fact that child doping also existed among middle class parents (Berridge, 1979, 1999, Harding, 1986). It has been argued that this criticism against the parenting practices of the working class served to distract the authorities from the poor living and working conditions. It provided a “scapegoat for wider class tensions” that was embedded in the development of “British industrialisation” (Berridge, 1999, Harding, 1986:12). Furthermore, these campaigns served the interests of the pharmaceutical and medical professions (Berridge, 1999, Harding, 1986). In fact, it is argued that these problems were exaggerated to support the professional interests of these professions and ultimately the rebranding of

opium from a widely available household remedy to a poison requiring expert regulation (Berridge, 1999, Harding, 1986).

The 1868 Poisons and Pharmacy Act placed the control of opium-based preparations in the hands of the pharmacists (Berridge, 1979, 1999, Harding, 1986, see appendix of Seddon 2010 for outline of Act). This regulatory framework that became imposed on opium, as well as other poisonous substances, was largely the result of the public health campaigns. This, for Seddon, was the first step in a separate “regulatory regime for opiates” (Seddon, 2007, 2010:55); a move, which has been pointed out, has left control in the hands of the medical profession (Berridge, 1999, Foxcroft, 2007, Seddon, 2010). Seddon (2010) suggests that rather than understanding this event from the perspective of professional influence, like that of Berridge (1999) and Foxcroft (2007), it can be mapped onto wider mutations in classical liberal governance (Seddon, 2007, 2010). For Seddon (2010), pharmaceutical regulation, which was linked to wider notions of freedom and free trade, was also part of the specialisation that replaced the police economy. Opiates, within this context, were “simply another set of commodities to be bought, sold and exchanged and consumed within a free market liberal economy” (Seddon, 2008:102). Limitations, however, were imposed on the circulation of opium through the use of a label that identified the substance as poisonous.

The public anxieties concerning criminal (intentional) and accidental poisoning with arsenic and the 1851 Arsenic Act were also important precursors to the 1868 Pharmacy Act (Bartrip, 1992, 1994, Berridge, 1999, Seddon, 2010). Interestingly, Berridge (1999) and to a lesser extent Foxcroft (2007), acknowledge how the techniques used to treat victims of poisoning were later incorporated into the treatment of opiate addiction. For example, the stomach pump was extended to the body of the opium user for the purposes of withdrawing the poison from the body (Berridge, 1999). Therefore, it can be argued, as chapter 7 will, that it is important to analyse the discursive links between the body, opium and the wider field of poisons and poisonings in the nineteenth century. This relation between the body and the field of poisoning, in particular criminal poisoning and treatment, has been occasionally acknowledged (Berridge, 1999, Foxcroft, 2007), but, on the whole, neglected. *This raises important questions concerning the impact of this relation with the discursive field of poisoning on how we think about and govern problem drug users.*

2.1.2. Morality, medicine and modernity: from ‘habit’ to ‘disease of the will’

Towards the end of the nineteenth century the notion of habitual opium use became replaced by a medical disease theory (Berridge, 1979, 1999, Harding, 1986, 1988). It is important to point out that for Levine (1978) diseases theories of alcohol emerged earlier in the nineteenth century. He, as well as Seddon (2010), argues that this provided a foundation from which to categorise the habitual use of opium as a disease. The ‘diseasing’ of the opium habit took place between 1870 and 1926 (Berridge, 1979, 1999, Harding, 1986, 1988, Parssinen and Kerner, 1980) and has been described as a hybrid model encompassing both medical and moral elements (Berridge, 1979, Harding, 1986, 1988). Its moral element, it has been argued, can be located in the “moral ideology” of the campaigns against the opium trade in China (Berridge, 1979:72, Harding, 1986, 1988, Parssinen and Kerner, 1980). Between 1820 and 1854 the number of chests rose from just over four thousand to almost eighty thousand per year (Scott, 1969). The opium trade began, for Scott, when the British required an object to exchange for China’s tea: “Tea was in every British home, rich or poor” (1969:83). Opium was the perfect ‘commodity’ because it created its own insatiable need in the user (McMahon, 2005, Scott, 1969).

The body of the Chinese opium smoker featured in the longevity debate at mid-nineteenth century (Berridge, 1999, Foxcroft, 2007, Harding, 1988). The Chinese opium smoker was described as immoral and the practice itself was considered more dangerous than the practice of eating opium (Berridge, 1999). It was argued that opium demoralised the Chinese people; “one opium eater demoralises a whole village” (Sir John Strachey cited in Scott, 1969:97). For Scott (1969), in India, as well as in Britain, opium eating was far less dangerous. The “Rajpoots”, she notes, are saturated with opium but they are considered the “finest, most truthful, and bravest people in the world” (Scott, 1969:97). Also, as Seddon (2010) has pointed out, the thread of this debate can be traced back to the investigations into the case of the Earl of Mar. Ultimately, the opium trade with China culminated in two opium wars linked to the British government’s demand for free-trade in China (for discussion of opium wars see Beeching, 1975 and Berridge, 1999).

The Society for the Suppression of the Opium Trade (SSOT) was the main anti-opium organisation and was modelled on similar Victorian pressure groups, such as the Anti-

Slavery Society and the Anti-Corn Law League (Berridge, 1999, Brown, 1973, Harding, 1986, 1988). For Harding (1986, 1988), who draws on Foucault's (2002) archaeological method, the SSOT's Quaker doctrine provided the necessary framework for the moral-pathological model to emerge when it did at the end of this century. Part of the Quaker doctrine is the idea that the path to righteousness is found in the worldly activities that nourished the soul and not in activities like opium eating which acted against it. Levine (1978) claims that the Puritan doctrine was an essential turning point from the traditional understandings of drunkenness, which were explained as resulting from the love of alcohol, to the new paradigm of addiction, in which the internal experience of the individual became described through the term 'out of control'.

Harding argued that for the SSOT opium "was inherently bad" and its use outside of medical practice was "indefensibly wrong" (1986:81). Because of the fluidity between temperance, anti-opium and medical organisations these moral views entered into medical practice (Berridge, 1979, 1999, Harding, 1986, 1988, Parssinen and Kerner, 1980). Within medical practice, this model allowed the individual to be reconceptualised from a person acted upon by opium to one that willingly adopted a path of self-destruction. For the medical profession, this allowed the blame to be shifted onto the patient (Berridge, 1999).

It is important to note a methodological problem in Harding's (1986, 1988) Foucauldian analysis. Harding makes the point that dependency on opium existed, but wasn't noticed until the person went into withdrawal when they were forced to go without opium. This type of thinking, also found in Berridge (1979, 1999), goes against Foucault's (2002) archaeological method because it fails to question key categories, such as dependency and withdrawal. It is worth making links with others that have criticised dependency and withdrawal, such as Coomber and Sutton (2007) who argue that the dependency syndrome lacks clarity; for instance, the length of time it takes to become physically dependant (Coomber and Sutton, 2007). It has also been questioned whether street heroin can actually cause physical dependency because of the varying levels of purity and the sporadic ways in which it is used (Glaser, 1974 and Primm and Bath, 1973). Furthermore, the experience of withdrawal and addiction may often be linked to the user's knowledge (Connors, 1994, Lindesmith, 1938, 1940). For instance, if a person has no knowledge of 'withdrawal' then can they tell that they are in withdrawal as

opposed to experiencing something else? These criticisms provoke important questions regarding the very foundation of how we think about and govern drug addiction.

The emergence of morphine and hypodermic technology are seen, in part, as precursors to the development of this ‘moral-pathological’ (Harding, 1986, 1988) or ‘hybrid model’ of addiction (Berridge, 1999, Hickman, 2004, Parssinen and Kerner, 1980). Morphine had first been isolated from opium during the 1820s, but had not come into widespread use until the 1860s when the hypodermic syringe emerged within medical practice (Berridge, 1999, Parssinen and Kerner, 1980). The use of hypodermic morphine in medical practice, it was initially argued, would allow opium to be detached from its anarchic domain into a safe and expertly controlled medical field where opium could be used without the evils of opium eating (Berridge, 1999). The use of the syringe, however, soon became a popular form of self-medication among the middle and upper class and efforts were made to prevent the practice from spreading (Berridge, 1999, Hickman, 2004, Parssinen and Kerner, 1980). According to Hickman, the use of the syringe threatened “the bourgeois subjects” sense of “autonomy, will power, and self-mastery” (2004:1274).

The first elaboration of a disease theory of morphinism (a precursor to the term addiction) was in 1878 by a German physician, Edward Levinstein (Berridge, 1979, 1999, Parssinen and Kerner, 1980, Seddon, 2010). This elaboration contained, for the first time, the “symptomatology, aetiology, prognosis and prophylaxis” of the morbid craving for morphia (Berridge, 1999, Parssinen and Kerner, 1980:279). Over the course of the next three decades, specialist texts dealing with aspects of morphinism were produced, which included specialists from Europe and North America (Berridge, 1999, Courtwright, 1982, Seddon, 2010). Disease theories were also being developed in other domains such as typhoid and cholera (Berridge, 1999), which, for Parssinen and Kerner (1980), demonstrates a paradigmatic shift in medical thinking within which addiction must be located.

The typical profile of the morphinomaniac, as they were called, was women and physicians from the middle and upper social class (Berridge, 1979, 1999, Courtwright, 1982, Valverde, 2008). A similar demographic picture is given for the United States (Aurin, 2000, Courtwright, 1982, Hickman, 2004, Valverde, 2008) and elsewhere in Europe (Berridge, 1999). This application of the addiction model to this particular

social class and gender have been explained by drawing attention to wider concerns for conditions of the nervous system, such as neurasthenia (Aurin, 2000, Berridge, 1999, Hickman, 2004). Neurasthenia was understood as a product of modern industrial society, and associated with 'brain-workers' (Armstrong, 1983, Hickman, 2004).

Berridge has argued that "Conventional ideas about the weakness of the female sex were also linked with the spread of morphine use" (1999:145). In part, this is the argument that the nervous constitution of the female body predisposed them to this modern affliction (Hickman, 2004). This was mainly through the use of morphine in the treatment of gynaecological complaints (Zieger, 2005). Zieger (2005) also points out that conventional ideas about women also included deception; "Morphine users, especially female ones, were routinely described as liars who would say anything to obtain a dose" (Zieger, 2005:60). Most addictions had an iatrogenic origin; meaning it was developed through medical treatment (Berridge, 1999, Courtwright, 1982, Hickman, 2004). This fact, it has been argued, reinforced a long standing scepticism towards the medical profession (Berridge, 1999, Courtwright, 1982).

Addiction was further implicated in concerns about national degeneracy and the ability for addiction to be passed from generation to generation (Berridge, 1999, Seddon, 2010). For Seddon, links with 'population management', which are central to the liberal project, "helps us make sense of the ways in which the emerging drug control system was rooted in the politics of race and gender" (2010: 65). In respect of working class opiate use, this was controlled by the pharmacy acts and, moreover, because of the medical knowledge of this period, it was claimed their brains were not developed enough to predispose them to addiction problems (Berridge, 1999). Valverde, in contrast, argues that working class drug and alcohol use was acknowledged, but were "absorbed into the 'feeble-minded' category" (1997: 253).

Developments in the alcohol field, it is claimed, also had a profound impact upon the drugs field (Courtwright, 2004, Levine, 1978, Seddon, 2010). The concept of inebriety, it is argued, provided specialists with a "single unified disease framework" (Berridge, 1999, Seddon, 2010:59); this was underpinned by the concepts of degeneracy, neurasthenia and diathesis (Courtwright, 2004). Seddon claims that with the development of the "great regulatory divide" at the beginning of the twentieth century, which divided drug regulation into pharmaceutical and criminal law systems of

regulation, the inebriety concept became difficult to sustain (2010:60). In contrast, for Valverde, this discursive network that built up around the practice of habitual opium and alcohol use was not as stable as others have suggested;

“no one term was ever adopted even within specialist medical circles. Oinomania, dipsomania, narcomania, alcoholism, inebriety, habitual drunkenness...the terms kept proliferating” (1997:254).

This argument raises questions over placing stable forms of identity and subjectivity at the centre of analysis (Valverde, 1997). The claim that the inebriety discourse was the governing idea, for Valverde (1997), is misleading.

Such mutations have been associated with the introduction of a social form of citizenship, through which the state could intervene into the life of the citizen (Seddon, 2010). By adopting this form of citizenship, the irrational conduct of the addict became governable through programmes of normalisation that targeted the personality or character of the individual;

“Those with defective characters then became legitimate objects for state intervention aimed at repairing these abnormalities of character which hampered their capacity to meet their obligations of citizenship” (2010:61).

Liberal regimes of government, which will be discussed in detail in the next chapter, are reliant upon the rationality of the individual. Seddon (2010) and Valverde (1998, 2008) both point out the political paradox contained in liberal forms of government. This political paradox, the “contradictions between determinism and voluntarism” (Seddon, 2010:62, Valverde, 1998), culminated in what Valverde (1998) has described as a ‘disease of the will’. In part, this resonates with Berridge’s (1999) idea of addiction as a hybrid model; a medical concept that has needed to accommodate both determinism and free-will.

The addiction concept, in addition from its links with medical, religious and political discourses, was also embedded within the wider culture of modern society (Hickman, 2004). For Hickman, the concept of addiction emerged at a time of cultural crisis when experts were attempting to make sense of human agency during a period of rapid

changes in “economics, transportation and technology” (2004: 1293). Addiction threatened notions of self-mastery that were the “cornerstone of nineteenth-century bourgeois identity” (Hickman, 2004:1273). It has also been pointed out that addiction’s alignment with neurasthenia demonstrated that the condition was understood, for some, as a disease of modern civilisation (Hickman, 2004). The final point to make is that the medical profession arrived in the early twenty first century with a formed concept of addiction: a concept that needed to be defended (Berridge, 1979, 1999, Harding, 1986, 1988).

2.2. The British System: medical profession and the state: conflict or consensus?

The disease concept and approach to the treatment of addiction became stabilised within what became known as the ‘British System’; a loose set of ideas and practices that conceptualised the addict as sick and legitimated the prescribing of opiates as medical practice (Berridge, 1989, 1999, Mott and Bean, 1998, South, 1998). Before the British System is discussed in any more detail it is important to draw attention to the international context which helped shape British drug policy and practice in the early years of the twentieth century. The United States placed opiates on the international agenda shortly after they acquired the Philippines following victory in the Spanish-American war of 1898 (Mott and Bean, 1998). America was forced to deal with the Philippines opium problem; which Britain profited from because of its trade links with opium. These international efforts concluded with international controls being developed by the Shanghai Commission in 1909 and The Hague Opium Convention 1912 (Berridge, 1999). The general theme from the literature is that Britain was, at first, reluctant to submit to these international measures (Berridge, 1999, Mott and Bean, 1998).

The turning point for Britain in recognising drugs as a criminal matter followed the acknowledgment of a new drug scene in the West End of London. Opiate use had been in decline during the early years of the twentieth century and was “less a part of everyday culture” (Berridge, 1999:236). This new drug scene involved the drug cocaine and musicians, actresses and men of other races (Berridge, 1999, Kohn, 1992). The use of cocaine by soldiers from the First World War also caused concern as it was feared it would “undermine the efficiency of the army” (Berridge, 1999:249). For Kohn (1992), this concern began when ‘drugs’ became ‘dope’; a process which had its origins in the

political and social order of the United States (Courtwright, 1982). In light of the new drug scene, identified above, the British government extended powers contained in the Defence of the Realm Act (DORA) to prevent the supply of cocaine to soldiers on leave from the war (Kohn, 1992). DORA also enabled the police to stop and search and to imprison if they refused (Berridge, 1999).

Kohn, interestingly, has argued that “the defence of the realm and the defence of the women were one and the same...all that the nation held dear” (1992:45). It was feared that women had been caught up in a drug induced slave-like relationship with ‘men of colour’ and ‘Chinese men’. Kohn (1992), therefore, points to the centrality of women in British discourse on drugs or, to put it another way, British drugs policy is profoundly gendered (Seddon, 2008). At the heart of this discourse of drugs was an autonomous woman who was engaged in “inter-racial sexual activity”; an activity that challenged normal categories of womanhood (2008:102). For Seddon (2008), this theme is part of the genealogy of Britain’s current harm reduction approach.

The restrictions that were placed on cocaine and opium were later developed through the Dangerous Drugs Act (DDA), which is a “major landmark in the regulation of heroin” (Berridge, 1989, 1999, Seddon, 2007:147, 2010). The DDA also situated the penal response at the heart of British drugs policy through creating a divide – the great regulatory divide - between the regulation of drugs, on the one hand, and the regulation of medicines, on the other (Berridge, 1999, Seddon, 2007, 2010). The Harrison Act 1914 in the United States had introduced similar measures (Berridge, 1999, Courtwright, 1982, Musto, 1973, Seddon, 2010). The DDA, however, was complicated by the issue of prescribing opium and cocaine to drug addicts and the self-prescribing by doctors (Berridge, 1999).

In 1924 the Home Office set up a committee chaired by Sir Humphrey Rolleston, then President of the Royal College of Physicians, to review these issues (Berridge, 1999, Seddon, 2010). The Rolleston Committee, attended by experts from the medical profession, argued that addiction in Britain was rare. For Berridge (1999), this was a reflection of the dominant patient group. It also argued, in line with previous medical developments, that the drug addict was a sick person and the prescribing of drugs like heroin on a maintenance basis to avoid the terrors of withdrawal and live a normal life was legitimate medical practice (Ashton, 2006, Berridge, 1989, 1999, Lart, 1998,

Seddon, 2007, 2010, Spear, 1994). Ashton (2006) has argued that this is the legacy of the Rolleston report; the management of withdrawal through maintenance prescribing. Webster (2007) has also made a similar point, regarding the history of the British System of drug treatment. He also acknowledges the importance of the globalisation of drug treatment and control practices.

It is important to briefly touch on a more marginal theme from the academic literature concerning the British System and point out that doubts have been raised as to whether “such a thing exists at all” (Grant, 1994: foreword). Put simply, most of the commentaries regarding the British System have been from outside of Britain (Grant, 1994, Spear, 1994). In fact, this overseas commentary is the most striking feature of the British System (Spear, 1994, 2005, Grant, 1994). Alfred Lindesmith, who was an important American sociologist, for example, was keen to acknowledge the low number of drug addicts in Britain. The main point of this debate, however, is that the British System was not really a ‘system’, but a loose selection of ideas and practices (Spear, 1994, 2005, Stimson, 1994). A set of ideas, it is worth pointing out, that has been captured elsewhere in an edited collection on the British System (Spear, 2002, Strang and Gossop, 1994, 2005)

A theme that is more central to the emergence of the British System concerns the relation between the medical profession and the Home Office. One perspective is that the British System was the product of a power struggle between the medical profession and the Home Office (Berridge, 1989, 1999, South, 1989). In this sense, the story is that Sir Malcolm Delevingne, from the Home Office, sought to build upon the legal powers contained in the Dangerous Drugs Act and was met with resistance by Sir Humphrey Rolleston, who sought to defend the position of the medical profession and their efforts to define and treat addiction as a disease (Berridge, 1999, South, 1998). This ‘tension’ between punishment and medicine, Berridge argues, often resurfaces at “crucial periods” in history (Berridge, 1989:30). South argues that although the British System did not reflect the American control regime, it was still a “system of control” (1998:90). This point is also shared by Berridge (1989, 1999) in that despite the fact that much medical autonomy was retained by the medical profession, its wider framework was regulated by the Home Office and the police (South, 1998).

The ‘power-struggle’ thesis has been problematised by Seddon (2007, 2010). It is important to mention that Seddon (2010) understands the emergence of the British System as part of the wider mutations in liberal government and he begins his genealogy in the early part of the nineteenth century with the first problematisation of opium by the insurance industry. Although not disputing the power struggle thesis, he argues that the penal and welfarist themes found in the British System was, like the emergence of the inebriety concept, part of the wider shift in the dominant political rationality. The “distinctive ‘medico-legal alliance’” found in the British System were products of the “new social realm” that we have come to associate with social forms of government (Seddon, 2007:149). This will be explained in more detail in Chapter 3. Ultimately, rather than the penal and medical elements being in tension with each other, their role is one of cooperation, directed under the same political rationality.

2.3. The ‘Clinic System’: treatment or social control?

The years between the 1920s and 1960s are considered a quiet period in British drugs policy (Lart 1998, Spear, 1994). Bing Spear (1994, 2002), who was the Home Office Drugs Branch Inspectorate between 1952 and 1986, was a key figure at this time and whose work provides an interesting account of wider activities during these early years. The quiet time for Spear (1994, 2002) had much to do with the outbreak of the Second World War and the lack of any obvious signs of drug use. There were, it is worth pointing out, a new (small) group of heroin addicts in London in the 50s who were supplied by doctors under the British System (Spear, 1994, 2002). In contrast, the United States had experienced a dramatic increase in the use of drugs during this period (Courtwright, 1982, Musto, 1973). The defining feature of this was a clear demographic change in the drug using population. By the 1940s the dominant feature in North America was no longer a female or professional middle class drug addict, but young lower class male intravenous heroin addicts from a minority group (Courtwright, 1982).

In the early 1960s the Interdepartmental Committee on Drug Addiction was set up to review the recommendations made in The Rolleston Report because of an increase in the size of this group (Lart, 1998, MacGregor, 1989, Mold, 2004, Spear, 2005, Yates, 2002). The increase was revealed by the Home Office Addict Index, a database of known drug addicts (Lart, 1998, see also Mott, 1994). A similar technique operated in North America which is not so well known (Winick, 1962, 1964), which will be

analysed in chapter six. The committee was known as the first Brain report after its chairman Sir Russell Brain (Spear, 1994, 2005) and it concluded that the problem was not big enough to warrant any changes to the current system; a sentiment that has been described as “something of a mystery” (Bean, 1974:74).

A few years later the Interdepartmental Committee on Addiction reconvened because an increase and clear demographic shift in the addict population from the medical addicts of the Rolleston era to a young, working class addict who were consuming drugs for pleasure and not because of a medical condition (MacGregor, 1989, Mold, 2004, Spear, 2004, 2005). This was revealed by the Home Office Addict Index (Lart, 1998, Mold, 2007). Yates is critical of this picture because it “ignored the emerging patterns of drug use outside of London” (2002:115). The second Brain report introduced a new phase in policy and practice known as the ‘Clinic Phase’ (MacGregor, 1989). This phase is characterised by the decline of the general practitioner, because of the perceived role of the medical profession in spreading addiction (Spear, 1994), and the rise of the psychiatrist as specialist (Glanz, 1994, MacGregor, 1989, Strang, 1989). The consultant psychiatrist undertook the lead role in the new drug dependency clinics that were introduced as part of the Brain recommendations (Lart 1998). For Glanz (1994), and to a certain extent Stimson and Lart (1994), this shift can also be understood as part of a broader change within the medical profession in general and the role of general practitioner in particular.

The clinic phase, it is argued, broke with the medical model that had dominated the Rolleston era (MacGregor, 1989). Stimson and Lart argued that the addict within the clinic was seen as the “undeserving addict” when compared to the deserving addict of the Rolleston era (1994:332). The policies of the clinic moved away from maintenance and turned towards withdrawal and abstinence (Lart, 1998, MacGregor, 1989). Not only did the psychiatrist emerge as the authority over the care of the addict (Lart, 1998), a feature that was dominant in North America (Musto, 1973), but social workers emerged in order to deal with the ‘social’ aspects of addiction (MacGregor, 1989). It is important to point out that North America operated a clinic system during the 1920s (Courtwright, 1982, Musto, 1973). This is seldom acknowledged or analysed with respect to the British experience and will be explored in more detail in chapter 8.

Stimson and Oppenheimer (1982, 1994) have argued that the clinic system signalled a new era of social control in British drugs policy and practice. In their ethnographic account of the clinic environment they illustrate a dual function; “that of treatment and that of the control of the drug problem” (1994:137). This dual function has also been acknowledged elsewhere (Lart, 1998, Mold, 2007). The prescribing practices, in particular, were integrated into the structure of the clinic with the purpose of containing the ‘heroin epidemic’ (Lart, 1998, Mold, 2007, Stimson and Oppenheimer, 1982, 1994). The Home Office Addict Index was important as it verified the identity of the drug addict (Stimson and Oppenheimer, 1982). After the fear of contagion had settled, and the prescribing practices had been successfully integrated, attention turned towards treatment practices within the clinic (Lart, 1998, Stimson and Oppenheimer, 1982).

The prescribing practices, for Lart (1998), were shaped within the context of the social control objectives. In this respect, the dual aims of treatment and control were, for Lart (1998), the same thing: A power-relation. Furthermore, in drawing on Foucault’s concept of power and knowledge, Lart (1998) explores the role of the Home Office Addict Index in constructing addiction within the population. This point is supported by Mold (2007). However, Lart (1998) further argues that as attention turned inwards, the involvement of psychiatry as authority figures over addiction were instrumental in reframing addiction as an object that existed in the mind. Mold (2004) argues that the medical and social dimensions of drug addiction had remained separate since the Rolleston era and were part of the “modern feature of reactions to drug addiction” (Mold, 2004:501). Rather than seeing the two as existing in tension with each other the staff had to negotiate, and support an amalgamation of the two to define and respond to the problem of heroin addiction (Mold, 2004).

Methadone also had an important role within the clinic phase of policy and practice (MacGregor, 1989, Stimson, 1987). The names of Dole and Nyswander, from the United States, are almost synonymous with methadone maintenance. The methadone maintenance model, as Courtwright (1997) points out, is underpinned by the metabolic theory of addiction; the model supported by the Rolleston era. In this respect, the medical model underpinning methadone was an element of “what went before” (MacGregor, 1989:170). However, it is important to point out that the introduction of methadone into the practices of the clinic supported the shift from the prescribing of

heroin and other drugs towards abstinence. Methadone was essentially about making up “socially productive...normal citizens” (Dole and Nyswander, 1967:20, Fraser and Valentine, 2008). The use of methadone as a social technology, a way in which to make up citizens, therefore, strongly resonates with liberal forms of governmentality (Dean 1999, Fraser and Valentine, 2008). The governmentality perspective will be explained in full in the next chapter.

Fraser and Valentine (2008) have investigated the role of methadone in liberal society and have argued that methadone subjects are products of “medical, social, legal and political forces” (2008:3). They point to the ambiguities inherent in methadone as a substance, also pointed out by Gomart (2002), who claims that the properties of methadone emerge in practice, and as a form of substitution for heroin. Bourgois (2000) also acknowledges similar points, and argues that the use of methadone, with a similar profile as heroin, is about the regulation of pleasure. Furthermore, Southgate, in mapping out the discursive field of methadone maintenance treatment, makes reference to methadone in terms of liquid handcuffs because it tied the individual to the local chemist and the state (Southgate, 2003).

The rise of epidemiology in public health is also seen as an important marker in the clinic phase and the development of addiction as a social problem (Lart, 1998, Mold, 2004, 2007, Seddon, 2010). Epidemiology is central to the debate as it provided experts with the discourse through which to speak about the spread of addiction in terms of an infectious disease (Lart, 1998, Mold, 2007). This interest in epidemiology has been traced to the links that were made between smoking and lung cancer which raised the profile of epidemiology in explaining the aetiology of diseases like addiction (Mold, 2007, Seddon, 2010). The key point is that it drew attention from public health policy onto the behaviour of individuals (Bunton, 2001). This is a feature, for Bunton, of neo-liberalism. Furthermore, he locates shifts from addiction to dependency by the World Health Organisation (WHO) within this same mutation of neo-liberal governmentality.

MacGregor has argued that there are distinct phases of policy and practice that have developed in Britain since the nineteenth century. Most importantly, each phase was “dictated by what went before” and contains obvious characteristics (1989:170). The rise of psychiatry and social workers in the clinic system and the turn towards social learning theories and abstinence are central to the clinic phase or reformist phase

(MacGregor, 1989). In contrast, Smart questions the view that the Brain report signalled a new direction and instead argues that the emergence of the clinics “symbolised a rationalisation of treatment” rather than an historical rupture (1984:37).

MacGregor’s (1989) argument, in some respects, resonates with that advanced by Seddon (2010). Seddon argues that mutations in liberalism can account for these transformations in policy and practice. In particular he argues that this phase of policy, characterised elsewhere by the clinic (MacGregor, 1989), is part of the “unravelling of welfarist politics and the rise of neo-liberalism” (Seddon, 2010:78). Whilst acknowledging a number of the above developments (Lart, 1998, MacGregor, 1989, Spear, 2002), his attention is on the rise of the ‘problem drug user’ as a neo-liberal subject. This point is also supported by Bunton (2002), who also claims the shift from conceptualising the individual as abnormal, belonging to an abnormal group, to being part of the population and therefore subject to the new public health measures associated with neo-liberal governance.

The “public health problematisation of the drug situation” is significant for Seddon (2010:83). The genealogy sketched out by Seddon, argues that this ‘problem framework’ was initially worked out and then applied to alcohol and, from here, the “idea began to take hold for other substances” (Seddon, 2010:83). Although in some respects I agree with this analysis, however, it is important to piece together other parts of this puzzle; in particular, the development and function of the concept of ‘drug-related problems’. More will be said about this point in chapter 8. However, the main point regarding the problem drug user is that it signified an important move away from exclusionary discourses of addiction towards inclusionary discourses of drug problems, which are characteristic of neo-liberal technologies of government (Dean, 1999). The governmentality perspective, as previously mentioned, will be discussed in the next chapter. The crucial point to make about this definition is that it is also part of the shift towards the harm reduction approach that has been so influential in drug policy and practice since this original formulation (Seddon, 2010).

2.4. The harm reduction paradigm: from improving health to reducing crime

The harm reduction policy was a response to the crisis of HIV and AIDS that hit Britain in the mid-1980s (MacGregor, 1989, Stimson, 1994, Yates, 2002). However, it is

important to point out that a few years previously most regions of Britain were experiencing significant levels of heroin use among young males from socially deprived areas (MacGregor, 1989, O'Bryan, 1989, Parker, 2005, Yates, 2002). The Wirral on Merseyside, for instance, is one of numerous sites that witnessed a "full-scale heroin outbreak" (Parker, 2005:80, Yates, 2002). In particular, unlike the HIV crisis, which will be discussed in the next section, the heroin was smoked rather than injected; a practice thought to be non-addictive, according to Yates (2002) and less harmful than injecting (Griffiths et al, 1994).

This increase has been linked to social exclusion (Parker, 2005), access to cheaper heroin (MacGregor, 1989) and new trade routes from Southwest Asia (Pearson and Gillman, 2005). Yates (2002) also points out that a large Iranian population of students which would have provided impetus for the spread of the 'art of heroin smoking'. For Parker (2005), and also acknowledged by Strang (1989), there was a normalisation of drug use; recreational use became "common place rather than exceptional" (Seddon et al, 2008:822). For Bunton (2001), this can also be explained by the influence of neo-liberal thinking on public health approaches to population management. In a similar vein, these two 'social facts' – global trade routes and normalisation - according to Seddon et al, can be understood as part of the "transition to late modernity" (2008:823). The developments created by this transition have, they argue, produced a new drug policy predicament for government to deal with.

The incidence of HIV and AIDS were reported in Scotland towards the end of 1985 (Robertson, 1994). The reports by the Advisory Council on the Misuse of Drugs have been used as key marking points (MacGregor, 1989, Seddon, 2010, Yates, 2002, Zibbell, 2004) as they signalled a "fundamental change in direction" from the abstinence policies of the clinic era (Yates, 2002:118). They argued that HIV and AIDS was more of a threat to public health than drug use. It was feared that similar rates might be found in the injecting drug using population in England and Wales and would spread from sex workers to the wider population (McDermott, 2005, Stimson, 1995). McDermott (2005) has also made links with observations made in New York where half of injecting drug users was infected with HIV.

Ultimately, the emergence of HIV and AIDS prompted a whole new debate about the "philosophical, political and practical issues concerning drug use" (MacGregor, 1989,

Stimson, 1992:39). Zibbell (2004) has made an interesting albeit brief point regarding the way in which states respond through reconfiguring policies and strategies, notably harm reduction, in times of contagious disease. However, in such a period of crisis it is possible to see a move away from use reduction policies and towards the now dominant harm reduction policies (McDermott, 2005, Roche et al, 1997, Stimson, 1994).

Harm reduction is a public health approach that aims to reduce the negative consequences of drug use (Riley and O'Hare, 2000, Stimson, 1994). Numerous texts have been developed regarding harm reduction (Inciardi and Harrison, 2000, O'Hare et al, 1992, Rhodes and Hartnoll, 1996). However, there is "no clear consensus on the meaning" of harm reduction (Hunt and Stevens, 2004, Inciardi and Harrison, 2000: vii), and it has been criticised for prioritising a middle class value system (Miller, 2001). Miller, moreover, is critical of the dominance of epidemiology within harm reduction and argues that it marginalises the individual by prioritising the needs of the overall population (Miller, 2001). McKeganey (2006), more directly, has questioned the effectiveness of harm reduction by arguing that despite the dominance of harm reduction in certain areas of the UK harms are increasing. Instead, he calls for the reversal; the reduction of drug use.

The experiment with the needle exchange in Merseyside has also been given as an important marking point (see McDermott, 2005). The needle exchange, for Stimson, is "symbolic" and central to the harm reduction movement (1994:249). The relation between the drug user and the syringe, on the other hand, has also attracted attention from psychiatrists. Although only a marginal debate in the literature, it is argued that injecting drug use is abnormal, and therefore have advanced the term 'needle fixation', as well as psychological tools, with which to identify and normalise the condition (Pates et al, 2001, Pates, Arnold et al, 2009:320, Pates and Gray, 2009). This response has encouraged criticism from others (Fraser et al, 2004) who have argued that the discourse merely provides injecting drug users with a framework through which to "construct the self as legitimate and understandable" (2004:75). This will be analysed in more depth in chapter 6.

It is argued that the rapid uptake of harm reduction approaches was supported by the previous expansion of the voluntary sector (MacGregor, 1989) and their frustration with dominant abstinence policies of the clinic system (McDermott, 2005). For Yates (2002),

such non-statutory services were linked with Christian churches and parent-groups (Turner, 1994). These voluntary agencies, for Stimson, were operating a “set of loosely related ideas and practices around the reduction of harm” (1994:248). In addition, such services were also encouraged by the Central Funding Initiative, which provided funds to improve the drug treatment services in England in light of the growing problem (MacGregor, 1994, Mold and Berridge, 2007, Stimson and Lart, 1994, Yates, 2002). Ultimately, this development supported a “completely new network of treatment services” (MacGregor, 1989, Yates, 2002:118), including the rise of the general practitioner and the decline of the specialist (Strang, 1989).

Links have also been made between harm reduction and the British System (Seddon, 2008). Seddon (2008) traces the discursive strands of harm reduction to the 1920s when “British drugs discourse was notably ‘noisy’ on the subject of women” (2008:100). This point was also acknowledged above. For Stimson, although there are “similar structural relationships”, it “would be unwise therefore to attribute current ideas of harm reduction to ideas of the 1920s” (1994:251). Instead, he argues that ideas of harm reduction were more likely to have developed in the “indigenous drug using culture” of the 1960s (1994:251).

Miller, after Mugford (1993), has argued that harm reduction has also followed a similar pattern to the developments in the mental health field; with both moving “from the corporal, to the carceral, to risk management” (2001:168, Mugford, 1993). The move towards risk management strategies, it has been argued, is a significant feature of neo-liberalism (Dean, 1999). Harm reduction’s risk management strategies have, therefore, been closely associated with changes in political rationalities (Mugford, 1993, O’Malley, 2004, Seddon, 2010). Furthermore, Bunton (2001), borrowing from the governmentality literature, has argued that there has been a pluralisation of governmental technologies; involvement of social workers, health workers, public health strategies, general practitioners, community interventions and the expertise of the service user; a point also acknowledged by Zibbell (2004).

Researchers analysing this particular problem, who draw from the governmentality perspective, have pointed to the tensions and conflicts that exist between the notion of the addicted subject, supported by social forms of government or welfarism, and the rational and autonomous harm reduction subject, supported by neo-liberalism

(O'Malley, 2004, Seddon, 2010). This was a point made earlier in this literature review. According to O'Malley;

“‘free will’ and ‘compulsion’ are displaced in harm reduction by two parallel but distinct terms: ‘choice’ and ‘risk’. If free will and compulsion exist at opposite ends of a spectrum, this is not the same for choice and risk, which are compatible and complementary” (2004:69).

The introduction of neo-liberal rationalities, for Bunton (2001), has produced important reconfigurations beyond the transformation of the addicted subject. For Bunton, the role of the expert within this particular manifestation of liberal government has also changed. Rather than the deployment of knowledge from the authority figures from the human sciences, neo-liberalism introduces “budgetary discipline over {experts}” (2001:232). This has held the expert to account.

The concept of ‘drug-related harm’, which is central to harm reduction, has come to prioritise crime as the dominant drug-related harm (Hunt and Stevens, 2004, McKeganey, 2006, Seddon et al, 2008). Hunt and Stevens (2004) have argued that the concept of ‘harm’ has increasingly been viewed from the perspective of harm to others rather than harm to the individual drug user. The concept of harm has thus been central the new criminalisation of drug policy. This has meant a shift from voluntarism to coercion (Hunt and Stevens, 2004). The observations made by Hunt and Stevens (2004) have also been noted by Stimson (2000). Stimson (2000) has argued that drugs policy has moved from a healthy to an unhealthy position. For Stimson, this has meant “major new resources to link the criminal justice and drug treatment sectors” (2000:260). The argument is that the best place to locate those problem drug users that are causing most harm is the criminal justice system (Seddon, 2010).

The link between drug treatment and criminal justice are underpinned by the argument that there is a connection between certain types of drug use and criminal behaviour (Bean, 2002, Seddon, 2000). Although there are other ways of explaining this link, such as the two are the result of low self control (Gottfredson and Hirschi, 1990, Ribeaud and Eisner, 2006), the dominant model has been that one causes the other to happen (Bennett and Holloway, 2005). This is the claim that either drug use causes crime or crime causes drugs use, or that there is a third variable that influences them both

(Seddon, 2000). This is a problematic model and the empirical evidence suggests it is not as straightforward as some would argue (Allen, 2005, Bennett and Holloway, 2009, Seddon, 2000).

Seddon has argued that this turn in British drugs policy was not as sudden as Stimson (2000) has claimed. At the same time as Liverpool was experimenting with the needle exchange (see McDermott, 2005), arrest referral schemes were also being piloted at local police stations (Seddon, 2010). Rather than concentrating on the differences, Seddon argues that it is possible to identify “family resemblances” between the two policies in terms of how “they imagine the problem” (2010: 89). For Seddon, the Tough Choices project and the Drugs Act 2005 is indicative of this new move and incorporates a number of neo-liberal governmental strategies. In other words, the government of the problem drug using citizen takes place through responsibility and choice. In this respect, rather than a break from the health focus of harm reduction, there is an underlying strategy that resonates quite clearly with the neo-liberal agenda that permeates both. It is for this reason that Seddon (2010) argues that our understandings of, and responses to, drug use has been caught up with changing conceptions of freedom.

2.5. The recovery agenda: a neo-liberal agenda

Chapter 1 made an important point about the most recent problematisation of drug policy and practice by discourses of recovery and the move towards a recovery-orientated system. Although it is not my intention to discuss this in any depth, it is important to give it some attention here. The move towards recovery is part of an attempt to reduce the costs of the drug treatment system and a response to the problem of ‘parking people on methadone’ rather than preparing them for social reintegration (Aston, 2007, DrugScope, 2007). This focus on retention and methadone, for McKeganey (2006), is a consequence of the HIV and AIDS crisis. It is also worth pointing out that recovery, as a movement, has always existed on the margins of drug treatment since the development of the twelve step movement in the 1930s (Narcotics Anonymous, 1988).

Recovery, however, is a contested concept, with a multitude of meanings, and operating within a variety of contexts (Bonney and Stickley, 2008) within both the addictions (Best and Laudet 2010) and the mental health field (Bonney and Stickley 2008). The

meanings given to recovery vary from an idea, a policy, a personal journey, a movement, a paradigm, and an instrument for change and self-formation (Best and Laudet, 2010, Bonney and Stickley, 2008, Rethink, 2011). In this recent interest in recovery, it has been defined as

“a lived experience of improved life quality and a sense of empowerment...the principles of recovery focus on the central ideas of hope, choice, freedom and aspiration” (Best and Laudet, 2010:2).

Recovery supports an emancipatory discourse of freedom and self-responsibility (Bonney and Stickley, 2008) and is, therefore, beginning to challenge the way we think about drug users and their treatment. With this in mind, its recent introduction into mainstream drug treatment can be crafted onto the neo-liberal political agenda that supports new ‘responsibilising’ forms of citizenship (Bunton, 2001, Seddon, 2010).

Best and Laudet (2010), who are at the centre of this new recovery movement, have argued that drug treatment agencies are best placed to facilitate an individual’s access to a recovery community and enable them to acquire the necessary skills to begin their recovery journey (Best and Laudet, 2010). As Zibbell (2004) has pointed out, there has been a wider acceptance of the ‘expertise’ of the service user and it is this expertise that the National Treatment Agency has articulated with the introduction of ‘recovery champions’. Recovery champions, according to Best and Laudet, may be the “key contagion that allows the ‘viral spread’ of recovery capital” (2010:5). The notion of capital is understood as “the body of resources that can be accumulated or exhausted” (Cloud and Granfield, 2008) and, in relation to recovery capital, has been divided into four areas: Social capital (obligations to family, friends, groups); physical capital (financial assets); human capital (health, hopes, education); cultural capital (values, beliefs, attitudes).

The concept has been accepted and according to the key figures in this new recovery movement (Best and Laudet, 2010) it is being polished and made ready for deployment. After a brief read through papers by the authors of the recovery capital concept, it is possible to detect a link with research into the natural recovery from drug addiction carried out from the 1960s onwards (Biernacki, 1986, Biernacki and Waldorf, 1981, Cloud and Granfield, 2008, Cloud and Granfield, 1994, Granfield and Cloud, 1996,

Granfield and Cloud, 2001, Robins, 1973, Waldorf, 1983, Winick, 1962, 1964). The research carried out by Biernacki (1986) involved middle class drug users that gave up heroin without treatment. Similar demographic profiles of participants have been used elsewhere (Cloud and Granfield, 1994). This raises questions over the links with middle class values; a link Miller (2001) has made with the harm reduction approach.

2.6. Summary

This review of the historical and contemporary academic literature has raised a number of problems that have been unquestioned and/or left unexplored. The theme of poisoning is arguably a central theme from the nineteenth century, and although it has been given some attention with respect to the regulation of drugs (Berridge, 1999, Seddon, 2010), its impact on the body, in terms of the way we think about withdrawal and addiction, has not been considered. These basic and underlying concepts are indispensable to the drugs field, such as withdrawal, dependence and addiction. However, this research will seek to build on the limitations identified in this literature review and address the emerging practices of recovery, and the role of power, within the changing context of drug treatment. Finally, the work of Seddon (2010) has demonstrated how the concept of governmentality can be used to structure an historical approach to the problems identified above. This will also complement the use of historical sociology in understanding the present of drugs policy and practice. Chapter 3 will now introduce the concept of governmentality and how it will inform the analysis.

Chapter 3

Theoretical framework: Governmentality

3.1. Introduction

The purpose of this chapter is to introduce the theoretical perspective that has informed this research. The theoretical perspective is drawn from the work of Michel Foucault (2007, 2008) and post-Foucauldian literature on governmentality (Dean, 1999, Rose and Miller, 2008). The first objective of this chapter is to contextualise the governmentality perspective within the literature on the sociology of power. I will then provide a detailed and critical overview of the concept of governmentality itself (Dean 1999, Foucault 2007). The second objective of this chapter is to draw on the Foucauldian and post-Foucauldian literature on governmentality in order to provide the framework of analysis and demonstrate the usefulness of this type of critique. This chapter will conclude by discussing the challenges and limitations of the governmentality perspective. Foucault suggested that his work be used as a 'tool-box'. I will be drawing from the Foucauldian 'tool-box' and from others that have developed this 'tool-box' in the years since.

3.2. The sociology of power

My aim in this first section is to provide an academic context within which the governmentality perspective (Dean, 1999, Foucault, 2007, 2008, Rose and Miller, 2008), as a tool for analysing power-relations, can be located. Foucault (1994e, 2007) introduced the idea of governmentality, which I will discuss in depth later in this chapter, against the backdrop of what he understood as serious limitations in the current conceptions of power within social and political theory. These conceptions of power coalesced around issues of sovereign power and the principle of legitimacy (Hindess, 1996, Taylor, 2010). The use of sovereignty as a framework for understanding the functioning of power within society has been not only persistent but influential in analysing power relations (Hindess, 1996, Lukes 1974, 2005, Taylor, 2010). This framework conceptualises power as the capacity which enables a person or institution to act on the behaviour of another. Weber (1978), for instance, defined power as the ability

of a person to realise his or her own *interests* despite those *interests* being resisted by the other person (Hindess, 1996).

Foucault (1994e) identified this model of power as underpinning the Marxist perspective. In Marxism, power is a property belonging to those that own the means of production (Morrison, 1995). The means of economic production provides the resource necessary for exercising power within modern capitalist society (Morrison, 1995, Westwood, 2002). At the heart of the Marxist approach is the idea that social and economic conditions of existence ultimately determine the consciousness of men and women (Jessop, 2001). In order to understand power, therefore, we need to investigate the historical development and organisation of economic structures and their productive relations. The outcome of this economic arrangement, consequently, is that society becomes organised into a dominant and a subordinate class (Jessop, 2001). This means that there will always be unequal distribution of power. Or a group that has power and a group that does not. Understanding power as a property opens up the possibility for it to be removed from the hands that wield power. For Marx, this could only be done when the subordinate class became aware of their domination and revolted (Morrison, 1995).

Nevertheless, the power held by the ruling elite is reinforced by the legal and institutional structures of society. This particular social arrangement of power is linked to the historical formation of capitalist societies. Historical materialism, the methodological approach adopted by Marxists (Morrison, 1995), argues that social, political and legal institutions and arrangements of power develop out of their productive relations (Jessop, 2001, Morrison, 1995). The exercise of judicial power, it is argued, will ultimately function to secure the conditions for economic and class domination (Jessop, 2001, Westwood, 2002). This view of political power, crucially, is underpinned by a particular model of power as a thing to be possessed. The attraction with this quantitative conception of power in the social and political sciences, Hindess suggests, is that an investigation into its distribution and uses in society becomes a “straightforward empirical matter” (1996:27). By limiting investigations of power to the economic and legal domains, Foucault (2007) insisted, we fail to recognise how it operates outside of these domains.

The principle of legitimacy, in contrast, has been an important model within social and political theory for understanding the nature of power-relations (Beetham, 2001,

Hindess, 1996). Throughout history individuals in positions of power have attempted to ground their political authority to govern, not only through ownership of the means of production (Morrison, 1995), or a quantitative capacity (Hindess, 1996), but in the principle of legitimacy (Beetham, 2001). In grounding their power to act in this principle, their authority appears rightful to the individual or group it is being exercised over (Westwood, 2002). The exercise of power, in other words, is based on the consent of the citizen. This particular idea can be traced back to the seventeenth century philosopher Thomas Hobbes and his social contract theory (Hindess, 1996). Power is understood not in the traditional sense, but as involved in the political constitution of society (Westwood, 2002).

The significance given to the principle of legitimacy in studies of power-relations within sociology has been linked to the work of Max Weber (1978). For Beetham (2001), two features of Weber's (1978) understanding of legitimacy are of value to debates on power. The first concerns the instability of power-relations when legitimacy is lacking or when it breaks down. If there is an acknowledgement of legitimacy then the use of coercion, as a technique of power, will not be needed. If legitimacy breaks down, however, the balance ultimately swings in the other direction. In a broader sense, this can be linked to the problem of maintaining the social and political order (Taylor, 2010). The second feature relates to the way legitimacy has been organised on the grounds of three types of legitimate authority. These are traditional, charismatic and rational-legal. In traditional legitimacy, power over others is sanctioned by tradition. It is fixed and passed down through generations. Charismatic legitimacy, in contrast, breaks with traditional ties through the perceived (extraordinary) qualities possessed by a particular person (Beetham, 2001).

Legal-rational legitimacy has been associated with the type of power found in the structure and institutions of modern bureaucratic states (Harrington, 2005, Weber, 1978). Within the context of such an administrative social system, power, in the form of domination, functions through rational forms of knowledge, norms and laws. These develop into a set of uniform principles. These principles have emerged, historically speaking, from the application of religious practices to social and economic life (Weber, 1978). For Weber (1978), these principles were fundamental to modern bureaucratic organisations and administrations and, moreover, the actual development of the modern

capitalist state (Morrison, 1995). The processes of rationalisation and bureaucratic forms of legitimate domination have, as a result, become embedded in the fabric of the social body. Weber described the consequence of this rationalisation of society using the metaphor of the iron cage (Harrington, 2005, Morrison, 1995, Westwood, 2002). These are also concerns of the Frankfurt School (Baert, 2001, Habermas, 1984). This will be discussed later in this chapter.

In *Power: a radical view* (1974, 2005), Lukes puts forward a radical alternative to the study of power-relations. He draws our attention to the insidious power that operates through ideological constraints (Lukes, 1974, Taylor, 2010). In this respect, he is moving in the same direction as critical theorists (Marcuse, 1964), by arguing the interests of the masses are not so much repressed by the ideas of the dominant class, but are in fact prevented from actually materialising in the first place. In this radical view, individuals are unable to directly observe what is being done to them as power affects their thoughts and desires through “socially structured and culturally patterned behaviour” (Lukes, 1974:22). Here, there is a distinct Marxist concern with the function of ideology in preventing the working classes from realising their own interests. The ruling ideas, in other words, are those of the ruling elite (Hindess, 1996). This is what Gramsci referred to as hegemony. Hegemony explained how the ruling class maintained power not only through coercion but also through promoting their own ideas as widely accepted cultural norms (Westwood, 2002).

The radical view of power, as pointed out elsewhere (Hindess, 1996, Taylor, 2010), has been associated with the work of critical theorists (Habermas, 1984, 1987, Marcuse, 1964). The project taken on by critical theorists, such as Habermas (1984), is the emancipation of society from the power of rationalisation. In this respect, their concerns are similar to those expressed by Max Weber (1978). The argument is that rationalisation, which has led to the formation of the bureaucratic and administrative state machine, has contributed to the loss of use of substantive rationality. Instead, politics has become driven by a form of instrumental reasoning preoccupied with finding technical solutions to problems. Instrumental rationality is believed to promote the smooth running of the social and economic system (Baert, 2001). Unlike Weber (1978), earlier critical theorists (Marcuse, 1964), and Foucault (2007), Habermas (1984) argues that the processes of rationalisation are not inherently dangerous. On the contrary,

for Habermas rationalisation is a two-fold process incorporating both instrumental and communicative rationality. Communicative rationality refers to the rules for reaching agreement in open dialogue.

In his *Theory of Communicative Action*, Habermas (1984, 1987) argues that individuals can in fact be emancipated from the domination of instrumental rationality by communicative rationality. Habermas essentially understands power as a repressive force that imposes itself on the true interests of human beings through ideological constraints. The task for Habermas, therefore, is to free us, as a collective, from such ideological constraints through a form of self-reflection advocated by critical theory. In breaking with the philosophy of the subject, which he understands as one of the problems inherent in the project of modernity, he proposes a philosophy of intersubjectivity through which individuals become members of the lifeworld (Habermas, 1984, 1987, Hindess, 1986). The lifeworld is the world of communicative action. It is the domain of norms, values, human interests and knowledge and the space of socialisation (Clarke, 2006). This is contrasted with the system world which is the domain of work, economic exchange, and is dominated by instrumental rationality (Baert, 2001, Habermas, 1984, 1987). The problem is that the system world, which although emerged from the lifeworld and has become external to it, has colonised the lifeworld. The lifeworld has therefore become dominated by money, power and the market and by administrative and instrumental rationality. The ideal goal, as pointed out above, is to separate the two.

The links between power and the processes of rationalisation are important concerns taken up by the governmentality perspective (Foucault, 2007, Rose and Miller, 2008). Rather than the process of the rationalisation of society (Habermas, 1984, 1987, Weber, 1978), however, Foucault was concerned with the process of rationality in relation to a “fundamental experience: madness, illness, death, crime, sexuality, and so forth” (Foucault, 1994e:329). The function of power is not to repress the experience. On the contrary, power operates by producing the subject of the experience. The delinquent, for instance, was brought into existence by the configuration of power found within the prison (Foucault, 1977). The productivity of power is, in part, a move away from the models of domination and legitimacy. In his essay *The Subject and Power*, Foucault argues that the various struggles in society were not against an “institution of power, a

group, or elite, or class” as we have seen above “but rather a technique, a form of power” (1994: 331). Foucault (2007) named this form of power as government and defined it, more broadly, as the “conduct of conduct” (Gordon, 1991:2). Instead of a state that dominates society, or a process of rationalisation that dominates a lifeworld, he put forward a critique that he referred to as the governmentalisation of the state (Foucault, 2007, 2008, Lemke, 2000). This not a form of power that is imposed from the top down, but rather a subterranean power that over time becomes adopted by state institutions.

3.3. Governmentality: The governmentalisation of the state

Michel Foucault (2007) introduced the concept of governmentality during a series of lectures that he delivered at the College de France, 1977-1978. The concept itself was not first coined by Foucault, but by Roland Barthes. Barthes first used the concept in 1957 to connect the process of government with efficiency (McKinlay, Carter and Pezet, 2012). In Foucault’s own work, however, this concept signals a shift from an analysis of the individualisation associated with the power of normalisation and the confession (Foucault, 1977, 1978) to “two seemingly disparate projects” including the genealogy of the state and the genealogy of the subject (Lemke, 2000:2). This project sought to demonstrate how the modern sovereign state and the modern autonomous individual co-determine each other’s existence.

In the lecture series identified above, Foucault (2007, 2008) went into great detail to describe the historical trajectory of governmental rationalities from the sixteenth century to the twentieth century (2007, 2008). He located the problem of government in the sixteenth century at the “crossroads of two processes...state centralization, on the one hand, and of dispersion and religious dissidence, on the other” (Foucault, 1994c: 202). This process of governmentalisation, which I will outline below, starts with earlier conceptions of government as an arrangement of ‘things’ for the common good, and the government of state by a model of the family, and then moves on to a type of government concerned with biological processes of populations (Foucault, 1978, Rose, 2007). This line of modification extends beyond the bio-political imperatives of the eighteenth and nineteenth centuries and into the twentieth and twenty first centuries with advanced manifestations of liberalism (Dean, 1999, Foucault, 2008, Rose and Miller, 2008).

3. 3. 1. Power and Sovereignty

The “narrative of the governmentalisation of the state” begins with sovereign power (Dean, 1999:103, Foucault, 2007). Mitchel Dean has provided two reasons for this assertion. The first is that sovereign power is behind our common conception of how power functions within the state. We have seen this is in the above debate within sociology on the notion of power (Morrison, 1995, Westwood, 2002). The second reason is that sovereignty was the dominant mechanism of power before the formation of nation-states. Prior to the eighteenth century sovereign power was exercised over a territory and over the subjects that inhabit that territory (Dean, 1999, Foucault, 1978). The territory and its inhabitants, for Foucault, is the fundamental element of sovereignty. These were acquired through either inheritance or conquest (Foucault, 2007). Most importantly, as Foucault claims, the sovereign stands in a position that is external to his territory (2007). Government, as we shall see, becomes separated from the “activity and person of the sovereign” (Dean, 1999:103). However, this is not to say that it is removed from the exercise of power. Sovereign power becomes an instrument of governmentality.

In the final chapter of the *History of Sexuality*, Foucault (1978) provides an outline of sovereign power as a deductive power that is exercised through the use of “laws, decrees and regulation” (Dean, 1999:105). He described it as the “right of seizure: of things, time, bodies, and ultimately life itself” (Foucault, 1978:136). The sovereign took the form of a “juridical being” that came into force when either an internal or external enemy threatened his existence or when a law has been violated (Dean, 1999, Foucault, 1978:138). An excellent example is Foucault’s graphic torture of Damians the regicide in the opening pages of *Discipline and Punish* (1977). From this illustration, it can be said that sovereign power is conditional, forceful, and is exercised when a prohibited act has occurred. The objective of sovereign power was the continuation of the sovereign himself. This is the “self-referential problem of sovereignty” (Dean, 1999:105, Foucault, 2007); i.e., nothing to do with governing in the modern sense.

3.3.2. Power and government

Foucault traced the notion of government to the pastoral power of the Church, where government operated as part of a complex assembly of power-relations between God,

the pastor and the pastorate (Foucault, 1994a). Defining government as the “conduct of conduct” (Gordon, 1991:2), Foucault (2007) argued it was an activity in leading, guiding and conducting individuals and collectives. The important point that Foucault makes is that “certain individuals can, by their religious quality, serve others not as princes, magistrates, prophets...but as pastors” (Foucault, 1994:333). Contemporary examples of this diagram of power are doctors, nurses, drug workers, counsellors, social workers, and teachers and so on. Unlike sovereign power’s concern for self-preservation, pastoral power is the idea of caring for each and every individual in a continuous manner and at every moment in their life (Dean, 1999, Foucault, 1994b, 2007).

Pastoral power is positive, omnipresent and “salvation-orientated” (Foucault, 1994b: 333). This objective provides a common destination and creates group solidarity (Dean, 1999). Furthermore, Foucault argued that pastoral power is an “individualizing power” (1994a: 334). The act of directing the conduct of each and every individual towards salvation essentially required a detailed knowledge of the inside of people’s minds and souls (Foucault, 2007). The art or technique that is used to extract the truth from the pastorate is the confession. Foucault illustrated the technique of the confession in the introduction to the *History of Sexuality* (1978). The objective of teaching the truth to the pastorate is so that they can look at themselves, at their souls, and identify and work on their own suffering.

3.3.3. An ‘art of government’: reason of state and police

Foucault (2007) argued that during the sixteenth century political thought was in pursuit of an ‘art of government’. In Guillaume de la Perriere’s *Miroir Politique*, Foucault uncovers an approach to government that is internal to the state and involves “governing a household, souls, children, a province, a religious order, a family” (Foucault, cited in Gordon, 1991:90). The definition of government that Foucault uncovers is as follows;

“the right disposition of things, arranged so as to lead to a convenient end” (1994c: 210). Things, in this context, refer to men in their relation to “customs, habits, ways of acting and thinking...and finally men in their relation to...accidents and misfortunes such as famine, epidemic, death, and so on” (Foucault, 1994c: 208-9).

The development of reason of state is an early example of a “secular reflection on the art of government” (Dean, 1994:184, Foucault, 2007). In contrast to sovereignty, the theory of rule is derived from within the state itself, rather than from divine right theories of rule (Dean, 1999). Government, in this context, becomes a rational activity that is concerned with the preservation of the state and not with the preservation of the sovereign (Dean, 1999, Foucault, 2007).

The internal techniques of governmental power that are used to strengthen the state were referred to as police (Dean, 1994, 1999, Foucault, 2007). There is a police of “religion, of customs, of health, of foods, of highways, of public order, of sciences” as well as poverty and childrearing (Gordon, 1991:10). For Gordon (1991), an accurate translation of police is policy; and for Dean, police, or “policy science”, is probably the first modern framework for public policy (1994:185). Indeed, police is a “governmental technology” that enables the state to specify targets for intervention (Foucault, 1994b: 317). Dean (1999) and Rose and Miller (2008) speak of police as regulation mania, suggesting that a police state is disciplined one. Bodies are organised and regulated through disciplinary systems in an attempt to make them useful in their contribution to the strength of the state (Miller and Rose, 2008).

The science of police, it is important to point out, in part, arose from the ancient householding conception of the economy (Dean, 1994, Foucault, 2007). This problem has been articulated by Foucault as a problem; that is, “how to introduce this meticulous attention of the father towards his family into the management of the state” (Foucault in Gordon, 1991:92). Mercantilism was the first political practice to apply this art of government to the state by using “knowledge of state...as a tactic of government” (Foucault, 1994c: 214). Mercantilism was, however, restricted by the framework of sovereignty, which was considered “too large, too abstract, and too rigid” and the theory of government also “suffered from its reliance on a model that was too thin, too weak, and too insubstantial” found in the family (Foucault, 1994c: 214-215).

Foucault makes the argument that at this point, it is possible to detect a shift in the meaning of economy. According to Foucault; “economy...in the sixteenth century signified a form of government...comes in the eighteenth century to designate a level of reality, a field of intervention, through a series of complex processes that I regard as absolutely fundamental to our history” (1994c: 208). For the art of government to gain

some autonomy from the framework of sovereignty, it needed to discover its own “ways of reasoning” that are distinct from the model of the family (Dean, 1999: 107, Foucault, 2007). The emergence of the ‘*population*’ within police sciences provided this new way of reasoning and allowed for the re-centring of the economy on to something beyond the family. Police, in this respect, was a political rationality that aligned the strength of the state with the “happiness of a new object, the population” (Dean, 1994:185).

3.3.4. Population and biopower

The population is an important concept for studies in governmentality (Dean, 1999, Foucault, 2007, 2008, Rose and Miller, 2008). Foucault traced the emergence of population to the eighteenth century to the “economico-political effects of the accumulation of men” (Foucault, 1994d: 95). Population provided a new conception of the governed as “members of a population are no longer bound together in a territory who is obliged to submit to the sovereign” (Dean, 1999:107). An inseparable element of the emergence of population is the science of statistics which came to reveal that “population has its own regularities” (Dean, 1999, Foucault, 1994c: 216). In other words, birth and death rates were revealed that were not reducible to the family or governable through the householding concept of government.

Hacking has argued that during the nineteenth century “there was an exponential increase in the number of numbers that was being published...enthusiasm for numbers became almost universal” (1991:186). Hacking (1991) has argued that many of the categories that are used to think about human beings were derived from attempts to quantify them. Ultimately, statistics has become linked with the emergence of the population and with the transformation in the way power functions within the state. Unlike sovereignty, power no longer reinforces itself, instead, it secures the object of population; it seeks to improve the health, longevity and wealth of the population (Foucault, 2007). This particular development in the economy of power is part of what Foucault refers to as biopolitics (Foucault, 2008).

In the final pages of the *History of Sexuality Vol I* Foucault (1978) puts forward a sketch of a diagram of power that he referred to as biopower. As pointed out above, in these pages Foucault argued that power was no longer exercised in the name of sovereignty, but had become “situated and exercised at the level of life, the species, the

race, and the large scale phenomenon of population” (1978:137). Indeed, political power had come to be directed at administering the life of the population through the two poles of biopower that came together through a series of relations.

The first pole of biopower to be formed was an “anatomico-politics of the human body”; a disciplinary form of power that “centred on the body as a machine” (Foucault, 1977, 1978:139). Foucault developed his ideas on disciplinary power in his lectures on Psychiatric Power (2006) between 1973 and 1974 and then later in his work on the prison in *Discipline and Punish* (1977). Disciplinary power, for Foucault;

“reaches the level of bodies and gets hold on them, taking actions, behaviour, habits and words into account; the way in which power converges from below to affect individual bodies themselves, to work on, modify, and direct” (2006:40).

Indeed, disciplinary power concerns the individual body and acts on it in order to modify and direct it towards a particular end. The mechanisms of disciplinary power, Foucault (1977) argued, produced knowledge of the individuals being observed. The relationship between power and knowledge is central to Foucault’s (1977, 1978, 2007, 2008) work. For instance, disciplinary power, it is argued, became linked to the development of the knowledge that formed the human sciences (Foucault, 1977, Pasquino, 1991, Rose, 1989, Rose and Miller, 2008).

Biopower, on the other hand, is a biopolitics of the population that focuses on the “species body, the body imbued with the mechanisms of life: birth, morbidity, mortality, longevity” (Rose and Rabinow, 2006:196). For Rose, since the nineteenth century, the responsibility of the state had developed from ensuring the health of the population through clean water and sewage systems to actively encouraging citizens to acknowledge health as a “key ethical value” (2007:22). These mutations in the exercise of political power or government will be developed further in the next section of this chapter.

These two poles of power, according to Foucault (1978), become conjoined within discourses of sexuality and opened up new spaces and life itself becomes subject to new power relations and therefore new political struggles (Rose and Rabinow, 2006). The foremost academic on matters of biopower and biopolitics is Nikolas Rose (1989, 2007).

Rose's (2007) work has not only been influential in the development of governmentality studies (see Rose and Miller, 2008), but has underpinned researches in the addictions field (see Bunton, 2001, Lart, 1998, Seddon, 2010) and its links with studies of the biosciences (Fraser and Valentine, 2008, Vrecko, 2010a, 2010b).

3.4. Three stages of liberalism: classical, welfare and neo-liberal.

3.4.1 Classical Liberalism

Classical liberalism emerged in the eighteenth century as a critique of the excessive power of reason of state and police science (Foucault, 2008, Gordon, 1991). Liberalism, in this respect, problematised reason of state's idea of a "megalomaniac and obsessive fantasy of a totally administered society" (Miller and Rose, 2008:203). In fact, liberal government has a problematising character that sets limits to the governmental activities of the state (Foucault, 2008, Rose and Miller, 2008). Rose and Miller refer to this feature of liberalism as a "recurrent diagnosis of failure" (2008:206). Liberalism asks pertinent questions about the act of government; for instance, "who can govern; what governing is; what or who is governed" and what ends should government be directed towards (Foucault, 2007, Gordon, 1991:3, Rose and Miller, 2008).

Liberalism does not mean a theory or a political ideology, instead, it is a "rationally reflected way of doing things" (Burchell, 1996:21) or a "style of thinking" that functions as a guiding principle for the art of government (Gordon, 1991:14). The critical principle of classical liberalism is *laissez-faire*. According to Burchell

"Government by *laissez-faire* is a government of interests, a government which works through and with interests, both those individuals and, increasingly, those attributed to the population itself" (Burchell, 1991:127).

Laissez-faire requires the autonomy of the realities outside of the state such as the "market, civil society, citizens" rather than their visibility and detailed regulation (Foucault, 2008:203, Gordon, 1991). These realities all have their own "intrinsic mechanisms of self-regulation" (Foucault, 2008:203) which for the state to increase its wealth must "function freely and naturally to optimum effect" (Burchell, 1996:22). So liberalism isn't 'really' anti-government but another form of government.

3.4.1.1. Government, expertise and knowledge

The liberal techniques of government, over the course of the eighteenth and nineteenth century, become tied to the positive knowledges of the human and social sciences (Rose, 1999, Rose and Miller, 2008). Gordon, on this point, argued that it was acknowledged that the “finitude of the state’s power to act” on domains such as the economy and population was a “consequence of the limitation of its power to know” (1991:16). In this context not only the economy but also “human existence” emerge as objects of political power (Burchell, 1991:136). The power of the expert was taken on by a range of individuals dispersed throughout the population such as police, medical experts and philanthropists. For Burchell, this meant the “subordination of some to others” (1991:136).

The law also becomes transformed into a regulatory mechanism in the government of the ‘natural’ process of population (Dean, 1999). In following Foucault (1978), Dean (1999) argues that the law has become invested with norms. The norm provides the group or population with a “common denominator” that does not require any reference to an external point (Dean, 1999:119). It is important to point out, as Dean does, that the norm is the population “so normalised” rather than there being such a thing as an “average man” (1999:119). Hacking (1991) has traced the idea of a norm or normal distribution to the nineteenth century’s enthusiasm for numbers. However, it is worth pointing out that the norm is both a ‘rule of judgement’ and a method for producing that rule (Rouse, 2003). Ultimately, the norm is tied into the practice of government and becomes increasingly important for expertise towards the end of the nineteenth century.

Foucault makes the point that such normalising processes become governed through a range of “apparatuses of security” (Foucault, 2007: 108). These are forms of intervention that operate to assure the security of those natural processes found in population (Dean, 1999, Foucault, 2007). These include techniques, theories, authority figures and the production of various truths that are concerned with the forms of subjectivity and guidance involved in the art of government (Dean, 1999, Foucault, 2008, Miller and Rose, 2008). Security, it is important to point out, is dependent upon the exercise of economic freedom and liberty by those individuals who are internal to society. Therefore, it has been argued that liberty itself is a condition of security and vice versa (Gordon, 1991). However, this is only insofar as the individual exercises

their freedom responsibly; thus in line with the needs of the economy and population (Dean, 1999). It is for this reason that Foucault claimed we are no longer living in a “disciplinary society”, but “a society of security” (Gordon, 1991:20).

3.4.1.2. The liberal subject: an ‘economic subject of interest’

The relation between individual subjectivity and political power becomes a central theme in liberalism (Burchell, 1991). Government by laissez-faire, as acknowledged above, depends upon the individual not only belonging to a population of subjects, but also as an individual with his or her own specific interests. For Burchell this particular individual “represents a new figure of social and political subjectivity, the prototype of economic man” (1991:127). It is this economic subject of interest that emerges as the object of the liberal art of government (Foucault, 2008). Economic man differs from the judicial subject in that this individual is motivated by choices which can be guided towards the public good (Burchell, 1991, Foucault, 2008). For this reason, with respect to government, Dean argues that the “capacities of free subjects are among the means of achieving its purposes and goals” (Dean, 1999:210). However, for classical liberalism, the “non-totalizable multiplicity” of the subject of interest, or the economic subject, and the “totalizing unity of the juridical sovereign” creates an irreducible problem for liberal forms of government (Gordon, 1991:22). This is a political problem of population.

3.4.2. Welfare liberalism; confronting the social

The notion of civil society emerged during the eighteenth century as a response to the “political problem of population” (Burchell, 1991:137, Gordon, 1991). For Dean, this provided a way in which to place a boundary around the problems of the “government of population within a territory” (Dean, 1999:124). Civil society provided an ensemble within which ‘economic man’ and all “forms of sociality” that are natural to man could be defined, analysed and made governable (Burchell, 1991:137). The function of statistics is important in this respect as it revealed society, like population, had its own statistical regularities that were not reducible to the choices and decisions of the economic subject (Dean, 1999, Gordon, 2003). *Civil Society*, therefore, must be understood as a technology for rendering the processes found in the economy and population governable.

The notion of a welfare state began to gather momentum during the second half of the nineteenth century (Donzelot, 1991, Rose and Miller, 1992). For Dean (1999), the notion of welfare was tied to the liberal problematic of social order and to the associated problem of the individualisation of modern society. These are problems also researched by Durkheim, such as suicide, social facts and even the discipline of sociology (Donzelot, 1991, Dean, 1999, Rose, 1999). The term social itself, Rose (1999) argues, implies anti-individualism and the need to conceive of the individual as part of a wider collective. This collective, however, is referred to as not only “a domain of cohesion and solidarity” but also of “breakdown and dissolution” (Dean, 1999:125). Gordon (1991), picking up on a similar point, argues that society is a fractured totality. This is a point that refers back to the liberal problematic of social order.

The idea of solidarity, according to Donzelot (1991), was fundamental for the emergence of welfare as an essential rationality for governing this fractured and multifaceted domain. The establishment of the welfare state, he argues, became possible when the idea of solidarity became distinguished from sovereignty. Furthermore, solidarity, as developed by Durkheim, encapsulated a “general law of social development”. It expressed a social bond, which, for Donzelot, would prevent revolutionary ideas from isolated individuals (1991:172). Ultimately, notions of welfare provided a solution by allowing the “principle of interdependence” as a point of reference for governmental activity (Donzelot, 1991:172).

During the course of the nineteenth century, according to Rose, the political objectives and interventions alluded to above began to change with the “invention of the social” (1999:112). For Rose, the invention of the social is also tied to a range of statistical investigations carried out by doctors, teachers, philanthropists and police into various activities within the urban space. The subjects of these investigations that were once part of the moral order were gradually regarded as social problems (Dean, 1999, Rose, 1999, Rose and Miller, 2008). Among the problems of this new social gaze were the conditions of the labouring poor, opium consumption and poisoning, social fragmentation, mortality and the uncertainties of employment, and child morality and the actions of working class women (Rose, 1999). The new social gaze also became directed towards the “dangerous classes” who were those individuals that could not exercise their liberty for the good of the public (Dean, 1999:129).

3.4.2.1. Government, expertise and knowledge

The emergence of the ‘social’ and arguments for its ‘defence’ was coupled by a whole new ‘social language’ and breed of social experts that encapsulated these problems within a power that claimed to know the truth (Burchell 1991, Dean 1999, Donzelot 1991, Rose 1999). These problems were related to the reality of social dangers and the impact on the well being of society (Miller and Rose, 2008). Social government, which haunted the nineteenth century (Gordon, 1991), functioned by;

“enforcing solidarity and preventing dissolution by the provision for the needs of the national population, ensuring the rights and liberties of socially responsible citizens and neutralizing the threat of social dangers” (Dean, 1999:153).

The exercise of power in the name of the social was legitimised as an essential mechanism for dealing with problems confronting liberalism (Rose and Miller, 1992, 2008). Gordon suggest that, in relation to civil society, we need to keep in mind the “history of this term’s instrumental value” (1991:35). For Rose, rather than thinking of this as the ‘welfare state’, it is helpful to think of this mode of government as governing from the ‘social point of view’ (Rose, 1999, Rose and Miller, 2008).

Rose and Miller argue that following the limitations of the power of the state through the acknowledgment of private domains within the ‘social’ a range of authority figures and agents begin to appear (Rose and Miller, 1992).

“What one sees is not a uniform trend of ‘state intervention’ but rather the emergence, at a multitude of sites in the social body, of health and disease, of crime and punishment, of poverty and pauperism, of madness and family life as problems requiring some measure of collective response” (Rose and Miller, 1991:181).

Indeed, the socio-political objectives found in liberal forms of government become linked up with the daily activities of individual and collective life through the notion of expertise.

Rose and Miller refer to this as a “double alliance” in which experts align themselves with political authorities by translating political problems, such as “social stability”, into

the language of the human and social sciences (1992:188). Furthermore, experts also begin to align themselves with “individuals themselves” by translating their own worries, concerns, fears and anxieties into a language “claiming the power of truth” (1992:188). The respect given to self-government or the exercise of individual liberty coincides with a range of authority figures (Dean, 1999, Foucault, 2008, Miller and Rose, 2008). It is through the power of truth that individuals learn to exercise their freedom responsibly and in accordance with the needs of society.

3.4.2.2. The liberal subject: social citizenship

Governing from the social point of view incorporates a conception of the relation between the citizen and political and expert power. Through social forms of government the individual is “integrated into society in the form of a citizen with social needs” (Miler and Rose, 2008:48). Subjects were transformed into social citizens – *a social citizenship* - with social rights. The idea of social citizenship ties the individual to society through notions of social responsibility and social obligation, which forms a two-way process (Rose, 1999). The emphasis on individual liberty and ideas of citizenship, Gordon argues, went hand in hand with various projects, or *programmes of government* (Rose and Miller, 2008), that sought to make liberalism operable by producing the conditions under which its mutual relations between citizen and society could function. However, for those who could not carry out their social obligations, they were considered anti-social and excluded from attaining social citizenship. The disciplines specify subjects in terms of norms of civilisation and effect a division between the civilised member of society and those lacking the capacity to exercise their citizenship responsibly.

The governmental techniques of social insurance and social work illustrate the totalising, responsibilising and individualising aspects of this new form of government. The technique of social insurance, which is a benefit of citizenship, incorporates a form of social solidarity “in collectivising the management of the individual and collective dangers” under the guidance and responsibility of the state (Rose and Miller, 2008). Social work, in addition, ensures security by imposing the obligations and duties of citizenship onto those more problematic members of society that were once excluded through moral technologies of government (Rose, 1999). If, for whatever reason, the individual was incapable of acting responsibly, government aimed to socialise the

‘deviant’ through expertise and techniques of normalisation (Foucault 1977, Miller and Rose 2008). It is important to point out that the normalisation of these ‘problematic citizens’ is undertaken by authority and expertise.

3.4.3. Neo-liberalism

In the 1960s and 1970s, the rationalities underpinning social forms of government became challenged in Europe and the United States by neo-liberalism (Burchell, 1996, Dean, 1999, Foucault, 2008, Gordon, 1991, Miller and Rose, 2008). Neo-liberalism introduces the economic as a principle for governmental activity (Gordon, 1991). The problem of governing from the ‘social point of view’ was not the anti-social effects of the market economy but the “anti-competitive effects” of society (Foucault, 2008, Gordon, 1991:42). As a result the social forms of government became criticised in terms of the financial burden they placed on the capitalist economy (Foucault, 2008, Gordon, 1991). This criticism has been termed the “economic argument” (Rose and Miller, 2008:210).

Closely associated with the economic argument is the criticism of too much government, which, it was argued, forged a culture of ‘welfare dependency’ that eroded individual freedom (Dean, 1999, Gordon, 1991, Miller and Rose, 2008). This critique was put forward by Friedrich von Hayek who warned that the interventionist state was self-defeating and put the nation on the path of a total state similar to that of Nazi Germany (Dean, 1999, Miller and Rose, 2008). Hayek’s attack on the welfare state was informed by his conception of individual freedom. He argued that the;

“principle of individual freedom was both the origin of our progress and the guarantor of future growth of civilisation” (Miller and Rose, 2008:209).

Ultimately, this transition to neo-liberal forms of government that are anchored in economic principles rather than social principles has produced mutations in the way in which we think about governing, the subjectivity of the individual and in the techniques to govern (Burchell, 1996, Dean, 1999, Rose and Miller, 2008). It is important to point out again that this does not lead to no government, but to a further transformation of government.

3.4.3.1. Community: reconfiguring the social

Miller and Rose suggest that advanced liberalism can be understood as the forming of “a new relationship between strategies for the government of others and techniques for the government of the self, situated within new relations of mutual obligation: the community” (2008:88). It is claimed by Miller and Rose that the deployment of the community, which develops new obligations that were originally found in society, is central to this shift in the exercise of governmental power. The community becomes a technical instrument of governmentality. It becomes a zone to be “investigated, mapped, classified, documented, interpreted” (Miller and Rose, 2008:89). The community is understood as an array of existing entities, or a number of existing communities, such as the drug using community, gay communities, and religious communities and so on. The conduct of the individual is tied to their community; they have a responsibility to their community (Miller and Rose, 2008). Miller and Rose describe this plurality of space, ethics, conducts and experiences as “a cosmopolitan moral universe” (2008:91).

The most common evidence used to highlight this criticism of social forms of government is a speech given by Margaret Thatcher in 1987;

“I think we’ve been through a period where too many people have been given to understand that if they have a problem, it’s the governments job to cope with it. ‘I have a problem. I’ll get a grant’. ‘I’m homeless, the government must house me’. They cast their problems on society. And you know what, there is no such thing as society. There are individual men and women, and there are families” (cited in Dean, 1999:151).

This shift in political discourse, according to Miller and Rose (2008), was paralleled by an identity crisis within sociology. The death of the social is not a reality for governmentality (Miller and Rose, 2008), “societal transformation is still at the heart of reflexive government” (Dean, 1999:196). Dean (1999) also cautions against taking too seriously the idea that society is dead. Rather it should be read, in line with the neo-liberal rationality, as a criticism of the link between the individual citizen and society.

3.4.3.2. Government, expertise and knowledge

This criticism of social government raises important questions concerning all forms of expertise that had forged strong links with welfare organisations through knowledge dependencies that underpinned the activity of rule. The “enclosures” that were built up by experts such as psychologists, social workers and psychiatrists since the nineteenth century, where “power and authority” became concentrated, become breached (Rose and Miller, 2008:69). The demand from these experts for funding in order to build empires, it was argued, only benefited the employment opportunities of the middle-classes rather than improving the conditions of the poor (Miller and Rose, 2008). Furthermore, the ‘client-mentality’ that they supported further enmeshed their subjects in cultures of dependency (Miller and Rose, 2008).

Rose and Miller (2008) argue that neo-liberalism forms a new relation between expertise and knowledge that has a formal character. These enclosures are penetrated by techniques that exercise critical scrutiny over authority; “budget disciplines, accountancy and audit” (Rose and Miller, 2008:212). Dean (1999) refers to this breach of expertise as the moment when government itself becomes subject to a ‘governmentalisation’. Dean has referred to this practice of government as technologies of performance which, underpinned by an economic logic, are;

“designed to penetrate the enclosures of expertise fostered under the welfare state and to subsume the substantive domains of expertise to new formal calculative regimes” (Dean, 1999:168-169).

These are deployed from above and aim to regulate the agencies in order to make the agency, the individual worker, and the space of operation, into calculable forms of government. The aims of these technologies, according to Dean, are to restore trust in the activities of professionals. However, through an emphasis on outcomes and monitoring such technologies promote an atmosphere of distrust.

3.4.3.3. The neo-liberal subject: *homo economicus*

As in social forms of government neo-liberalism incorporates a conception of the relation between the citizen and political and expert power. Neo-liberalism attempted to

overcome the governmental problems intrinsic to the welfare state by transforming the responsibilities into commodified forms that could be governed according to market principles (Dean, 1999). This means that individuals no longer exercised their freedom through mutual and social obligations where freedom was connected to society through a form of responsibility. Instead, through neo-liberal rationalities, freedom becomes tied to the market where individuals now become active agents seeking to maximise their own advantage. In other words, this “active entrepreneurship” replaces “passivity and dependency of responsible solidarity” (Miller and Rose, 2008:79).

The neo-liberal *homo economicus*, it is argued, is, to some extent, a return to the economic man of classical liberalism (Foucault, 2008). As Gordon points out, this reactivation of economic man emphasises the “fundamental human faculty of choice” (1991:43). The consequence of this new faculty is the displacement of the ‘social subject’ and / or ‘psychological subject’, which, according to Rose and Miller (2008), characterised twentieth century subjectivities. Market forces, therefore, begin to construct and shape the right kind of citizen. The terms ‘technologies of agency’ (Dean 1999) and ‘technologies of citizenship’ (Cruikshank, 1996) have been advanced as ways in which government aims to produce citizens who can exercise their citizenship responsibly. The ideal neo-liberal citizen-subject is one who can calculate the benefit and costs of acting in certain ways and provide security to themselves and their communities (Dean, 1999, Foucault, 2008).

3.4.3.4. New prudentialism and risk rationalities

The emergence of neo-liberal rationalities has, according to some (Dean, 1999, Gordon, 1991), coincided with an emphasis on risk thinking as a guiding principle for governmental activity. Dean, after O’Malley (2004), has referred to this as the *new prudentialism*, which is the “coupling of risk technologies with contemporary formulas of rule” (Dean, 1999:166). The new prudentialism is tied to the responsabilisation of individuals and communities for the management of their own risks, such as mental health, drug and alcohol abuse, becoming a victim of crime, and so on (Dean, 1999). The government of risk by the individual and their community is a way of being prudent.

The government of individuals and populations through risk thinking, according to Castel (1991), indicates a significant departure from nineteenth century concepts of risk

and dangerousness. Nineteenth century notions of risk, for Castel (1991), referred to the danger that was embodied in the dangerous individual. It was a qualitative judgement based upon what was seen and observed in the behaviour of the individual (Dean, 1999). Risk, in this context, would have been articulated in the question of “was he or she dangerous” (Castel, 1991:283). Risk, therefore, was represented an element of uncertainty and unpredictability. In contrast, contemporary formulations of risk have become a way of calculating certain possible events and representing those events in the form of reality (Dean, 1999). Risk is not a naturally occurring entity. In fact it only exists insofar as it is used to order reality and guide the conduct of the individual, community, society or population. It is for this reason that Ewald has argued, “there is no such thing as risk” (1991:199). Certain groups come to be defined, organised and regulated according to the level of risk they pose to themselves and their communities; drug related, mental and sexual health, health and illness, their child’s education or self esteem (Cruikshank, 1996, Dean, 1999). Risk, ultimately, is never eradicated, it is minimised and managed.

3.5. Criticisms and limitations

Despite the strengths of the governmentality approach, it has been criticised and there are arguments that it has limitations. The first challenge to the governmentality perspective is that it often fails to acknowledge the ‘real’ (Lippert and Stenson, 2010, McKee, 2009). This criticism is directed at the type of data that is used by governmentality theorists. By limiting the field of analysis to texts, often having a programmatic nature, it has been argued, governmentality neglects the daily experiences within which the act of government actually takes place (Lippert and Stenson, 2010). In other words, despite the many advantages of analysing and drawing attention to governmental rationalities, through which problems become thought about and governed, there is a question mark over the extent to which these governmental rationalities are embedded in the lives of those being governed. There is a disconnection between the knowledge produced and its reflection of the object of the study. This has prompted others to argue for a realist version of the governmentality perspective (McKee, 2009). For some, this is linked to the governmentality approach failing to understand the motives or the reasons behind why a particular configuration of government emerges (Gilling, 2010). Put simply, this is a neglect of the ‘why’ question.

On this point, I would argue that addressing the ‘why’ of governing is not what Foucault’s (1994e) distinct approach to analysing political power is intending to do. In fact, it is seeking to avoid this problem.

In addition, the governmentality perspective has been criticised for its use of the market as a master category (Kerr, 1999). In *‘Beheading the King and Enthroning the Market: A Critique of Foucauldian Governmentality’*, Kerr (1999) argues that by placing an emphasis on market rationalities it indirectly endorses them. In fact, the overuse of neo-liberal forms of governmentality as led others to argue that governmentality is guilty of homeostasis (Rose et al, 2006). In other words, in drawing on the governmentality framework, outlined above, historical events are approached as if they were formed by a single principle. The three historical frameworks, classical liberalism, welfarism and neo-liberalism, however, are used in governmentality studies as a heuristic device (Seddon, 2010), rather than as a fixed narrative. In defence of the governmentality position, Rose et al (2006) have rightly pointed out that these criticisms and limitations are often misdirected. They raise points about what governmentality never claimed to do in the first place. However, this is not to ignore the value of empirical investigations into the way rationalities of government are experienced in the lives of problem drug users in the present. In fact, a similar point has been made elsewhere by Garland (1997). However, my intention in this thesis is, after Seddon (2010), to draw out its genealogical foundations (Foucault, 2007, 2008, Rose et al, 2006, Rose and Miller, 2008), and draw on the framework of the perspective not as a fixed period of time, but as analytical framework for analysing local configurations of power.

3.6. Summary

The aim of this chapter has been to provide a critical overview of the governmentality perspective. As identified at the start of this chapter, governmentality, in Foucault’s (2007, 2008) own thinking, can be located within the wider debates on social power within social and political theory (Hindess, 1996, Weber, 1978, Westwood, 2002). The main theme was Foucault’s (1977, 1978, 2007) radical break from conceptions of power that were based on state domination. The narrative of the governmentalisation of the state provided a significant point of departure for the chapter. It provided a point from which to demonstrate not only the emergence of governmental power, but its important break with, and reconfiguration of, sovereignty. The concept of biopower was

introduced as a new positive form of power used in the management of populations. The three phases of liberalism, which was used to structure the historical narrative contained in the analysis chapters, was then introduced. In each phase of liberalism, important elements of the rationality and its links with expertise were identified and discussed. Finally, this chapter concluded by outlining the main criticisms and limitations of the governmentality perspective.

Chapter 4

Methodology: Foucauldian genealogy

4. Introduction

The methodological approach adopted in this doctoral research projects was informed by Foucauldian genealogy (Foucault 1994c, 2007, Dean, 1994). The aim of this chapter is to provide a critical discussion of the methodological approach used in this research. The chapter will begin by introducing the notion of discourse that informs the Foucauldian approach. It will then outline the main principles used by this researcher in analysing discourses. From here, the chapter will provide a critical discussion of Foucault's distinct approach to history, notably archaeology and genealogy, before introducing the analytical framework. This chapter will conclude with a reflexive account of using the genealogical method.

4.1. Background to the research

In taking on the limitations of the governmentality perspective (Lippert and Stenson, 2010, McKee, 2009), in particular the need to ground analyses in the daily experiences of drug users within treatment, during the planning and preparation stage I spent time visiting a drug treatment agency. My intention was gather and read literature on the practice of drug treatment and observe and talk to both staff and users of the service in order to get a better impression of the type of discourses that were in circulation within the agency. Through these observations and conversations I developed a number of research interests that were then refined into research questions by further discussions with those within the agency.

These discourses that are analysed in the next chapter are recovery capital, needle fixation and withdrawal. The questions that informed these initial genealogical investigations are: What constitutes the discourse recovery capital? How has it been mobilised as an instrument of power and with what effects? How has needle fixation formed within historical power-knowledge relations? What tensions exist between

needle fixation and the dominant ways of governing the injecting drug user within the present? How has withdrawal become what it is? How has it become situated within a discourse of fear? How have drug users come to recognise themselves as being ‘in-withdrawal’?

4.2. Discourse and data analysis

The first point to make about Foucauldian discourse analysis is that, apart from the *Archaeology of Knowledge* (Foucault, 2002) and a few scattered interviews on the topic of discourse, there are no explicit texts by Foucault on ‘doing’ his version of discourse analysis. In their insightful manual *Using Foucault’s Methods*, Kendall and Wickham caution against believing that there is such a thing as “a Foucaultian method” and that Foucault’s approach was characteristically “so ‘unmethodological’” (2002:viii). With reference to discourse analysis in general, Parker (1992) and Potter and Wetherell agree that “there is no analytical method” (1987:169). However, there are some helpful commentaries on Foucault (Veyne, 2010) and criteria (Jager and Maier, 2002, Kendall and Wickham, 1999, Parker, 1992) that were used in this research to support the analysis.

Nonetheless, before this is made explicit it is important to provide some words on the meaning of discourse itself. A good working definition, according to Parker, is to think of discourse as a “system of statements which constructs an object” (1992:5). Foucault himself defined discourse as “the general domain of all statements...an individualizable group of statements and...a regulated practice that accounts for a certain number of statements” (2002:90). The meaning of the statement, however, is often left undefined (Kendall and Wickham, 1999, Parker, 1992). Statements, for Foucault (2002), are not propositions or utterances. The statement is “not a grammatical entity...Maps can be statements if they are used as representations of a geographical area” (Dreyfus and Rabinow, 1982:45).

Statements, therefore, make reference to a common object, they define it, and they place a boundary around it and determine what can be said, or not said, about the object. This is the primitive function of the statement (Deleuze, 1999). Foucault, for example, in *Madness and Civilisation* described how an individualised group of statements on mental illness was formed which allowed for a new way of speaking about madness to

take over from a previous manner of speaking. The notion of discourse, in other words, constitutes the objects and provides limits to what can be said about a particular object at a particular time. The next important point to make about discourse, before moving onto unpick this notion some more, is that discourse shapes reality and provides meaning for individuals and groups (Jager and Maier, 2009).

4.3. Seven principles for doing discourse analysis

The actual criteria that was used to structure or guide the analysis of discourse of the historical material, was taken from Parker (1992). The criteria were developed both using Foucault's own work (1978, 2002) and helpful commentaries on his work (Jager and Maier, 2009, Kendall and Wickham, 1999).

4.3. 1. A discourse is realised in texts;

The first point relates to the process of data collection and what counts as a discourse. The object of the discourse analyst is the text which, it is important to say, has been collected or produced by the analyst.

4.3. 2. A discourse is about objects

In following the second point, it was essential to remember that discourse or its system of statements concern the reality of various objects. It was important, therefore, to ask myself when reading the text what objects are being referred to and described in the discourse (Parker, 1992). This point is in line with Foucault who argues that discourses are "practices that systemically form the objects of which they speak" (2002:54). In attempting to describe the objects of discourse it was important to study "those statements which had as their object a certain experience" (Dreyfus and Rabinow, 1982:61). In this respect, the statements that form a system – *a discourse* - as mentioned above, construct certain realities, domains and representations of the object in question.

4.3. 3. A discourse contains subjects

The modes of objectification within the human and social sciences are closely associated with the process of subjectification; the production of subjects. The formation of subjects is, for Foucault (1994), part of the power of discourse. In the

Subject and Power Foucault made the point that “my objective...has been to create a history of the different modes by which, in our culture, human beings are made subjects” (1994:326). This particular function of discourse resonates strongly with the governmentality perspective discussed in the previous chapter, in particular, the production of subjectivities (citizens) through political and scientific discourses.

This particular function is, in respect of the governmentality position, (Dean, 1999, Foucault, 2007, 2008, Rose and Miller, 2008), an essential part of analysing discourses or the discursive field. In considering the Foucauldian account of the subject, therefore, attention is given to the ways in which “power relations differentially position subjects in discourse” (Kendall and Wickham, 1999:54). The positioning of the subject or “discoursing subjects” formed an important element of Southgate’s (2003:180) analysis of the discursive field of methadone maintenance. For instance, “patient patients...recovering addicts...wily junkies” and the “subject position of the grateful user” (2003:182).

4.3. 4. A discourse is a coherent system of meanings

In advancing this fourth principle of discourse analysis Parker (1992) is drawing attention to the various elements of the discourse – metaphors, analogies, words, phrases – that allow a coherent picture to form. This coherent system of meanings draws on Foucault’s point that discourse is “a regulated practice that accounts for a certain number of statements” (2002:90). Jager and Maier (2009) use an interesting concept that opens up this last point. If each discourse provides the limits on what can be said about a particular topic, they argue, the “borders to what is not sayable are called discursive limits” (2009:47). The limits of a discourse, its discursive limits, resonate with Foucault’s (2002) archaeological method which will be discussed in the next section. It is important to acknowledge that there can be “different competing cultures” which have a different angle on the discourse (Parker, 1992:11). Parker is referring to the point that discourse can benefit certain groups in society, and marginalises others. However, it is important to acknowledge that discourse can be a “hindrance, a stumbling-block, a point of resistance and a starting point for an opposing strategy” (Foucault, 1978:101). It is therefore not a closed system of meanings but one that is open to criticism and change.

4.3. 5. A discourse refers to other discourses

In making this point, Parker is drawing attention to the fact that discourses can draw on metaphors, ways of speaking, objects and institutional support from other discourses (Parker 1992). The existence of a discourse and its systematic character, for Parker, presupposes other discourses. For Foucault, there is a “reflexive relation formulated in discourse itself” (Smart, 1984:41) which enables a space, a collateral space, for Deleuze (1999), within which statements can be produced; for instance, the links that have been formed between familial and risk discourses within the addictions field. This point can be nicely as well as usefully developed by Dean (1999) in relation to governmentality or ‘regimes of practices’. Dean (1999) makes the point that various (historically constructed) practices come together and form relationships with each other in order to carry out the task of treating, caring and punishing. At a conceptual level, this point about discourses referring to other discourses relates to the actual function of a discourse as a system of meanings within which links are formed at the level of the statement (Foucault, 2002).

4.3. 6. Discourses reproduce power relations

The relation between discourse and power is an important criterion to include in any Foucauldian discourse analysis. For Foucault (1994c), power is not conceived as a property or a possession of any particular individual or group. Rather, it is seen as a strategy that is deployed through tactics or, to use the language of governmentality, it is exercised through technologies of government (Dean, 1999). The analysis of power proceeds from the how question; how is power exercised and by what means and with what effects? The concept of power is bound up with forms of knowledge – which allow for its deployment; for practices of power (or government) produce forms of knowledge, which, as Foucault (1994c) has argued, reinforce power. Relations of power have a need for discourse, as power cannot be “established” without the “production” and “circulation” of a discourse (1980:93). In addition to making a link with the production of subjects through the power of discourse, it is also important to make a link with a point made above about challenging discourse or resisting its power. The task of the analyst, in this respect, is to describe the way in which resistance operates as a particular function of power (Kendall and Wickham 1999).

4.3.7. A discourse is historically located

The final point about ‘doing’ discourse analysis is that “discourse analysis can not take place without locating its object in time” (Parker, 1992:16). The task of situating the discourse within its historical context, affirms the position of “knowledge as perspective”; that what is known is “grounded in a time and a place” (Foucault, 1980, Smart, 1984:58). In making this final point, it is important to recognise that the discourses that were uncovered using the above criteria are not static entities that are unchangeable, but are instead ‘things’ have developed and changed over both short and long periods of time. The discourse, therefore, contains elements past struggles, which, it can be argued, might not make any sense in the present. Here the aim of historical analysis is to render the familiar unfamiliar (Foucault, 1978).

4.4. The Foucauldian methods

4.4.1. Foucault and history

Although there have been a number of historical studies in this area (Berridge, 1999, Foxcroft, 2007), as Seddon (2011) has recently pointed out, there are few in the historical sociology tradition. Furthermore, those within this latter tradition (Seddon, 2010) and even the Foucauldian tradition (Lart, 1998, Harding, 1986) fail to pick up on key themes and problems. These problems were identified in the literature review, in Chapter 2.

The historical method is central throughout Foucault’s work (1977, 1978, 2002, 2007, and 2008). Foucault’s thoughts on the use of history can be seen most clearly in *The Archaeology of Knowledge* (2002), which is a methodological reflection on his three previous histories. Foucault’s use of history, for Dean, suggests a “form of critical historical study” that moves away from conventional historical approaches (1994:13). Again, this opposition to traditional history is set out in the introduction to *The Archaeology of Knowledge* (Foucault, 2002). The traditional historian, for Foucault, turned their “attention to long periods” and assumed that underneath “political events” were constants and “irreversible processes” (2002:3). Furthermore, the historian held the view that underneath such continuities were “a single mind” or a “collective mentality” (2002:4). In using the term “total history” Foucault defined this particular

approach as seeking to establish a “network of causality” within which history itself may be “articulated into great units” - the spirit of an age - which contain “within them their own principles of cohesion” (2002:10-11).

Instead, Foucault put forward the notion of a “general history” that can, in short, avoid the totalising principle in favour of deploying the “space of dispersion” (2002:11). It is worth pointing out that in adopting this approach to history, Foucault is moving in a similar direction as Gaston Bachelard (1984) and George Canguilhem (1989). For Foucault, the “analyses of...Canguilhem may serve as models” (2002:5). These links with the Annales School have been identified elsewhere (Dean, 1994, Dreyfus and Rabinow, 1982, Flynn, 2003, Smart, 1984 to name a few), though Scheurich and McKenzie argue that there is a lack of “understanding of the philosophical context and influences” of Foucault’s work (2008:316). In other words, they suggest that the influences of the Annales School are seldom recognised. I would have to disagree with this point as links have been made elsewhere. However, the general point to make is that Foucault adopted a particular perspective of history and an analysis of historical data; archaeology and genealogy.

4.4.2. Archaeology: a ‘history of things said’

In *The Archaeology of Knowledge*, Michel Foucault (2002) went into great detail to describe the methodological approach that he undertook in his three previous books; *Madness and Civilisation*, *The Birth of the Clinic* and *The Order of Things*. Foucault’s use of history, it has been pointed out (Dean, 1994, Kendall and Wickham, 1999), was influenced by the Annales School; in particular their problematisation of the document (Dean, 1994). For Foucault, the document was “treated as a language of a voice since reduced to silence” (2002:7). Rather than seek the interpretation of the document, to determine its truth, the task is to “constitute series: to define the elements proper to each series, to fix its boundaries, to reveal its own specific type of relations” (2002:8). In other words, as Dean (1994) points out, archaeological research is against an interpretation of the unsaid, in favour of the “simple inscription of what is said” (Deleuze, 1999:15). Ultimately, this latter statement, for Deleuze, that “everything is always said” is Foucault’s “greatest historical principle” (1999:47).

The level at which archaeological research is conducted at the level of the statement. Dreyfus and Rabinow point out that Foucault (2002) identified the statement as a “previously unnoticed type of linguistic function” (1982:45). The actual definition of the statement has already been provided in the discourse analysis (4.1.4.) section above. The target of archaeology is “the description of the archive” (Foucault 1991: 59). The archive for Foucault is defined as a set of rules which “at a given period and for a given society” define the limits of what can be said or not said, by whom and with what effect (1991:60). For Smart, the archive is “literally” what may be spoken of in discourse (1984:48). That is, the “regulated practice that accounts for a certain number of statements” (Foucault, 2002:90). Discourse, or a system of statements, is also subject to transformation or mutation. For Flynn, the archive is modified by discursive practices; “any set of practices constitute the conditions of existence for other discursive practices” (2003:30). In *The Birth of the Clinic*, for example, Foucault describes how the body emerged as the subject of medical examination and the object of medical knowledge.

Indeed, an investigation into the conditions of existence is an essential objective of the archaeological method, as well as the genealogical method (Dean, 1994, Dreyfus and Rabinow, 1982, Foucault, 1980, 1991, 2002). Flynn notes that the “proper object” of the archaeological method is discursive and non-discursive practices (2003:31). The non-discursive practices important for Foucault were the prison, the hospital and the asylum. The notion of practice, for Flynn, refers to the point of “linkage” between “what one says and what one does...the rules one prescribes oneself and the reasons one ascribes” (2003:31). It is in this respect that Foucault refers to discourse not as language but as *practice* (Kendall and Wickham, 1999).

In addition, Deleuze (1999) makes the point that in Foucault’s thought what can be said is also informed by what can be seen. These links between the visible and the sayable can be found in Foucault’s (2007) work from the practices of confinement to the use of statistics in revealing the population. This link is also picked up by Kendall and Wickham who note that statements and visibilities “*mutually condition* each other” (1999:25). As a form of critique, ultimately, archaeology directs our attention to the actual practice of the discourses of the human and social sciences which produce norms, exclusions and truth claims (Flynn, 2003, Foucault, 1978, Kendall and Wickham, 1999).

We only have to look at the importance that Foucault (1978) gave to the practices within the prison that gave birth to the object of criminology. In Foucault's later studies, archaeological analysis became complimented by what is referred to as his genealogical period, which is concerned with power (Dean, 1994, Flynn, 2003).

4.4.3. Genealogy: a 'history of the present'

Foucault's (1994) genealogical period is marked by an essay entitled *Nietzsche, Genealogy, History*. Genealogical analysis is a term Foucault borrowed from Nietzsche (1996), in particular, from his work *On The Genealogy of Morals*. The object of Nietzsche's genealogy was the dominant system of morality – "equality, justice, and compassion" - that governed late nineteenth century Europe (1996:xv). The turn towards genealogy, however, was not a move away from archaeology. Genealogy, as Kendall and Wickham point out, maintains many of the essential ingredients of archaeology, "including, paradoxically, the examination of bodies of statements in the archive" (1999:29). Archaeology, however, is concerned with the past whereas genealogy is concerned with the present; a history of the present. Foucault (1977) makes this latter point in *Discipline and Punish* and became his favoured term for the combination of archaeological and genealogical analysis (Dean, 1994, Kendall and Wickham 1999).

In the essay on Nietzsche, Foucault (2000) continues the approach to history that he outlined in the introduction to *The Archaeology of Knowledge* (2002). In moving beyond this traditional notion of history, Foucault (2000) proposed two concepts or tools to support a genealogical analysis; *descent* and *emergence*. The analysis of descent reveals the multiplicity of events which exist behind historical beginnings. It "underscores the jolts and surprises of history, the chance occurrences, in order to maintain passing events in their proper dispersion" (Flynn, 2003:34-35). Identifying this "space of dispersion" resonates with the archaeological method in general and a 'general history' in particular (Foucault, 2002:11). In dispensing with the pursuit of the origin the genealogist aims to study "numberless beginnings" in order to discover how a "trait or a concept", against the backdrop of a countless number of events, "were formed" (Foucault, 2000:374).

In the tracing of descent, for Foucault, the “task is to expose a body totally imprinted by history” (2000:376). Here Foucault attempts to demonstrate that the most natural of all entities – the body – is not stable but “subject to the play of historical forces” (Smart, 1984:57). Therefore, the genealogist, like a doctor, must attempt to “diagnose the illness of the body” (Foucault, 2000:373). In doing so, genealogical analysis is concerned with the historical emergence which “seeks to reestablish the various systems of subjection...the hazardous play of dominations” (Foucault, 2000:376). The essential point to make is that no one person is responsible for an ‘emergence’, it is the product of the “play of domination” (Smart, 1984:57). In this respect, Foucault is drawing attention to the role of power in the “discursive delimitation of statements” (Dean, 1994:33).

The notion of power and knowledge is an important dimension to genealogy. Flynn makes the point that “power relations underwrite all Foucault’s genealogies” (2003:35). Relations of power have a need for discourse, for power cannot be “established” without the “production” and “circulation” of a discourse (1980b:93). Foucault ties the production of discourse and the exercise of power with truth; “We are subjected to the production of truth through power and we cannot exercise power except through the production of truth” (1980b:93). The relationship between power and truth is important for Foucault. Problems emerge on the historical stage when “we are forced to produce the truth our society demands” (1980:93). Foucault attempted to demonstrate how social practices enabled domains of knowledge to come into existence with their own forms of subjectivity and new potential areas for knowledge. However, this also marginalised other forms of knowledge, subjugated knowledges, which it is the task of the genealogist to uncover.

4.5. Collection of historical data

The historical data was collected, initially, by using key words such as ‘addiction’, ‘drug addict’, and ‘withdrawal’, ‘recovery’, to search relevant databases such as JSTOR, SocINDEX and Social Science Citation Index. JSTOR, in particular, covers journal articles dating back to the end of the nineteenth century and provided important in collecting psychiatric material on addiction from the early twentieth century. These articles were then analysed and searched for relevant references which could then be collected through the university’s interlibrary loan service, which uses the British

Library. The internet was another important resource and websites, such as Google Books, provided an important resource for much of the historical data from the seventeenth and eighteenth century. In addition, the collection of historical data also relied upon the references contained in Berridge (1999) and Musto (1973). These then allowed for further citation services.

4.6. Foucault's historical cartography: a guide for historical analysis

As mentioned in the previous section on doing Foucauldian discourse analysis, there is no clear method on doing archaeological and/or genealogical analysis. There are, however, some helpful tips, points and commentaries that can be raised from the existing literature, such as Deleuze (1999), Flynn (2003), Foucault (1994, 2000, 2002), and Kendall and Wickham (1999). For Flynn, the approach can be termed a “philosophical “style” a la Nietzsche” rather than a theory (2003:39). The “four overlapping fields” proposed by Flynn (2003) were developed using the methodological principles suggested by Deleuze (1999) and Kendall and Wickham (1999). These coordinates were used, alongside the principles of discourse analysis and genealogical analysis, identified above, to construct each of the genealogies in this thesis.

4.6.1. Historical nominalism

The first suggestion from both Flynn (2003) and Kendall and Wickham (1999) are that Foucault adopted a nominalist approach to history. This approach is based on a “profound distrust of essences, natures, and other kinds of unifying, totalizing and exclusionary thought that threatens individual freedom and creativity” (Flynn 2003:40). In other words, the concepts we use are not timeless, ahistorical ‘things’ but are constructs that emerge onto the historical stage at specific points in time. Kendall and Wickham refer to them as “accidents of history” (1999:5). In revealing such accidents, for Kendall and Wickham (1999), we need to suspend judgment. That is, not give such concepts an ahistorical existence. In doing so, we take the position that there are “no constants to provide a stable foundation for understanding” (Smart, 1984:59). It is worth pointing out that Foucault's nominalism is not total as the body, power and discourse are all universals.

4.6.2. The Event

The concept of the event, for Flynn (2003), is at the centre of Foucault's analysis of history. The use of the concept of event is to avoid using historical concepts such as influence and continuity. The concept of the event is comparable with the concept of emergence identified above. In particular, the event supports the argument that there is no "necessity at work in history" (Smart 1984:58). Rather, what lies behind every event / emergence is a complex range of factors; chance, therefore, becomes a central principle of history. In revealing the multifaceted character of the event, the genealogist can reveal the heterogeneity of elements involved in an emergence. The idea of using the event is, like the nominalist principle outlined above, to reveal that there are no constants at work and that things were not self-evident.

4.6.3. The spatialisation of reason

In using the phrase 'the spatialisation of reason', Flynn (2003) draws attention to Foucault's spatialised thinking. His most well known example is the use of the panopticon in *Discipline and Punish* (1977) to relate power and knowledge. Further uses of space, or practices of visibility, can also be found in *Madness in Civilisation* (2001). The practice of confinement opens up a field of visibility in which the mad person can be observed, described, analysed and given a discursive form. It is for this reason that Deleuze suggests if we ignore the visible we "distort Foucault's conception of history...and his conception of thought in general" (1999:43). In terms of governmentality, Dean argues that forms of visibility are necessary to the operation of regimes of government. Forms of visibility allows for government to picture "who and what is to be governed" and how "relations of authority" and different "locales and agents" are to be connected with each other (1999:30). The mapping technique identified in the ethnographic phase of this research became an invaluable tool in not only opening up the data in new ways, but also in seeing the heterogeneity of elements involved in emergence.

4.6.4. Problematisation

The notion of problematisation has not only been associated with Foucault (2007, 2008, Flynn, 2003, Kendall and Wickham, 1999), but also with recent developments in post-

Foucauldian governmentality (Dean, 1999, Rose, 1999, Rose and Miller, 2008). The link can be made with what Rose and Miller refer to as the “recurrent diagnosis of failure” within liberal government (2008:206). Rose and Miller (2008) suggest that to govern is to say that the conduct of a person or a community is in need of directing because an aspect of that conduct appears problematic to someone (Rose and Miller, 2008). For Dean, “Problematizations are made on the basis of particular regimes of practices of government, with particular techniques, language, grids of analysis and evaluation, forms of knowledge and expertise” (1999:28). The link with the event or emergence is also important as problems are not “pre-given and lying there waiting to be revealed...they have to be constructed and made visible” (Rose and Miller, 2008:14). Dean makes the suggestion that an analysis begins with the “specific conditions in which the activity of governing comes to be called into question” (Dean, 1999:27). In this respect, the notion of problematisation can act as the starting point for an analytics of government.

4.7. Reflecting on the genealogical research process

Paying attention to “how one thinks about thinking” – the practice of being reflexive - has become a significant component of social science research (Alvesson and Skoldberg, 2010:8, Clarke, 2007, Denzin and Lincoln, 2008). The concept of reflexivity emerged within qualitative research as a response to the ‘crisis of representation’ within the social sciences (Denzin and Lincoln, 2008). This crisis referred to the uncertainty of some researchers within the social sciences about being able to describe the social world. The practice of being reflexive, from this perspective, challenges the assumption that the research process or the knowledge produced through this process can actually “capture lived experience” (Adkins, 2002:333). Furthermore, it was accompanied by a struggle by researchers to find themselves and their subjects in reflexive texts (Clarke, 2007, Denzin and Lincoln, 2008). This, in many ways, forces the researcher to be aware of the social, cultural and political context within which their research is situated (Alvesson and Skoldberg, 2010). This also picks up on the point that researchers are the people that ask the questions that produce knowledge. In this respect, this concern has Foucauldian (1977, 1978, 1994e) undertones about the way knowledge (by whom, what type, and how it is used) is produced and circulated within our society.

In their influential book *Reflexive Methodologies*, Alvesson and Skoldberg (2010) have advanced two characteristics to reflexive research. The first is the rejection that the text produced during the research process mirrors the reality that was studied. All references or accounts of the data, in this respect, are the result of the researcher's interpretation. Law and Urry (2004) and Law (2007, 2009) have expressed similar concerns regarding the claim that reality exists independently of the researcher. They argue that research methods produce reality and are therefore in the "business of 'ontological politics'" (Law and Urry, 2004:391). Reflection, they argue (Law and Urry, 2004), in a similar manner as Alvesson and Skoldberg (2010), should be a common practice within social science research. The second characteristic refers to the practice of turning the focus of the researcher back on her/himself in an attempt further reveal to the reader (and themselves) the complex process of knowledge development. This approach to knowledge production stimulates critical reflection (Alvesson and Skoldberg, 2010). The refocusing of the gaze of the researcher onto the research process has also been taken up by Law and Urry, (2004) and Law (2007, 2009). Their work on method has presented a number of important challenges to the philosophical make-up of *method* itself. At the heart of their argument is that our methods are based on the idea, born in the nineteenth century, that the world is out there (Law and Urry, 2004).

In the course of doing method we are performing a kind of intellectual hygiene that makes method look clean and tidy. In contrast, they argue that the world is messy and the approach to method dominant in the social sciences is to repress this mess. "Do your methods properly. Eat your epistemological greens. Wash your hands after mixing with the real world. Then you will lead the good research life" (Law, 2007:595). They propose an alternative, "complex and performative sense of social inquiry" (Law and Urry, 2004:403). For Alvesson and Skoldberg, the 'doing of research' is part of a "naive and unconscious undertaking" (2010:9). They argue that it is virtually impossible for a researcher to identify all of the underlying assumptions and blind spots within their own culture. This is not to say that reflexivity is a fruitless exercise, but only highlights the fact that there is 'stuff' going on in the performance that we might not be aware of.

The level of reflection I have concerned myself with in this chapter is that of the research process itself. In this account my aim is to provide a couple of illustrations of my experience of working with the genealogical method. In doing so, my intention is not to provide a typical narrative, which has a beginning, middle and end, but just a few

examples. To put my own difficulties, challenges, frustrations and achievements of working genealogically into words within a short section of a chapter within an ordered doctoral thesis would be unrealistic. I would also see this as approaching the type of methodological cleanliness criticised by Law (2007). The genealogical approach, I would argue, lends itself to this way of thinking as it attempts to present a history without any coherent order. It is also satisfied to remain with an incomplete picture in an attempt to dislodge the progressive and orderly narrative.

I would describe my overall research journey as a collection of periods of frustration, a sense of doing it wrong and not making any progress and, importantly, a sense of achievement. I began this journey knowing that I had to first find out exactly what it meant to work genealogically. I discovered that books and papers on Foucault (Dean, 1994, 1999, Flynn, 2003, Foucault, 1972, 1980, 1994c, 1994, Kendall and Wickham, 1999, Rose and Miller, 2008, Scheurich and McKenzie, 2008) are helpful at telling you what he had to say about power and knowledge, truth, discourse and the subject, and even archaeology and genealogy. However, I had to find my own way. I did this by developing a set of guiding principles and practices. These principles included keeping both an open and active mind and allowing each of the genealogies to find their own rhythm and guide the direction of the research (Tamboukou and Ball, 2003). This task also involved visiting the books (*Archaeology of Knowledge* (1972) and the *Order of Things* (1989) in particular), interviews and essays that do not feature in your typical lecture on Foucault or form part of any research methods courses.

In his essay on *Nietzsche, Genealogy, History* Foucault (1994c) advocated, in doing genealogy, that a vast accumulation of material is needed. This, I would argue, also provides a useful measure for evaluating a genealogical project. The collection of material not only takes time to collect, but, as I found out, is also determined by what is available. I mostly spent the majority of my time searching and collecting documents from the present day all the way back to the fifteenth century. For instance, after reviewing part of literature (Berridge, 1999, Seddon, 2010) the involvement of pharmacy in the regulation of opium stood out. I spent months collecting and reading various types of documents, often feeling like I had wasted time and used up precious interlibrary loans collecting material that I might not need. I came to the conclusion that these intense periods accumulating source material is the part of the task of being a genealogist. Another important realisation was the need to be mindful of the dominant

narratives (paradigms might be another useful description). What I mean by this is that there is a tendency to work within parameters set out by certain researchers (Berridge, 1999). Berridge (1999), for instance, has had an enormous influence on the way researchers think about addiction in the nineteenth century. I found it helpful, in this respect, to practice my historical nominalism (Flynn, 2003, Foucault, 2007).

In one of my first genealogies, needle fixation, this task was, at first, not overly complicated. This was because key ‘source materials’ within the present had been authored by the same people (see Pates and McBride, 2001). The starting point – not long after the invention of the syringe - had also been mapped out previously (Berridge, 1999). In telling the story from this point of emergence to present my approach was to move back and forth between documents in order to make comparisons, exploring potential issues, significant changes and lines of development. I found making maps, which listed some of the contingencies and writing my thoughts in memos particularly helpful. In addition, I found it effective to ask questions of the data to generate possible leads. How were those individuals using the syringe referred to? How did it become possible to use this term? What was the problem? Was there competing opinions on this? How did this new category of person and subsequent responses fit within broader strategies? These proved to be an effective way of investigating the contingencies, complexities associated with their historical development. For instance, in the present I found two contradictory discourses articulating the injecting drug user; needle fixation and risk management. These discourses exist in tension with each other. At different points in the narrative, these discourses interact and switch their political importance. Needle fixation has recently been displaced by risk management.

The doing and writing of the genealogy of withdrawal also proved to be, at times, rather challenging and mysterious. The aim of descent is to follow the line from the present and back to its emergence. In tracing its descent, and trying to preserve its history, I became interested in a particular ‘event’. In this event, withdrawal, which is a taken-for-granted experience, disappeared. It was relegated from being a priority, even a matter of life or death, to being refuted. This raised the problem of explaining how this had happened. What in the ‘bigger picture’ can I find that had caused withdrawal to disappear? Who in their ‘right mind’ could deny the existence of withdrawal? This was *irrational*. I consider this an important lesson. My first explanation was that it obviously existed, because in the present it is an undeniable, universal human experience. I cannot

recall how many times I used the present as a point of reference for thinking about past events. What minds think and what appears rational or irrational is determined by the order of things. In other words, within this historical moment it was rational and scientific to dispute the truth of withdrawal. It was rational because the procedures for producing the truth had changed. Withdrawal was pushed through the eye of a psychiatric discourse and never came out the other side.

Working genealogically, as I found out, is also about working within the boundaries dictated by resources and factors beyond my control. I am thinking about my reliance on source materials, which are central to writing a genealogy. In fact, the range and amount of material (and the researcher), I would argue, are fundamental to what a genealogy will look like. For instance, my thinking about the emergence of withdrawal was dependent upon locating and then waiting for historical documents to turn up through the post. At the time of writing my genealogy of withdrawal I can remember the British Library was carrying out some type of work – maybe refurbishments if I remember correctly – and there was a backlog of requests to work through. I did not notice it at first, but soon realised that as new information came to light, or through the post, I had to rethink and move the ‘emergence’ back several times.

My initial emergence was in the middle of the nineteenth century. This was when two ‘experts’ both offered alternative perspectives on how to best to treat the problem of habitual opiate use. This fitted the narrative I was trying to avoid a bit too well. However, with the arrival of my new interlibrary loan materials, I had to rethink my emergence, which I located over a hundred years before. Besides rethinking my emergence of withdrawal, this also led me to question my use of genealogy and what type of history needs to be written in order to perform a genealogical critique. Is there a requirement to locate an emergence as far back as possible? What does this add or remove? I think this is a matter of preference, or perhaps the one of the differences between the genealogy performed by Nietzsche (1996) on the history of morality and that adopted by Foucault (1994b).

4.8. Summary

This aim of this chapter has been to provide an outline of the methodological approach that was used in the process of this research. The chapter began by introducing the topic of discourse analysis. From here the chapter then went onto to introduce and describe

the seven principles of doing discourse analysis that were used to support the analysis of the historical material. These principles, as I have explained above, were integrated into the Foucauldian framework. This chapter then went onto to provide an overview of the Foucauldian approach to writing histories and how it differs from traditional approaches to history. In particular, this involved a critical discussion of his archaeological and genealogical perspectives. These methodological perspectives are important to the distinctively Foucauldian approach. This was accompanied by a set of principles used as a guide for the historical analysis. Finally, this chapter concluded with a reflexive account of the research process. My intention was to provide a personal account of my experience of doing genealogical research.

Chapter 5

Genealogy of concepts: Natural recovery and recovery capital; needle fixation; and withdrawal

5. Introduction

The purpose of this chapter is to investigate, from the genealogical perspective, the discourses of recovery capital, needle fixation and withdrawal. The following questions were developed to guide the genealogical investigations. What constitutes the discourse concerning '*recovery capital*'? How has it been mobilised as an instrument of power and with what effects? How has '*needle fixation*' formed within historical power-knowledge relations? What tensions exist between needle fixation and the dominant ways of governing the injecting drug user within the present? How has '*withdrawal*' become what it is? How has it become situated within a discourse of fear? How have drug users come to recognise themselves as being 'in-withdrawal'?

The first genealogy is the discourse of recovery capital. This genealogy makes an important link with the various historically constituted phases of natural recovery. It begins in the early twentieth century with the incurable figure and demonstrates the numerous attempts by experts to problematise and discipline this subject. The genealogy demonstrates how knowledge of natural recovery has recently been introduced as an effective way of governing the drug treatment population through a neo-liberal dividing practice.

The second genealogy investigates the historical relation between the individual, the syringe and truth. It begins in the nineteenth century with the medicalisation of the syringe and then traces its relation to power-knowledge from early psychiatric and subcultural practices to the present day and its encounter with notions of risk management. The third genealogy tackles the historical constitution of withdrawal as a human experience. In a similar fashion as the other two genealogies, it traces its development pointing to discontinuities and ultimately the constitutive function of power-knowledge. The key theme is the formation of withdrawal as a dangerous experience.

5.1. Recovery capital; power, the subject and natural recovery

5.1.1. The incurable self: the drug addict

At the beginning of the twentieth century drug addiction was understood as a social problem and a “dangerous menace to human civilisation” (Hickman, 2002, Weber, 1918a:129). It was a problem that was initially associated with the “changing modern environment” and related to problems of the nervous system (Beard, 1869, Hickman, 2002:1281). Psychopathology, at this time, conceptualised mental pathology “in terms of a relation between an inherited constitution and the stresses to which it was subject in the life of the individual” (Gordon, 1986, Rose, 1986:46). As such the brain, it was thought, could be damaged by over exhaustion, worry, drink and drugs and a lack of proper nutrition. Because of the threat to the political and social order, drug addicts became the object of psychiatric discourse and produced as incurable subjects (Ball and Snarr, 1969, Kolb, 1927). The aim, in line with social forms of government (Rose and Miller, 2008), through the use of Public Health Service Hospitals, was to bring “about an adjustment of the addict...to end his continued menace to the city, and make him a self-supporting, productive citizen” (Kolb, 1927, Lambert et al, 1930:448). It was claimed by a psychiatrist that the “drug addict” became the “step-child of the neurologist and psychiatrist” (Somerville, 1924:108).

On the one hand, this was linked to the “anticlinic campaigns” of the 1930s in America, in which physicians were criticised for making large profits from selling prescription drugs and spreading addiction (Musto, 1973:182). This particular accusation and response can be found in Britain in the 1960s when physicians were criticised for increasing the size of the drug addict population because of their over-zealous prescribing practices (Glanz, 1994, MacGregor, 1989, Strang, 1989). On the other hand, this encounter with psychiatric power dates back to the last decades of the nineteenth century when the drug addict, or *morphinist* as they were called, was institutionalised whilst opium or morphine was removed from their body; or as one psychiatrist referred to it, “unpoisoned from his narcotic” (Lambert et al, 1930: 463). As Gordon has argued, “psychiatry has...been entrusted by society” - that is Western liberal societies - to function as a “political technology” for regulating various problematic groups deemed unable to be integrated into the social order (Gordon, 1986:277).

The involvement of psychiatry in addiction treatment contributed to an alternative ‘representation’ of the drug addict as an incurable figure. The incurable figure was not isolated to the problem of addiction. Foucault (2003) makes reference to the incurable figure as a subject within psychiatric discourse in general. This subject was not ‘thought up’ in the mind of the psychiatrist, but was produced through the techniques for judging, examining, dividing the individual within the asylum; such as, personality reaction techniques (Rose, 1989). The aim of using these techniques was to “separate the addicts into two classes, the curable and the incurable” (Lambert et al, 1930: 462) or the “non-psychopathic” from the “psychopathic” (Lambert et al, 1930:464). Lambert et al (1930) believed psychopathy among this population to be 87% and Kolb (1927) as high as ninety percent. Ultimately, the problem of addiction was located in the personality (Kolb, 1927 and Lambert et al, 1930) and governed through the personality (Rose, 1989).

In the *Subject and Power*, Foucault makes an important point about the modes of objectification by which human beings are turned into subjects. In relation to the argument being developed here is what Foucault called dividing practices. “The subject is either divided inside himself or divided from others. This process objectivizes him” (1994e:326). The practice of dividing the drug addict into the categories of normal and abnormal through psychiatric techniques allowed experts like Lambert et al (1930), Kolb (1927) and Schultz (1930) to argue that abnormal drug addicts become drug addicts because of an underlying condition which separated them from normal addicts. In this respect, drug addicts are in fact abnormal individuals or as Lipton puts forward, a “certain number of psychopaths, in order to escape difficult situations, resort to alcohol...morphine and other narcotic drugs” (Lipton 1950:585). Schultz argued that psychopathic addicts “give very poor hopes for rehabilitation, as no drug treatment can change a fundamental personality defect” (1930:481).

‘Normal drug addicts’, in contrast, were not a serious problem to treat because most “seek to rid themselves of it” and are often deterred from continuing, or taking up the habit again, by the “physical suffering connected with withdrawal” (Lambert et al, 1930:460). Furthermore, it was claimed that there were a large number of cured addicts in the United States. These ‘normal’ addicts, who only suffered from a physical dependency on the drug – *or whose bodies were poisoned* – were, for the most part, of middle class origin (Kolb, 1927). Lambert et al argued that the normal group “can easily

be reconstructed if separated from the abnormal” because in both normal and abnormal drug addicts the “herd instinct is powerfully developed” (1930:461). For some this classification system was based on social class (Lindesmith, 1940, Amsel et al, 1971). Psychiatry arguably targeted sections of the population which can not be assimilated into the bourgeois social order (Gordon, 1986). In summary, objectifying the drug addict through the discourse of psychopathy and technology of the personality – *as a failed citizen* – constructed the drug addict’s ‘self’ as incurable and the true object of psychiatric power.

5.1.2 Locating the incurable self in contemporary discourse

Before moving on to discuss the next ‘representation’ which allowed the drug addict to break free, only after a certain period of time, from the incurable self, it is important to point out the continuity of this discourse within movements such as Alcoholics Anonymous (1963), Synanon (Yablonsky, 1965), Narcotics Anonymous (1982) and Cocaine Anonymous. For instance, in Narcotics Anonymous the discourse regulating its members is based on “an incurable disease called addiction” (1982:7). Members are directed towards transforming their incurable ‘selves’ into “acceptable, responsible, and productive members of...society” (1982: 19). The statements of incurable disease and the production of social subjects were identified above in psychiatric practices. The techniques of government found in Narcotics Anonymous and Synanon have been applied to other problematic behaviours (I am thinking of the emergence of other Twelve Step groups) and even “people who were never addicts, criminals, or had any history of serious character disorder in their lives” (Yablonsky, 1965: v). Most importantly, the incurable self still underpins the practices within anonymous groups and drug rehabilitation centres which reproduce this ‘incurable figure’ for the purpose of linking self care to self-responsibility.

5.1.3. The maturing out subject; first problematisation

The first problematisation of the incurable self became possible due to the formation of “Narcotic Registers” that recorded attendance at ‘psychiatric and correctional institutions’ (Amsel et al, 1971:225, Winick, 1962, 1964). The Narcotic Registers provided an alternative way of seeing and knowing the drug addict *population* in North America. In particular, it highlighted the population’s regularities and changing patterns. This knowledge was, however, underpinned by the assumption that all drug addicts will

at some point come to the attention of the authorities. For this reason, it was claimed, they represented “as complete a picture of the addict population as it is possible to obtain at this point” (Winick, 1962:2) because “it is practically impossible for an addict who has reverted to drug use to avoid coming to the attention of the authorities” (1962:3). These systems of surveillance were operating beyond the United States. British addiction experts operated the Home Office Addict Index to measure and make truth claims about the individual drug addict and population in Britain (Bewley et al, 1968). As Lart (1998) has demonstrated, this contributed towards a social contagion model of addiction. It is also worth reiterating the point that the productive power of the Narcotics Register has not been acknowledged elsewhere.

The objectification of the drug addict population through Narcotic Registers was technically enhanced through dividing individuals into active and inactive files; and *active and inactive subjects*. This was based on whether they had come to the attention of the authorities for a five year period (Winick, 1962). The rationality underpinning this practice was based on a medical model of disease and recovery. As Winick points out that the “five-year period” was “well established in medicine as the period after which a person with a chronic disease may be assumed to have recovered from the disease”, therefore, “transferring names to the inactive file is both realistic and medically sound” (Winick, 1962:3). Of most interest were the “inactive addicts” (Maddux and Desmond, 1980:15) because, according to this medical truth, they were no longer committing crime or visiting psychiatric institutions because all drug addicts commit crime. The inactive addicts formed the object of analysis for a number of studies on addiction and recovery (Amsel et al, 1971, Anglin et al, 1986, Ball and Snarr, 1969, Harrington, 1979, Maddux and Desmond, 1980, Snow, 1973, Winick, 1962, 1964).

The variables used in the construction of the registers – *and therefore their representations* - arguably placed a limit on the part of the drug addict population that became visible and known. The dominant variables used for analysis at this time were the age and duration of addiction. Basing the analysis of the drug addict population on these variables revealed that recovery from addiction was based on “larger regularities and generalisations of nature” (Winick, 1964: 8). This point resonates with the operation of biopower through its relation with the norm (Foucault, 2007, Rose, 2007). Organising the population according to these variables constructed a normal or “an

average or modal addict” based on the fact that “many addicts cease taking narcotics in their thirties” (1962: 8) when “the stresses of adolescence became less insistent and the drug user felt less threatened by the need to respond to such stresses” (1964:2). Another researcher working at the same time (Drew, 1968), without citing the work of Winick (1962, 1964), came to the same conclusion for the alcoholic.

This particular representation of the addict and alcoholic population (Drew, 1968, Winick, 1962, 1964) outside of institutions became represented in ‘thought’ through the discourse of ‘maturing out’ which was in circulation at this time. The normalising judgement was based on the truth that “adult development parallels physiological development and is completed by the 30’s” (Waldorf, 1983:271, Winick, 1962, 1964). Similar statements made possible the argument that maturation was an important “contributor to de-recidivism” and this had been “confirmed by several different studies” (Winick, 1964:3). Furthermore, “students of psychopaths have noted that psychopaths seem to “disappear” by their early thirties” and juvenile delinquents are ““going straight” when they reach the age of about 30” (1964:3). *In summary, the first problematisation of the incurable figure became possible because of the formation of techniques used to represent the conduct of the ‘population of drug addicts’ outside of the psychiatric institution and through the re-production of the maturing out subject in explaining this anomaly in the incurable figure.*

5.1.4. The social subject; second problematisation of the incurable figure

The emergence of the maturing out subject failed to make any significant impact though it did provide the basis for a further criticism. One of the events that helped elevate the problem of addiction, and the concept itself, to a political level (the other two are youth drug use and high crime rates) was the return of a large number of opiate addicted American soldiers from Vietnam (Robins, 1973). Robert DuPont, the Director of the Special Action Office for Drug Abuse Prevention, which was created by President Nixon, commissioned research into this phenomenon as it was feared that a high level of opiate use existed among soldiers who would contribute, on return, to yet another problematic group in American society (Robins, 1973). The research revealed that various patterns and successful attempts at reducing and coming off drugs existed within this population that was inconsistent with the (incurable) addiction concept (Robins, 1973). It is worth pointing out that the truth of this only became possible after

they introduced urine testing into the army. This opened the body to new forms of medical examination and truths.

These inconsistencies with the addiction concept have led to questions like '*how long does it take to become physically dependant?*' (Coomber and Sutton, 2006); *or can physical dependency be maintained given the varying levels of purity and the sporadic ways in which the drug is used?* (Blackwell, 1983). These questions have, on the whole, been unanswered and silenced by drug treatment discourse. It can be argued that such questions are historically contingent. Chapter 7 will attempt to give substance to this argument. With reference to the addicted soldiers, it was acknowledged that many continued their civilian life as non-addicted individuals without any need for expert intervention (Robins, 1973). These individuals were conceptualised as situational addicts (Waldorf, 1983) because they were governed not by underlying psychiatric (Kolb, 1927) or biological processes (Winick, 1962, 1964), but rather by the social context itself (Robins, 1973, Waldorf, 1983). This acknowledgement of a possible recovery without treatment failed to make any impact on treatment practices other than opening up a 'space' within which arguments could be made for a natural recovery (Biernacki, 1986, Waldorf, 1983).

The maturing out subject was excluded from debates on natural recovery because the 'style of thought' associated with *maturing out* was perceived to be an outdated biological model of the life cycle (Waldorf, 1983, Winick, 1962, 1964). The life cycle model that legitimated the 'truth claim', and made this subject thinkable, became replaced by a developmental model containing several distinct phases of psycho-social development and various points of maturation, which arguably excluded the truth of Winick's claim (1962, 1964). This does not mean the disappearance of the maturing out subject. Waldorf (1983) reported that a third of his sample of two hundred and one research participants used this discourse to articulate their experience of giving up their addictions. It is important to point out that these models of maturation developed into social, as opposed to simply a biological model. The discourse is still in circulation and provides a way in which to relate to the self, it has just been excluded from the debates on natural recovery because it is tied to a less dominant (biological) model of human development.

5.1.5. Natural recovery: hidden populations and the middle class

The space opened up by Robins (1973) on the problematic nature of addiction was investigated by Biernacki (1986). Biernacki, in his research into middle class cannabis users, observed that a number of them had been heroin and morphine users who had stopped without expert intervention. Investigating natural recovery highlighted a fundamental limit to observation and knowledge production outside of psychiatric, medical and legal institutions. It is therefore important to briefly articulate how this limitation, which is effectively a limitation of political and expert power, has been overcome by governmental power. This was identified in the ethnographic phase as a form of resistance to power. It can be argued that this problem is inseparable from the problem of ‘seeing’ and ‘knowing’ hidden populations which escape the gaze of the modern expert. *What are hidden populations?* Hidden populations, according to Watters and Biernacki, are groups “concealed from the view of mainstream society and agencies of social control” (1989:417). The technology used for overcoming this problem of visibility has been the technique of snowball sampling (Biernacki and Waldorf, 1981, Cloud and Granfield, 2008, Cloud and Granfield, 1994, Granfield and Cloud, 1996, Granfield and Cloud, 2001, Waldorf, 1983, Watters and Biernacki, 1989).

Snowball sampling or chain referral, according to Biernacki and Waldorf, is a “self-contained and self-propelled phenomenon, in that once it is started it somehow magically proceeds on its own” (1981: 143). Snowball sampling puts into operation a network of power relations that attempts to create a network of relations between subjects by transforming individuals into ‘objects of knowledge’ and ‘instruments of power’. The deployment of the technology of snowball sampling – *which implicates social research in power-knowledge* – which requires individuals to become assistants in your research, has enabled researchers to integrate individuals into the machinery of knowledge production, which then penetrates, through a chain of relations, into the heart of hidden populations. *Without technologies for seeing hidden populations, it is difficult to see how natural recovery as a truth claim could be made.*

Sociologists and social psychologists (Biernacki and Waldorf, 1981) involved in natural recovery research have made use of the discourse of ‘career’ as a technique for mapping out and representing the conduct of the drug addict; ultimately producing the ‘career addict’. Links can also be made with the idea that problem drug users have a treatment

career or a *treatment journey*, as it has been framed. Researchers working in the tradition of the Chicago School used the concept of career to re-represent the drug addict from a passive, pathological, and out of control subject - *the incurable figure of psychiatric discourse or the biological subject of 'maturation'* - to an economic-rational actor. This point was articulated by Waldorf in his claim that “Contrary to popular belief, addicts are not inactive” like dominant representations found in media and psychiatric discourse, “he is active in pursuit of a demanding life that requires considerable skill and ability to sustain” (1973: 10). This transformation in the subject of analysis from a psychologically deficient person to “a person just like any other”, Foucault has argued, forms part of the application of market concepts to the analysis of social problems (Lemke, 2001: 199). For example, the conduct of the drug addict is represented in terms of a process of acquiring capital like the right “knowledge and skills” which are needed to “learn how to use the drug efficiently, how to buy and sell, how best to administer it” (Waldorf, 1973:9).

The utilisation of ‘career’ in addiction studies has provided the framework for analysing and representing the incurable figure as an economic-rational citizen. Although it is acknowledged that addiction is, in part, pathological from this perspective the individual is always a rational being. They have the ability to transform their own social world from a drug-subculture into one aligned with conventional society. Biernacki’s work on the social processes involved in natural recovery stated that most addicts “come to this juncture in their lives” when ideas about giving up are “formed rationally and stated explicitly” (1986:43). On the one hand, natural recovery is conceptualised as the result of an entrepreneurial activity involving an individual performing self-responsibility by making a rational and moral decision to stop. On the other hand, this rational and moral decision to discontinue drug use and engage in another career pathway is governed by key resources in the individual’s environment. *In summary, this neo-liberal technology transforms the pathological subject into a rational actor by placing them in charge of their own life and providing the conditions for rational choice to be exercised responsibly.*

5.1.6. From natural recovery to recovery capital; a neo-liberal dividing practice

It can be argued that research into the experience of natural recovery has focused entirely on the various resources that are available to middle class drug addicts.

Resources that provide the conditions in which a rational decision to stop taking drugs can be practiced (Biernacki, 1983, Granfield and Cloud, 1996, Waldorf 1983). It is difficult to explain why the middle class drug addict population have been over-represented in natural recovery research, though for researchers such as Granfield and Cloud it is clear that middle class resources, including “families, job skills, formal education, economic security, and other conditions”, are effective in encouraging self change in the individual (1996:55). It is important to point out that self-change, in this context, is the practice of participation and self-responsibility in the pursuit of abstinence and social productivity. In the disadvantaged population, it is argued, a lack of natural recovery is the result of a lack of these key resources that provide “stakes in conventional life” (Cloud and Granfield, 1994: 115). It is for this reason that Cloud and Granfield (2001) have used this domain of knowledge, and through an economic form of analysis have constructed the concept of recovery capital.

The concept of recovery capital has its origins, as just pointed out, in natural recovery research on middle class populations. It is worth acknowledging that the concept has links with Pierre Bourdieu (1985), who discussed social and cultural capital, and Robert Putnam (2000). Recovery capital was introduced into the academic literature by Cloud and Granfield (2008) and to the recovery movement in the United Kingdom by Best and Laudet (2009). Recovery capital is made up of various forms of ‘capitals’ which include social, human and cultural (Cloud and Granfield, 2008). Social capital refers to the network of social relations from which an individual can draw support in order to maintain a successful recovery; human capital includes knowledge, skills, education and the health and mental health of the individual and; cultural capital refers to the “values, beliefs, dispositions, perceptions” of conventional life (2008:1974). These have been instrumental in constructing the concept of recovery capital through re-articulating resources into measurable forms of capital which individuals can be measured against and directed towards.

The technology of recovery capital arguably puts into operation a knowledge that divides up and classifies the drug addict population according to its own internal rationality and the rationality of natural recovery. This arguably imposes a middle class paradigm in the field of drug policy and treatment. Miller has made a similar criticism against the use of a middle class paradigm in the measuring of harms in harm reduction (2001). The key point being made is that the concept of recovery capital has introduced

a new problem space into the field of drug treatment based on the lack of middle class resources. In turn, the deployment of recovery capital divides and classifies the drug addict / treatment population into those that have recovery capital and those that do not.

This begs a final question: If recovery capital has been proposed as a new way of governing the drug treatment population, what is it a solution for? As Rose and Miller (2008) have pointed out, there is a “recurrent diagnosis of failure” in liberal forms of government (2008:206). Recovery capital has emerged within a wider recovery movement that is currently encroaching on the drug treatment system. This has emerged against the backdrop of a series of criticisms that have problematised the current ‘art of governing’ the drug using population through the dominant methadone and harm reduction rationalities and techniques. These criticisms featured in a recent meeting between drug treatment experts, service users and other interested parties (Drugscope, 2009). The meeting, termed ‘*The Great Debate*’, revealed an over reliance on substitute prescribing like methadone as well as a dependency on the actual treatment system itself. This coupled with the high economic cost of the current system and the present fiscal conditions, has arguably moved the debate on and opened up a space in which neo-liberal political rationalities in the form of recovery are seen as the solution to the said problems.

The introduction of neo-liberal rationalities through the concept of recovery capital, on the one hand, reduces the excessive cost of drug treatment by displacing responsibility for recovery onto the individual and population in the form of self-care. In this respect, a technology of self-recovery directs individuals towards the attainment of recovery capital as a way in which to produce ‘neo-liberal subjects’ or ‘subjects of recovery’. The recovery movement, therefore, must be situated within the broader mutations in political power. This point will be developed further in chapter 8. The deployment of recovery capital, on the other hand, objectifies the problem drug user as an individual lacking in recovery capital and in terms of a new problem space based on this lack of middle class resources. *This arguably continues the division in drug treatment which was started by Kolb (1927) based on curable/incurable, normal/abnormal, psychopathic/non-psychopathic, mature/immature, those that have / those that have not.*

5.2. Needle fixation: Power-knowledge and the subject

5. 2.1. The problem of the syringe-in-use: From unregulated to regulated

The use of the syringe as a governmental problem – a problem of conduct – emerged during the latter half of the nineteenth century in an article by the physician Dr Clifford Allbutt entitled *On the Abuse of Hypodermic Injections of Morphia* (1870). The literature search did not reveal any concern expressed before this publication only evidence of its *fashionable* albeit *unregulated* use by both medical and non-medical individuals (Allbutt, 1869, 1870, Anstie, 1871 and Sharkey, 1887). Since its emergence within medical practice, with which the names Dr Rynd, Dr Alexander Wood and Dr Charles Hunter are associated (Berridge 1999), physicians from France, Germany, Britain and America were refining the mechanical features of this modern medical technology (Howard-Jones, 1947).

In the year preceding Allbutt's initial publication on the abuse of the syringe (1870), he claimed to be "convinced of its importance" (1869:342) only to follow this up, one year later, by separating himself, through using the terms use and abuse, from those "practitioners of whom the syringe...are as constant companions" and those injectors that continued to inject for non-medical reasons (1870:327). In contrast, Anstie (1871) argued that the medical benefits gained from using the syringe outweighed the need to direct patients away from its abuse; *or, in other words, its uncivilised and non-medical use*. Oliver (1871), likewise, claimed that if a morphia habit developed during treatment then it should be dealt with as a secondary issue by withholding the morphine following treatment (Cited in Howard-Jones 1947). Statements on withdrawal or removing poison from the body were not yet articulated. Although there was inconsistency over whether abuse, as it was framed, was a primary or secondary issue, physicians agreed that an over reliance on the syringe by the medical profession had contributed to the emergence of a "new class of patients" (Allbutt, 1870:328, Anstie, 1871); an uncivilised group of patients that injected themselves, or were injected by others, in opposition to medicalising and civilising processes.

The medical profession feared that this group of 'patients' – organised through the power relation of doctor/patient - belonged to the middle class and had taken up the use of the syringe, on the one hand, to cope with the problems modern life had imposed on a

fragile nervous system and on the other, as an uncivilised, hidden form of pleasure (Allbutt, 1870, Anstie, 1871, Levinstein, 1878). The narcotic use of the syringe, defined by Anstie as its secondary effect, forced itself on the nervous system to such an extent that the “moral energy” of the patient “steadily decline in power” (1871:152). This anxiety and crisis within middle class society was confirmed in claims that the syringe had found its way into “festive occasions” (Allbutt, 1870, Atthill, 1889:1221) and it was even represented within “sensational novels...as a melodramatic device” (Allbutt, 1870:327). Among women it was “common practice to inject themselves” (Anstie, 1871:148) and Professor Regnard warned that the “pink of society in Paris, and probably in London and Berlin too, is peacefully poisoning itself” (cited in Sharkey, 1887:336 see Zieger, 2005 for detail discussion of gender and the syringe). Eulenberg (1880, cited in Howard-Jones, 1947), a German physician, like other physicians at this time (Anstie, 1871) pointed the finger at the excessive and unregulated use of hypodermic morphine by patients. The bottom line was that the unregulated use of this modern medical technology threatened “the bourgeois subjects” sense of “autonomy, will power, and self-mastery” (Hickman, 2004:1274). Consequently, 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, or as a “cultural crisis” (Hickman, 2004:1274), provided the means, as well as the necessity, for a number of rules to be integrated into the discourse regulating its use. These restrictions were, in part, characteristic of the preventative logic in circulation during the nineteenth century which governed dangerous individuals unable to govern themselves (Castel, 1991). In providing a solution to this threat against the autonomous and responsible individual, Anstie argued that the “risks of such mischief may be reduced to a minimum by strict attention to certain rules and principles which seem to be as yet imperfectly understood by many practitioners” (1871:149). Although not well understood, such rules were also being formed in the United States (Bartholow, 1879). Hickman (2004) notes how Bartholow, who had published a series of manuals on the mechanics of the hypodermic syringe, acknowledged this problematic conduct and began to address it within his 1879 manual.

Such ‘rules of conduct’ can be situated within the broader context of neurasthenia and nervous disorders within which an individual’s ‘moral conduct’, it was claimed, was determined by nervous energy (Anstie, 1871). Beard (1869) introduced the concept of neurasthenia as a way of representing nervousness and nervous exhaustion within the population through an expert discourse. Neurasthenia, he argued, characterised the “changing modern environment” (Hickman, 2004:1281). Moreover, statements linking opium and morality with the functioning of the nervous system were regular during the last quarter of the nineteenth century (Clarke, 1879, Sharkey, 1887). The nervous system was seen as both the cause and the object of treatment for the undesired behaviour of ‘injecting subjects’ soon to be represented through political and scientific rationalities as morphinomaniacs (Sharkey, 1887).

The regulation of the syringe through medical power not only restructured and assisted with the medicalisation of the relation between physicians, the syringe and the patient through medical knowledge, but functioned to produce a subordinated albeit civilised patient. *The civilised patient lacks the necessary medical knowledge and skill to use the syringe responsibly and is therefore unable to self-administer medicine through the syringe.* With this in mind, it is understandable how the medical profession were able to make statements such as the public “are allowed to poison themselves without let or hindrance” (Sharkey, 1887:342); the syringe “is only safe in the hands of the medical men who appreciate its dangers”, and, “abuse almost certainly follows if its administration be left to the patients themselves” (Sharkey, 1887:335). 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’ incapable of handling formalised medical objects; *or in other words, the deployment of a medicalising technology.*

5.2.2. Needle habit and the paradox of injecting water

The injection of water is used as an example of needle fixation in contemporary accounts (Pates et al, 2001). However, the practice of injecting water has not always been thought of in this way. It is documented in the *British Medical Journal* that injecting water was an effective treatment of pain (Yeo, 1875) and there are cases in which warm water was used for the treatment of the “habit of taking morphia” (Griffith,

1875:702). Griffith argued that water produced great improvements in the health of the individual and supported the medical expert, in “weaning them off the baneful poison”, as well as treating delirium tremens (Griffith, 1875:702). Yeo, in seeking to explain rather than pathologise the phenomenon, claimed it worked by producing a “mental impression on our patient’s nervous system” (1875:702), which, as expected, became supported by the wider interests in neurasthenia. The mental impression was not considered a problem in need of normalisation or modification.

This mental impression on the nervous system came to be repeated some fifty four years later in the work of Light and Torrance when they observed that “Addicts frequently speak of the “needle habit”, in which the single prick of a needle brings about relief...It is not uncommon for one addict to give another a hypodermic injection of sterile water and the recipient to derive a “kick” and become quiet” (1929:15). The use of water in bringing relief, however, was not articulated outside ‘normal injecting’, as found in the discourse of needle fixation, even though it contains the same statement used by Griffith (1875) and Yeo (1875). Instead, the abnormal becomes the removal of withdrawal symptoms with water.

5.2.3. The culture of the needle: from medical to subcultural subjects

The formation of drug using subcultures in America (Becker, 1963, Davis and Munoz, 1968, Merton, 1938) marked the emergence of a new set of problems concerning the relation between the syringe and the opiate user outside medical and psychiatric institutions. Unlike the uncivilised sub-group of middle class *patients* resisting medical power by injecting themselves (Allbutt, 1870), the problem became a small, albeit dangerous, group of injectors who lived on the margins of society (Cherubin, 1967, Davis and Munoz, 1968). This reconfiguration, in particular, was characterised by a shift from a predominately middle class female group of subcutaneous morphine injectors (Allbutt, 1870, Anstie, 1871, Courtwright 1982, Levinstein 1878), to a group of young lower class male intravenous heroin injectors (Chein et al, 1964, Courtwright, 1982, Schur, 1963).

Prior to 1929, according to O’Donnell and Jones (1968), no references exist regarding the use of the intravenous method by heroin or morphine self-injectors. In fact, a point also acknowledged by Courtwright (1982), injectors would have stumbled upon this

route of administration when they hit a vein by accident (O'Donnell and Jones, 1968). The diffusion of the intravenous method among heroin users (Courtwright, 1982), explained through a subcultural discourse and evidenced by an increase in cases of malaria within this population (O'Donnell and Jones, 1968), generated interest from the medical profession (Cherubin, 1967). On this point Cherubin argued that the "clinical diseases of drug addicts receive relatively scant notice" (1967:23); arguably because of the legal direction of America's drug policy (Musto, 1973, Schur, 1963).

The morbidity and mortality identified within this group of injectors was problematised and represented through statistical modes of analysis; a type of power associated with biopolitics (Foucault, 2007, 2008, Rose and Miller, 2008). Biopolitics is a "set of mechanisms through which the basic biological features of the human species became the object of a political strategy" (Foucault, 2007:1). The biological characteristic of the drug addict population, revealed through this form of statistical representation, was "a mortality rate considerably greater than what would be expected in terms of their age" (Cherubin, 1967:23). Contributing to this mortality rate, it was claimed, was a "high prevalence of serum infectious hepatitis" (Howard and Borges, 1970:220) thought to be associated with the "illness producing behaviour" of the injector (1970:229). This problematic behaviour was thought of in terms of a danger associated with the conduct of this particular population and located within the body.

Problematising the conduct of the injector through public health discourse provided the justification for the (*sociological*) gaze to be deployed as a technical instrument for seeing and knowing this particular conduct through the subcultural epistemological framework (Davis and Munoz, 1968, Howard and Borges, 1970). The gaze, a concept developed by Foucault (1989), can be understood as the "means of making the body *legible* to an observing eye" (Armstrong, 1983:1). Informed by the discursive field of subcultures, the gaze allows for the everyday lives of individuals to be thought of and seen as subjects of a subculture. Mapping out the terrain of the subculture, moreover, can also be understood as an extension of a bio-politics of the population (Foucault, 2007). On this point, 'subculture' itself becomes technical by representing this group of injectors as subjects belonging to a "needle culture" (Levine, 1974:298) and as a public health concern (Cherubin, 1967, Howard and Borges, 1970).

The rationalities representing the practices of the drug using subculture had shifted at this time. No longer was this domain of conduct considered a deviant response to the capitalist system (Merton, 1938). Rather, through the work of the Chicago School (Becker, 1963), these subcultural practices were understood as functional aspects of a subculture (Ren, 2005). In explaining this transformation Ren (2005) argues that the accumulation of knowledge on subcultures by economists led to the introduction of a 'neo-liberal framework of thought' which allowed subjects of subcultures to be regarded, not as deviant individuals, but as normative and rational actors.

Within this particular framework of representation, as opposed to the medical (Allbutt, 1870) or psychological (Pates and McBride, 2001) frameworks of representation, the spectacle of "bruises and tracks" seen on the body of the injector "confers status...prestige symbols" (Howard and Borges, 1970:227). It was not articulated as evidence of self-harm (Pates et al, 2001). On the contrary, "Excelling in the ritual is a means of gaining prestige among shooters" (Howard and Borges, 1970:228) rather than hypothesising their injecting behaviour as "obsessive-compulsive" (Pates et al, 2009:315). In other words, these forms of conduct are illustrative of sociological accounts of subjectivity; accounts that are practiced by subcultural subjects, rather than accounts which reproduce the subject within a psychological framework as pathological subjects.

On the basis of this subcultural representation of injecting drug users, certain individuals came to be considered more dangerous than others because their behaviour predisposed them to hepatitis, and as a result were divided and categorised according to their relation with the syringe. The dangerousness intrinsic to the injector, however, was something that could not be seen or known without the individualising techniques of the medical examination (Armstrong, 1983, Foucault, 1989). On this point, being restricted by visibility, it was not possible to locate this dangerousness as existing anywhere else other than within the individual body. Chein et al had made policy recommendations only six years before suggesting that injectors "should be informed of the proper techniques" so they can take responsibility for avoiding the dangers associated with viruses (1964:360). The aim was to construct injectors as self-regulating citizens, a characteristic of neo-liberal forms of government (Dean, 1999), which could navigate the dangerous terrain of the subculture through integrating the medicalising technology

of the syringe into the practice of self-government. This strategy can be contrasted with nineteenth century measures of removing the syringe from the hands of the patient (Allbutt, 1870, Anstie, 1871, Levinstein, 1878, Sharkey, 1887). Instead, injecting drug users were provided with medical knowledge so they could take responsibility for protecting themselves from danger.

The American response, however, failed to integrate this form of self-government with the government of the injecting drug using population because medical power could not represent such a population. The dangers of hepatitis could only be understood in relation to the body of individuals. In other words, governmental practice itself was caught within the *self-syringe paradigm*.

5.2.4. The emergence of the psychological ‘injecting’ subject: Needle freak and fixator

The medico-subcultural practices demarcated a domain of practices within which the injector was understood as both a medical and social problem. On the other hand, following the anticlinic campaigns of the 1930s, in which physicians were criticised for making large profits from selling prescription drugs and spreading addiction (Musto, 1973), psychiatrists, through the Public Health Service, attempted to bring about an “adjustment of the addict...to end his continued menace to the city, and make him a self-supporting, productive citizen” (Kolb, 1927, Lambert et al, 1930:448).

Psychiatry emerged at the beginning of the twentieth century as a political technology for regulating various problematic groups deemed unable to be integrated into the social order (Gordon, 1986, Rose, 1986). Basic to this programmatic intervention was the assumption that the health of the nation was now dependant upon the physical health of the individual (Rose, 1986). In this respect, rather than being understood as a passive object infected by its environment, the individual became seen as being active in the spread of ill health (Dean, 1999, Gordon, 1986, Rose and Miller, 2008). It was through the United State’s Public Health Service (Kolb, 1922, 1927) that drug addiction became integrated into this governmental framework.

Psychiatric power, at this time, organised and acted upon individuals through various techniques, such as personality reaction techniques (Rose, 1986). Interest in the

personality developed during the Second World War when a concern for manpower led to the promotion of research into the assessment of the personality and aptitude of soldiers (Rose, 1989). Psychological testing, furthermore, meant that large populations were available to analysis through advanced statistical techniques (Armstrong, 1983, Rose, 1989). Through personality reaction techniques drug users became divided into “two classes, the curable and the incurable” or as these groups were categorised, the “non-psychopathic” and the “psychopathic” (Lambert et al, 1930:464). Normal drug addicts, Lambert et al claimed, were not a serious problem to treat because most “seek to rid themselves of it” (1930:460). This is an example of how subjects are produced through, what Foucault has referred to as, dividing practices; “The subject is either divided inside himself or divided from others. This process objectivises him. Examples are the mad and sane, the sick and healthy” (1994c:236). It is worth point out that the needle fixation screening tool is a recent example of such reaction techniques (Pates, Arnold et al 2009:320, Pates and Gray 2009). The needle fixation screening tool is a way in which to arrange (and reproduce) injecting drug users into four “distinct types of reactions to injecting” (Pates, Arnold et al 2009:320, Pates and Gray 2009). Such categories are the ‘non-needle fixated subject’, the ‘rush seeking subject’, the ‘ritualised and skilful subject’ and a “group of injectors who may be truly described as NF” and who also demonstrate signs of “obsessive-compulsive behaviour” (2009:320). The tool, arguably, provides a governmental technique for dividing up the injecting drug using population by organising them into the above distinct reaction types with the aim of transforming them into not only recognisable, but governable subjects.

After the Second World War psychiatry began to realign itself with a range of treatment technologies, including pharmacological treatments, social therapies, psychoanalysis and behavioural therapies, for acting upon the domain of personality (Rose, 1986). It was through the techniques of behaviourism that psychiatry was able to provide an alternative way of conceptualising the complex relation between the individual and the syringe from its ‘medico-subcultural framework’ (Howard and Borges, 1970) to one located within the psychological space of the individual. The conduct of the injector, within this space, became amenable to conditioning and reconditioning techniques (Levine, 1974), or, from the governmentality perspective, techniques of normalisation (Dean, 1999, Foucault, 2007, Rose, 1986). It is noteworthy to mention that this

psychological space was formulated in the laboratory through “experimental methods and advanced statistical techniques” (Rose, 1989:229).

Levine’s (1974) article on *Needle Freaks* is an exemplar of how the body of the injecting drug user became subjected and reproduced through psychological discourse. For Levine, the problem arose when the act of injecting becomes an end in itself (1974). This particular relation, he claimed, set them apart from other drug users from the subculture because of its irrational aspect. The problem for Levine (1974), however, was how to make the injecting behaviour of the needle freak visible. These are the same problems shared by Pates et al (2009). It is not the invisibility of their dangerousness, such as in medical and public health discourse, which is the problem; it is the “elusive quantitative factor that enters into the behavioural equation” (Levine, 1974:299). Representing the *needle freak* in terms of learned reflexes, or the “behavioural equation” (Levine, 1974:299, Pates et al, 2009), binds the *self* to the *syringe* in a new and complex way and removes the above form of medical power and knowledge out of the equation. In fact, this particular practice imposes a boundary around the practice through which the act of injecting becomes segregated and individualised. It produces and marks the territory of governmental practice by reconfiguring the self-syringe paradigm through psychological discourse.

The use of behaviourist rationalities for representing the conduct of the injector opens the door for behavioural modification techniques, such as the use of “An “electric needle” that delivered a shock when the plunger is depressed and can be connected to a single patient or to a number of patients in a series...addicts wired together have shown a remarkable tolerance to the shock” (Levine, 1974:299). Pates and McBride et al acknowledge the problem of using behavioural modification techniques in chaotic drug treatment centres though advocate the use of “cue exposure with conditioned problems” (2001:15). Understanding the subject in this way opened up the possibility of making additional statements regarding the potential for the *heroin snorter*, the opposite to the needle freak, to be normalised using the behaviourist equation and modification techniques (Levine, 1974). Interestingly, Tompkins et al (2007), in citing Pates and McBride et al (2001), make reference to the problem of ‘needle fear’ among female injectors who, because of their relation with the syringe, rely on other injectors to inject them.

So far, this genealogy has demonstrated that this pathologised relation between the individual and the syringe was thought about and acted upon through, what I have referred to as, the self-syringe paradigm. This paradigm can be contrasted with the current paradigm, which will be discussed in the next section, underpinned by epidemiological ways of thinking. In terms of the argument of this genealogy, this is where the tension lies between boundaries of needle fixation and the risk management strategies of harm reduction that dominates drug policy and practice.

5.2.5. Beyond needle fixation: From the ‘fixated subject’ to the ‘epidemiological space’

In 1986, an influential paper was published in the British Medical Journal by a group of general practitioners expressing concern over an unusually high prevalence rate of HIV among injecting drug users in Edinburgh (Robertson et al, 1986). And, as the number of injecting drug users in England and Wales was estimated by the Advisory Council on the Misuse of Drugs (ACMD) to be somewhere in the region of 37, 000 to 75, 000 (Stimson, 1995), there was growing concern that the virus might spread from injecting drug users to the wider population through sexual transmission (Degenhardt et al, 2010, Robertson et al, 1986). This event marks an important reconfiguration (Zibbell, 2004), even a paradigmatic shift (McKeganey, 2006), in the way in which problem drug users were conceptualised and governed by the state. Responding to this problem, the liberal state, with input of the ACMD, began the task of directing its injecting drug users away from the danger of HIV through risk thinking (Castel, 1991, Rose, 2007) incorporated into harm reduction policies and practices (Strang, 1988). Harm reduction is underpinned by the idea that HIV poses a greater threat to public health than the misuse of drugs (McKeganey, 2006). In essence, harm reduction places priority on reducing the levels of harm associated with the problem drug using population rather than minimising their drug use (Miller, 2001).

At the heart of my argument is that the productive powers inherent in the political and scientific rationalities and technologies that responded to the HIV epidemic gave rise to a new framework for understanding the conduct of injecting drug users. Before this event, an explanation for the rise in the levels of blood borne viruses was caught within the self-syringe paradigm. Increases in blood borne viruses was explained, for example, by making reference to the “number of shots” (Howard and Borges, 1970:222) or the

“number of injections” (Robertson et al, 1986:527) an individual gave him or herself. This particular way of thinking gave rise to problems like needle fixation (Pates et al, 2001:15) and needle fear (Tompkins et al, 2007). This new framework, in contrast, pointed to the risk of infection between injecting drug users and moreover a risk of infection from drug users to the non-drug using population through sexual transmission (Degenhardt et al, 2010, Robertson et al 1986, Thorpe et al 2002). Fundamentally, this new way of thinking moved beyond the self-syringe paradigm and pointed to an alternative account directed towards the ‘at-risk’ activity of sharing syringes, the spaces between injectors and their link with the wider population. As a result, any problematic relation between *self* and *syringe* (Levine, 1974, Pates and McBride et al, 2001) had to be reconstructed with reference to the *syringe*, the *injecting population* and *non-injecting population*.

Mitchel Dean (1999) has pointed out that there is an affinity between rationalities and technologies of risk and neo-liberal forms of government. Characteristic of this association is that the management of risk has been relocated from the responsibility of the expert and situated directly onto the individual and their community (Dean, 1999, Rose and Miller, 2008). Understood as the ‘new prudentialism’, citizens are to be active in monitoring their own risks; from becoming a victim of crime to catching a sexually transmitted disease (Dean, 1999). Rather than perceiving the dangers associated with these activities as problematic, like forms of injecting, it is the risks that traverse each and every member of the population, like catching a blood borne virus, that has become problematic and the target of intervention (Rose and Miller 2008). In explaining this shift in thinking, the abstract and probabilistic existence of risk, as a way of bringing the future into the present, has meant that risk itself has become detached from danger (Castel, 1991); relations (between self, others and objects) have become relations of risk rather than relations of danger. Furthermore, it has introduced, according to Castel (1991), a new mode of surveillance that no longer addresses the individual but seeks to reconstruct an arrangement of factors that are liable to produce risk.

Governing the conduct of injecting drug users through neo-liberal and epidemiological rationalities and technologies of risk has arguably transformed the landscape of drug treatment from a policy and treatment infrastructure based on abstinence to a system dominated by risk management strategies, such as the needle exchange (Stimson, 1995,

Zibbell, 2004) and safer injecting environments (Rhodes et al, 2006). One of the consequences of this reconfiguration is that the expert, the one providing guidance through *psyche* expertise, “finds themselves now cast in a subordinate role” (Castel, 1991:281); because the task of governing risky populations has become an administrative one, made possible through developments in laboratory testing, databases and spreadsheets, targets and measurable outcomes.

This displacement of risk from the expert onto the individual necessitates the need to transform the injecting drug user from an out of control “careless addict”; the needle sharing deviant whose behaviour is a threat to the population because of poorly disposed syringes to a “conscientious addict” (neo-liberal citizen); the safe injector who would “place them in the nearest litter bin” (Beckett, 1985:1425). Transforming the injecting drug user, Stimson et al argued in their review of the needle exchange pilot scheme, meant that all agencies provide clients with information needed to reduce the risk of transmitting HIV by changing behaviour and that “some agencies staff have begun to rethink the character of their work” (1988:1719). The role of harm reduction techniques was to transform “at risk injecting” into “safer injecting...insofar as the latter place may exist” (Strang, 1988:237). Rather than providing behavioural modification techniques (Levine, 1974), experts must begin the task of (re)constructing the spaces, through risk thinking, so that the active injector can practice safer injecting. This new set of practices, most importantly, has become concerned with the regulation of spaces rather than with the regulation of individuals. Rhodes et al have raised this issue for debate; essentially whether constructing ‘safer injecting environment interventions’ that “maximise opportunities for injecting safely through the availability of sterile injecting equipment...sterile water, good light, clean surfaces and safe sharp disposals” can be incorporated into governmental practice (2006:1387). Within this ‘risk environment’ it is difficult to point out how it is possible to see or speak of a subject of needle fixation and be heard against the dominant backdrop of risk management strategies that have come to dominate drug policy and practice.

5.3. Withdrawal

5.3.1. Liberal medicine, poisoning and the politics of health

Before sketching out this genealogy, it is worth setting forth my thesis on withdrawal. This genealogy will argue that before the nineteenth century, the human experience we call withdrawal, in the way we currently ‘think’ about it, did not exist. This is not to say that people who suddenly stopped taking opium did not experience ‘something’; it is to say that this ‘something’ has become known and experienced by the drug user through a discourse which produces the truth of withdrawal. The starting point of this genealogy is the beginning of the eighteenth century, in particular, the point at which the body became caught between the forces of liberal medicine and the politics of health (Foucault, 1994f).

In his essay on *The Politics of Health in the Eighteenth Century*, Foucault described the development of a medical market, a liberal medicine that centred on “private clienteles” (1994f:90). Liberal medicine, as Foucault referred to it, was “subject to the mechanisms of individual initiative and the laws of the market” (1994f:90). On the one hand, the supply of medical practice, Foucault notes, was met with a growth in “individual and family demand for health care” (1994f:90). On the other hand, this loosely regulated circulation of medicines became problematised by accusations of poisoning (Anon, 1701). The anonymous writer argued that apothecaries were providing medicines in an “exorbitant quantity” that were “destructive as poisons” (Anon, 1701: preface). The position taken by this anonymous observer appears to be that of a physician expressing concern at the practices of apothecaries. This conflict between physicians and apothecaries dates back to the early seventeenth century (Bell, 1843). The context within which this criticism was made is very important and will be explored in chapter 7.

The claim made by the anonymous observer, it can be argued, can be situated within the wider political context; in particular, the politics of health in the eighteenth century. For Foucault, the politics of health was the

“consideration of disease as a political and economic problem for social collectivities which they must seek to resolve as a matter of overall policy.

“Private” and “socialized” medicine, in their reciprocal support and opposition, both derive from a common global strategy” (Foucault, 1994f:91).

The “common global strategy” or the “objective of policy”, which becomes the main priority for all, and whose intervention emerges from multiple sites (1994f:92), was the “health and physical well-being of the population...as one of the essential objectives of political power (1994f:94). Population emerged, as pointed out in chapter 3, as a new *problem space* and provided a different economy of power from that of sovereignty, it was directed at “biological processes; propagation, birth and mortality, the level of health, life expectancy and longevity, with all the conditions that can cause these to vary” (Foucault, 1978:139). Medicine, and its functions, its privileged position, essentially became “*an instance of social control*” (Foucault, 1994f:98, original italics).

The central mechanism through which this power became exercised, and medical knowledge produced, was the hospital (Armstrong, 1983, Foucault, 1994f, Jewson, 1976). James (1747) argued that the hospital dispensary emerged as a technique through which to provide a cheaper and safer alternative to the poor instead of the expensive services being offered by apothecaries. The hospital dispensary produced a reconfiguration, not only in the way medical knowledge was produced, but in the rationale of prescribing; its governmental rationality. The important question asked at this time, I am arguing, was when does a medicine become a poison? Or, how can one tell the difference between a medicinal dose and a poisonous amount. The point of friction (or force) between this private - *profit-making* –medicine, in which medicines were sold as commodities, and the wider political concerns with health and longevity, comes to the fore with the problem of dosing and how a correct dose should be measured or what criteria should it be measured against. *Ultimately, as a discursive practice, the rules that govern a correct dose are not natural but historically located.*

The practice of medicine and the production of medical knowledge, before the hospital, was organised around the bedside of the paying customer (Jewson, 1976). This bedside medicine observed the ‘whole body’ of the ‘sick man’ (Foucault, 1973, Jewson, 1976). Armstrong points out that illness was understood as being “coterminous with the symptoms that patients experienced and reported”; a “headache or abdominal pain was the illness” (1995:394). The medical gaze, Foucault (1973) argued, was directed at the signs and symptoms that could be seen on the surface of the body. This was referred to

as ‘classificatory medicine’ and enabled diseases to be differentiated from one another (Foucault, 1973). The clinical picture was dependant and provided entirely by the patient. Hospital medicine, in contrast, introduced a three-dimensional model of medicine “involving symptom, sign and pathology” (Armstrong, 1995:394). The gaze of the doctor moved beyond the surface of the body, on which symptoms could be observed, and into the interior of the human body, where the cause of such symptoms was now identified (Foucault, 1973). The important point to make, rather than the paying customer, population became the object of political power and therefore of the hospital. A new way of thinking about medicine and dose emerged.

5.3.2. Leaving off as a side effect of an incorrect dose

The hospital opened up a whole new field of medical knowledge and practice directed at the body (Armstrong, 1995, Foucault, 1994f, Jewson, 1976). The hospital dispensary, it is being argued, also provided the space within which the body and its relation to poison became subjected to the power of observation and knowledge of detail for the first time. The objective was two-fold: reducing the number of deaths caused by overdose and establishing a correct dose that was favourable to the philanthropic attitude of providing cheaper medicine to the poorer classes (James, 1747). This still leaves the question of what is a medicinal effect. How does one know when one has a medicinal effect? What does it look like? It had already been established that a non-medical effect was a poison (Anon, 1701). This question can be answered with an analysis of shift in practices between Banyer (1721) and James (1747) and the practices contained in the medical commentaries of Jones (1700) and Mead (1702, 1747).

The *Pharmacopeia* provided a standardised formula to the medical profession which guided the conduct in mixing medicinal compounds. In an earlier manual the instructions are “Take the best of opium, 4 ounces, dissolve it, and boil it in a sufficient quantity of clear water” (Banyer, 1721:70). This practice of mixing is influenced by knowledge of the substance itself rather than by knowledge of the body. It is important to put this practice into the framework of sovereign power, through which power, deployed through the rights of the physician, ensured correct mixing procedures were upheld. In contrast, within the *New Universal English Dispensatory* these statements include a new set of rules and descriptions of opium. For example, opium has a “blackish brown colour” and the “Greeks distinguished two kinds of it” (James,

1747:386-387). Most importantly, it is possible to identify a new discursive relation between the body and opium, not in terms of poison and pleasure, but “Rules to be observ’d in taking opium” (James, 1747:386-387), such as it “does not make the pulse quicker or harder” and “opium ought never to be taken on a full stomach” (1747:388). Before this period, and the publication of Jones’ (1700) *Mysteries of Opium Revealed*, the ‘rules’ are imbedded within the Galenic – *humorist* - framework of medicine based on the four humors. The objective of the dose was to remove pain or symptoms, and not follow rules that would protect the body from itself (its own unwanted effects).

The discourse on prescribing in Jones (1700), appears to be the first text that directly tackles the truth of correct dosing and indicates a problematic experience when leaving off opium. His reflections are directed towards increasing the productivity of the body by moving opium away from its association with sleep and poisoning and towards the practice of moderation in dosing. In trying to clear the name of opium, to arguably make it safe as a commodity in the liberal market conditions, Jones argued that it should be used in moderation (he juxtaposes ‘moderate’ with ‘excessive’ and ‘long and lavish’). It is important to point out that the term moderation, at this time, referred to the way “Man governs his Sensual Appetite” (Burnet and Hale, 1710:352). In other words, moderation is a religious practice. The required effect from a dose of opium previous to Jones (1700), as he pointed out, was to support sleep and remove pain.

The discourse of moderation discussed by Jones (1700) is also found in Mead (1702, 1747) and refers to a way of distinguishing between a medicinal affect in the body and a non-medicinal affect. With an “immoderate use of opium”, Thicknesse observed “a deep and insupportable sadness, with anxiety, languidness...unless he returns to the use of opium, or of wine” (Thicknesse, 1749:378). These statements were repeated by Lewis; users of opium “upon leaving it off, are seized with great lowness, languor, and anxiety; which are relieved by having recourse to opium, and, in some measure, by wine or spirituous liquors” (Lewis, 1778:189). There are three points that can be made from this. First, knowledge of ‘leaving off’ emerged between the forces of the market, a new form of political power and an ascetic practice of moderation. The experience existed. It became raised to the level of discourse. The second point is that the experience itself was not governed by the expert and there were then no reasons found for doing so. Possibly because there was no internal pathology as leaving off manifested itself on the surface of the body. The new rules concerned dose and the experience was merely the

result of an incorrect rule for dosing. It can also be said that ‘leaving’ suggests the act of doing nothing, as opposed to ‘withdrawing’ something from the body. The final point is that the statements found in Thicknesse (1749) and Lewis (1778) are linked to the practice of self-governing the ‘leaving it off’ experience by using either wine or opium in its place.

5.3.3. Governing the leaving off experience

It is worth reflecting on this final point and on some further evidence. The practice of self-governing ‘leaving off’ is important and can be classified as a subjugated knowledge. That is

“knowledges that have been disqualified as inadequate to their task...knowledges, located low down on the hierarchy...beneath the required level of...scientificity” (Foucault, 1980:81).

It is now taken-for-granted that withdrawal, in particular heroin withdrawal, requires expert intervention, such as institutional support with the assistance of nurses and specialist medication; or, in the form of gradual and substitute prescribing operating under the surveillance of the drug treatment system. It is by identifying these disqualified knowledges, for Foucault, that “criticism performs its work” (1980:82).

This discursive practice (Thicknesse, 1749, Lewis, 1778) continued into the nineteenth century. Even De Quincey (1971) reduced his daily amount over a period of weeks. He described it as the “*torments of one man passing out of one mode of existence into another*” (De Quincey, 1971:115). The *Medica Materia* makes reference to “those who do make the attempt to discontinue the use of opium, usually mix it with wax, and daily diminishing the quantity of the opium, the pill at last contains nothing but wax” (Pereira, 1854:1038). In a dialogue between the English Opium Eater, which of course is De Quincey (1971), and the Modern Pythagorean, the Opium Eater discusses using substitution as a ‘political technology’ for governing alcohol use among the lower classes; he asks the Modern Pythagorean if “opium be a safer substitute to the poor, for spirituous liquors?” (1830:392). In *The Materia Medica*, Steggall refers to alcohol users turning to opium as “a substitute for intoxicating liquor” (1837:222). Such practices articulate a form of substitution, in which opium can be substituted by wine, and vice a versa. De Quincey, however, was concerned with raising the morality of the lower

classes through substitution with opium. In many ways, methadone and buprenorphine perform a similar political function.

5.3.4. The discursive field of poisoning: opium, leaving off and the nervous system

The experience of ‘leaving off’, in the middle of the nineteenth century, became reproduced and articulated as a symptom of a “disorder...of the nervous system” (Anstie, 1871, Fleming, 1868:137, Kerr, 1894). The gaze, in other words, moved past the symptoms on the surface and into the inner depths of the body. Fleming (1868) makes a number of claims regarding the removal of opium from the body as a form of de-poisoning. It is the notion that if the body is being poisoned then the poison must be removed. This problematisation of the leaving off experience by a discourse of poisoning was made possible by a broader series of processes concerned with the position of poisons and the threat to population. Links have been made elsewhere regarding opium and public health (Berridge, 1979, 1999, Foxcroft 2007, Seddon, 2010). Burney (2002) and Bartrip (1992, 1994), additionally, have both described the nineteenth century as a poisoned century. The discourse of poisoning will be explored in the next chapter; however, the discursive relation between opium and poison became more prevalent, repetitive and influential as incidents of accidental and intentional poisoning came to the fore.

In addition from this *population-poison dynamic*, the individual body became the object of knowledge and governmental intervention. Knowledge of the *body-poison dynamic* was produced by Christison (1829) for informing ‘judgement’ or truth claims within criminal poisoning trials. The poisoning trials have been discussed by Burney (2002). Christison, as noted elsewhere (Berridge, 1999, Foxcroft, 2007, Seddon, 2010), was the expert involved in the Earl of Mar case (this was discussed in the literature review). The statement above on the experience of ‘leaving off’ as a form of poisoning (Fleming, 1868, Kerr, 1894) - a “disorder of the nervous system” – was, in fact, first advanced by Christison (1829: 208). Christison, within this legal context, produced a discursive representation of the body as a poisoned object. At first, this informed criminal proceedings on the truth as to whether a body had been poisoned. Later, the practice became aligned with biopolitical objectives; a set of discursive practices on how this ‘poisoned body’ could be de-poisoned; how it could be removed. This included opium and arsenic; they shared the same diagnosis as disorders of the nervous system

(Christison 1829). In fact, at some levels, which will be discussed in the next chapter, descriptions of arsenic and opium poisoning became difficult to differentiate. *It became possible to speak of arsenic addiction*. I will say more on this in the next chapter.

The rule for removing poison from the body - whether by arsenic or opium – was that the poison should be removed from the body abruptly (Christison, 1829). For example, the stomach pump was deployed for this task (Christison, 1828). It was also advocated by Dr Chowne writing in *The Lancet* (1842). When Christison was confronted with the body of the opium user, it is understandable why he argued that the habit could be “broken off abruptly, without danger” (1850:537). It was no longer, as in the previous model, understood as a side effect which can be avoided by simply introducing moderation and substitution into dosing practices. Instead, the experience of leaving off became governable through the discursive practices found in the field of poisoning. No longer was it a passive process: It became an active one. In other words, *as a form of poisoning it could be governed, not by the self but by the expert*. It is important to point out that this statement of poisoning as a “disorder of the nervous system” (Christison, 1829: 208) later provided the basis for experts to speak and govern the habitual use of opium and morphine as forms of chronic poisoning (Fleming, 1868, Kerr, 1894). The full extent of this ‘poisoning rationality’ will be discussed in the next chapter.

5.3.5. Instilling fear into the discourse of withdrawal; collapse and neurasthenia

The use of poisoning as a way of seeing and speaking about treatment continued and gathered momentum at the last quarter of the nineteenth century. Levinstein, who later problematised the habitual hypodermic use of morphine, described it as a form of “morphia poisoning” (1878:2) and represented the leaving off experience in the following terms:

“[Q]uarrelsomeness, want of sleep, hallucinations...trembling of the hands, and increased reflex action” (1878:11); the patient even “runs around the room, cries and screams” (1878:51).

The experience of being de-poisoned and leaving off are similar, though within this ‘poisoning context’ the subject becomes a patient – an irrational subject - and is situated within the institutional and power-knowledge arrangements of the medical profession. This form of government resonates with liberal forms of subjectivity and the

exclusionary practices of confinement (Dean, 1999, Rose and Miller, 2008). These reconfigurations in the domain of government can, in part, be explained by transformations in political power.

Up until the latter part of the nineteenth century the nervous system had not informed the way leaving off was seen, known or governed. The problem was treated by removing poison from the body abruptly. In this new arrangement of practices, however, it becomes rearticulated by the language associated with the problem of neurasthenia. Beard (1869, 1878) developed the term neurasthenia and claimed it was “the cry of the system struggling with its environment” (Cited in Hickman, 2004:1281). For Armstrong, neurasthenia was

“characterised by nerve ‘exhaustion’ or ‘fatigue’ ...believed to be brought on by over-exertion, and treatment was mainly rest and routine” (1983:20).

Beard (1869, 1878) argued that progress in civilisation had brought with it various conditions, including neurasthenia, whose symptoms - drug use, hay-fever and hysteria - reflected the darker side of our modern society (Wiener, 1956). Neurasthenia, as Courtwright (2005) has argued, was an underlying governing principle of the inebriety concept under which habitual opiate users, alongside alcohol, were governed. It is not my intention to go into detail about the experience of leaving off alcohol, though similar practices also operated for the alcoholic. In fact, as pointed out, narcotic poison was also a governing idea at this time. The regulation of the shattered nervous system of the withdrawing subject was not only complicated and shaped by the bio-political concerns with neurasthenia, it was shaped by concerns of the system itself collapsing.

Johnson argued that “the main reason why collapse is so deadly is that the arrest of circulation impedes in a corresponding degree the eliminative process, so that the retained poison or ferment has more time to spoil the blood” (1866:436). This statement on collapse was not isolated to the morphinist, but was situated alongside other forms of “blood poisoning”, such as “cholera-poison” and “strychnia” poisoning (Johnson 1866:436). For Levinstein collapse was symptomatic of forced abstinence and claimed it manifested itself in the following objective symptoms; “pulse gets small, the face becomes pale, the patient stops in bed and has the appearance of being utterly exhausted” (1878:40). He observed the “patient while sitting in bed...fall back on the

pillow, and sink into a state of unconsciousness” (1878:40) and had believed that “death ensues, accompanied by symptoms of paralysis of the brain” (1878:41).

The government of the exhausted nervous system, which affected women and ‘brain workers’, included “rest in bed...forced feeding...regulated muscular exercise”; “all these measures in combination...were supported in their contention of many successful results” (Drummond, 1906:13). The general theme on the subject of collapse can be summed up in a statement by Mattison:

“Collapse, *which we have never seen*, as threatened by irregular pulse and breathing, pallid, livid skin, or faintness, demands prompt treatment or the patient will die...An immediate injection of morphine, full dose, must be given” (1892:12 emphasis is mine).

Physicians never observed collapse, as Mattison pointed out. However, this sentiment is *still plaguing the discourse of withdrawal* up until this day. Examples will be referred to throughout the remainder of this genealogy. The removal of poison from the body, in light of the above problematisation and its fight against nervous exhaustion, shifted from abrupt to gradual. Governing the nervous system – as the site of ‘withdrawing’ - involved the use of *bromide of sodium* in a continuous manner. As a “continued dose” it was given at regular intervals to keep the “blood constantly charged with the drug” (Mattison, 1892:2). This practice prevented the nervous system from collapsing under the strain of withdrawal.

The distress of withdrawal – a problem for both drug user and expert – permeates contemporary discourses on maintenance prescribing. The origin of maintenance prescribing, according to Ashton (2006), is the Rolleston Report. The Rolleston Report, it is argued, set the agenda for drug policy for the next forty years by placing emphasis on the use of a substitute drug on a continuous basis. Here, the role of maintenance or continued dose (Mattison, 1892) allowed “patients to lead useful and relatively normal lives, and that if deprived of this non-progressive dose they became incapable of work” (1926:section13). Furthermore, those that attempted “complete withdrawal” were faced with “intense suffering...even fatal collapse” and “mental and physical distress” (Department of Health, 1926:section2). On the other hand, Willcox refers to the “Vicious Group” who were, interestingly, excluded from this discussion and not

considered a priority (1923:1013). These were treated using the abrupt withdrawal method within which no “alarming symptoms occurred” (1923:1016).

5.3.6. Withdrawal and psychiatry: from scepticism to syndrome

In the twentieth century the problem of drug addiction in Britain, the United States and elsewhere in Europe was becoming represented as a “dangerous menace to human civilisation” (Adams, 1939, Armstrong-Jones 1915, Weber 1918a:129) and subject to drug control strategies (Berridge, 1999, Seddon, 2010). In terms of Britain, it was the citizen class, made up of brain workers and women, rather than the vicious group (Willcox, 1923), that posed a direct threat to the liberal social order. This was because of the size of this group of drug addicts in relation to that seen in the United States (Musto, 1973). This threat can be summed up by Armstrong-Jones; “we are in too great a hurry to think for ourselves” and many of the “masses, as well as the classes, have sought ease and avoided stress” in these “so-called remedies” (1915:126). The problem, in this respect, was that of social and political order advanced by classical liberalism. The problem was not directed at the excluded *dangerous classes* but at the *normal population*; the “ignorant public” (1915:126).

This is the reappearance of the problem of poisons (now drugs) in that their threat, in terms of addiction, towards population - *population-poison dynamic* - has been rearticulated and expressed through the discourse of neurasthenia. The threat towards the population, articulated within the eugenics strategy for promoting internal fitness (Rose, 1989), was with its productive capacity. Addiction was, in this respect, both the consequence of a lack of nervous energy and, moreover, it drained this very same energy, which was seen as vital for the individual to remain intelligent and productive. In other words, the circulation of addictive drugs was becoming “a serious menace to the health of the best worker” (Armstrong-Jones, 1915:126). The potential increase in addiction due to both its availability and its overreliance within medical practice prompted a search for a morphine substitute (Adams, 1939, Himmelsbach, 1941). The search for a substitute drug was, therefore initially part of a preventative strategy to reduce levels of addiction with the population. In other words, attention was not just given to the new drug scene in London (Kohn, 1992) and its gender and race dimensions (Seddon, 2008), but at the population as a species body.

In relation to the treatment of addiction, it was reported that good work was being done in Britain, evidenced by the British System (Adams, 1939, Ministry of Health, 1926) which practiced the continuous rationality. The abrupt and gradual methods continued to operate inside the prison (Adams, 1939, Willcox, 1923) without problem. However, for Adams, the “greatest advances” and “important investigations” were hailing from the two large state hospitals in the United States (1939:19) that operated as part of the mental hygiene movement under the guidance of the Public Health Service. The psychiatric institution, as Ausubel argued, provided an “experimental laboratory” (Ausubel, 1948:219) for the study of addiction. From a Foucauldian point of view (Foucault, 1977), it operated as a human observatory; an instance of power and the conditions for knowledge of addiction. Whereas the poisoned body was made visible to the expert by the medical gaze, within the psychiatric institution this gave way to what was heard; the patient became opened up to medical knowledge “by demoting observation in favour of interpretation” (Rose, 2007: 192). This is an important shift that refocused the gaze from the physical to the psychological.

For Rose (2007), both Freud and Kraepelin mark a move away from the eye as a diagnostic tool within mental medicine. The diagnostic tool became the case history (Rose, 2007) and the “mind became represented to the gaze in words” (Armstrong, 1983:25). The mind of the individual represented the moral space between the “organic brain” and the “social space of conduct” (Rose, 2007:194). Withdrawal, within this new arrangement of power-knowledge, could not offer itself to interpretation as a real human experience unstained by the desires of the unconscious. This can be explained by the new discourse of psychopathology within which the words of the drug addict became a symptom of their psychopathic personality (Kolb, 1927, Lambert et al, 1930).

The personality, therefore, became the primary ‘tool’ through which the expert came to know and act upon the conduct of the drug addict (Kolb, 1927). It is important to point out that they did not totally abandon withdrawal, but it was seen as less important. The importance of the personality as a technology for governing the drug addict has already been acknowledged above in the genealogy of recovery capital. The incurable drug addicts were considered untruthful and, it was claimed, exaggerated their withdrawal symptoms to get more drugs (Kolb, 1927). In fact, as the words of the incurable patient were problematic, the existence of withdrawal was undermined. As one psychiatrist commented, the “signs of physical dependence are very dramatic and reminiscent of

hysteria...they are undoubtedly influenced by the personality of the addict” (Ausubel, 1948:226). The point being made is that the experience of withdrawal became displaced by the technology of the personality as a way in which to best govern the drug addict. This is not to claim withdrawal, as an experience, evaporated into thin air; it is to argue that the words of the drug addict were met with scepticism.

The truth of withdrawal later became established by Himmelsbach (1941) who was a physician at Lexington’s Public Health Service hospital. He argued that withdrawal was real and, moreover, it was the biological reaction of the body to the removal of the drug. Rather than the establishment of truth through interpretation, the truth of the abstinence syndrome became produced through an “objective quantitative manner” in the laboratory (Himmelsbach, 1941, Himmelsbach and Andrews, 1944:288). The objectification of withdrawal as a collection of signs and symptoms gave it a scientific truth. The truth of the abstinence syndrome, as it was referred, became known by the Abstinence Syndrome Intensity (ASI) and visualised through the use of graphs and point scale (Himmelsbach, 1941). This became a widely recognised system for seeing, knowing and governing withdrawal. The measures produced allowed for classifications and comparisons to be made with normal functioning. Abstinence deviations ranged from respiratory rate and temperature to caloric intake and basal metabolic rate (Himmelsbach, 1941). The most important point was that with respect to a condition in the body, a claim to truth and could be seen by the gaze.

Early psychiatry explained social and political problems, such as drug addiction, alcoholism, and syphilis, by making reference to “an inherited constitution” and the “stresses to which it was subject in the life of the individual” (Rose, 1986:46). From this stress and strain point of view, the experience of withdrawal, or abstinence as it became known, was explained as a form of strain on the physical body. This impact upon the individual, or organism to be more precise, became reconfigured according to the governing idea that underpinned early systems theory and medical discourses at this time; in particular, the extent to which the “mechanisms for the maintenance of homeostasis” were affected by the drug (Himmelsbach, 1941:829). Unlike the previous “eliminative treatments” in which the task of the expert was to remove poison from a body – within this ‘homoeostasis’ discourse - it was argued that “the organism...is suffering because of *abstinence from* and not the *presence of* morphine in the body” (Adams, 1939:21, emphasis original).

The body is no longer a fixed object being poisoned, but it has adjusted its own internal physiology to accommodate the poison and restore the balance to the organism. These disturbances caused by the abstinence syndrome, Himmelsbach (1941) hypothesised, were *possibly* located in a region of the brain called the hypothalamus; a region implicated in the homoeostatic functions. Importantly, this was not the only theory proposed for withdrawal; others included immunity theory, endocrine dysfunction, anaphylactic theory (Ausubel, 1948) and hyperthyroidism (Himmelsbach, 1941). It did, however, explain how the body's reaction following abrupt withdrawal of the drug and, as Himmelsbach (1941) claims, it was the theory best suited to the models of tolerance and habituation.

The ASI not only made the experience of withdrawal visible to the psychiatric gaze it also served additional functions with respect to treatment. As Winick (1957) pointed out, there is no reliable test to confirm whether a person is a drug addict or not unless they exhibit withdrawal symptoms. The ASI produced statements on the intensity of abstinence and diagnosed not only the existence of a physical dependence but also produced statements on how long it takes for the body to become physically dependent upon an opiate. Andrews and Himmelsbach (1944) claimed that signs of withdrawal were detectable only days after the first dose of morphine. The diagnostic capability of the ASI revealed the truth that “physical dependence of truly strong intensity is found only in 20 to 25 percent” of addicts (Himmelsbach, 1941:835). Since these early investigations into the abstinence syndrome (Himmelsbach, 1941, Andrews and Himmelsbach, 1944, Himmelsbach and Andrews, 1943, Wikler et al, 1953) the existence of withdrawal has become an important diagnostic criteria of an addiction and physical dependence. The abstinence syndrome, additionally, operates through a system of exclusion. This point was acknowledged by Winick. “Abstinence symptoms are not found in users of cocaine, marijuana...because these drugs do not produce physical dependence” (Winick, 1957:11). These drug users, in other words, were excluded from the category of withdrawal and therefore from the discourse of physical dependence.

The ASI produced statements that were used in the process of its treatment (Andrews and Himmelsbach, 1944, Himmelsbach and Andrews, 1943). As a rule the abstinence syndrome was to be governed within a hospital setting. This was because withdrawal was “a severe experience which may become so intense as to cause death”; it was claimed that this can only be overcome by close observation and the use of morphine

(Himmelsbach, 1941:829). There are also statements of this type in the Rolleston Report (Ministry of Health, 1926) and Mattison (1892). This statement reinforced the rule that “withdrawal should be attempted in a hospital” (1941:835). The treatment commenced upon the appearance of the withdrawal signs and symptoms and the level of morphine given to the patient was then determined by the intensity of what has been rendered visible by the medical gaze (Andrews and Himmelsbach, 1944, Himmelsbach, 1941, Himmelsbach and Andrews, 1943).

5.3.7. Withdrawal: a psychological and risky experience

The 1970s marked an important mutation in the way withdrawal was thought about and governed by the medical expert. In Britain, the approach to the treatment of drug addiction was in the process of being reconfigured, in part, due to the overzealous prescribing practices within general practice and the representation of addiction as a social problem (Lart, 1998). The psychiatrist replaced the general practitioner as an authority in the new social approach to drug addiction (Lart, 1998:61). This phase has been referred to as the *clinic phase* (McGregor, 1989) within which problems were explained through a psychiatric paradigm. The task of the clinics was to reduce the spread of addiction, mapped out by epidemiology, by removing the responsibility of prescribing addictive drugs from the general practitioner and placing it in the hands of the psychiatrist (Lart, 1998, Stimson and Lart, 1994). This new psychiatric terrain was based upon the diagram of the dispensary and took the form of out-patient units often attached to large teaching hospitals (Lart, 1998). For Armstrong (1983), the dispensary formed part of the new medical gaze of the twentieth century that developed in response to the challenges of contagious diseases like tuberculosis and venereal disease at the beginning of the twentieth century. In this new “community of psychiatry, elements previously dispersed can be brought into a functioning relationship with one another” (Rose, 1989:67). The new drug dependency units, according to Lart (1998), formed part of this new social arrangement of medical power-knowledge.

The new social arrangement of psychiatry, according to Rose, was supported by the growth in psychiatric pharmacology (1989, 2007). Psychiatric pharmacology, for Rose, merely attempted to “maintain individuals as subjects who can cope with their social roles” (1989:69). The drive to produce individuals as social citizens was very much part of the drive behind the introduction of methadone maintenance prescribing in the

United States (Dole and Nyswander, 1966) and Britain (Strang and Connell, 1994). Methadone facilitated the shift onto the controlled substances of the drug dependency clinics. Within this social form of government, the problematisation of withdrawal was based on the consideration that it was the driving force behind the addict's unproductive lifestyle. It became governed through either methadone maintenance in the community or detoxification in a psychiatric institution (Strang and Connell, 1994). The attempted banishment of the abstinence syndrome from the daily life of the drug addict was, for experts, an attractive feature of methadone maintenance prescribing (Dole and Nyswander, 1966).

Nevertheless, for certain individuals methadone failed to remove the psychological aspects of withdrawal. This marked a new and significant way to problematise the government of withdrawal both within inpatient and outpatient regimes. The problem, for Cohen et al (1983), and also Meyer (1995), was that whilst receiving methadone maintenance prescriptions some patients reported experiencing (withdrawal) symptoms and requested higher doses of methadone. The problem involved a new type of experience. This was articulated by Cohen et al as a "chronic covert abstinence syndrome" (1983:174). This hidden aspect of withdrawal was also acknowledged by Gossop and Green (1988) who claimed that following methadone detoxification some patients were still experiencing "withdrawal distress 10 days after the medication had finished" (Green and Gossop, 1988:305). This failure to diagnose the subjective account of withdrawal within the abstinence syndrome, it was argued, was attributed to Himmelsbach (1941) and his concern with the "more objective, easily measurable signs of opiate withdrawal" (Cohen et al, 1983:167, Gossop et al, 1987).

Knowledge of the psychological experience of withdrawal – *the withdrawing self* - became possible because of the objectification of the individual's inner experience by the Opiate Withdrawal Scale (Gossop et al, 1987, Green and Gossop, 1988). The use of such scales for measuring internal states, such as moods, was characteristic of behavioural approaches (Rose, 2007). These approaches, characteristic of the clinic period (McGregor, 1989), were part of a coming together of psychology and psychiatry (Rose, 1999). For Rose, this was due to the need of psychology to establish a working relation with psychiatry and legitimate itself over psychoanalysis in terms of theory and practice. This became accomplished through the language of "scientific psychology" that did not need to dig deep into the psyche but could remain, as Rose (1999:79) claims,

at the level of the problem itself; “the discrepancy between behaviour produced and behaviour desired” (1999:79). In other words, unlike biological psychiatry, it did not need to make reference to organic malfunctions – *as psychological withdrawal is not an illness* – but a “misshaping of a psychology” (1999:79). In these terms, as argued by Meyer, writing in the *British Medical Journal*, this psychological withdrawal could potentially be “often unending” (1995:310). The truth that withdrawal has a time-frame, which is often reported by drug users and experts – it has a beginning, middle and end - dissolves within this behaviourist rationality (Gossop and Green, 1988, Meyer, 1995). It then becomes possible to experience withdrawal symptoms at times long after the drug has been removed from the body. This is also proposed as a possible explanation for relapse (Wikler, 1973).

Within this ‘psychological’ discourse, the panic and fear associated with the withdrawal takes on a new form. We have seen that at the beginning of this genealogy leaving off, as it was previously known, was a concern for the individual and did not situate them within a power-relation with an expert. At the end of the nineteenth century, leaving off became reconfigured by the medical gaze as a fatal human experience and the poisoned body became, in part, dependent upon medical power and knowledge for its security. Withdrawal, as it became known, emerged as a political problem that drained the vital energy from body and population. The level of severity, for Andrews and Himmelsbach (1944), was explained by the level of opiates consumed. In contrast, for Gossop et al, it was not the dose, but “neuroticism and the levels of distress” that predicted the severity of withdrawal (1987:5). The problem of withdrawal distress was not the result of an underlying organic disorder, but a learned response to an event that had not yet happened. In other words, by the late twentieth century this fear and panic has become reproduced as a psychological experience rather than a physiological one.

As a collective and as individuals, those who take heroin over long, and possibly short, periods of time have come to recognise certain bodily or subjective experiences through the discourse of withdrawal; as *withdrawing subjects*. Withdrawal is arguably a discursive practice; a way of thinking about and acting upon the physical body and individual subjectivity of the heroin addict. The practice is not only articulated within the confines of a detoxification unit or a in the doctors surgery, in terms of a power-relation with an authority figure, but also in the cultural context within which drug taking takes place. These subcultural experiences of withdrawal have been represented

in films such as *Trainspotting* in which withdrawal is represented as an almost impenetrable barrier to a socially productive life. Interestingly, Paul Hayes, the Chief Executive of the National Treatment Agency, referred to heroin users as the *Trainspotting* generation; suggesting that fiction is also used as a reference point for the truth of withdrawal. However, within this cultural context Connors (1994) points to the fact that withdrawal is an experience that is shared and understood by other heroin users. In fact, she argues that when drug users speak about the horrors of withdrawal it can be seen as an expression of chronic emotional pain. Withdrawal, she goes on to claim, has situated the injecting drug user within risky relationships with other injecting drug users. In other words, within this field outside of the institution – and out of the reach of the psychiatric gaze – withdrawal has caught the eye of the epidemiologist.

The epidemiological gaze has become an important feature of contemporary manifestations and arrangements of governmental power (Castel, 1991) as well as a significant feature of neo-liberal forms of governmentality (Dean, 1999, Rose and Miller, 2008). The points of interaction or spaces between drug users whilst ‘in-withdrawal’ have been problematised and reconceptualised within and by epidemiology as risk enhancing (Mateu-Gelabert et al, 2010, Michel et al, 2009). This shift is articulated by Connors in an epidemiologically informed ethnographic approach that argues withdrawal had become a “barrier to HIV prevention” because it situated the injecting drug user within “at-risk” situations (1994:58). Mateu-Gelabert et al (2010) argued, in the same vein, that withdrawal contributes to poor decision making by drug users regarding whether they chose to share a syringe or not with a person who has Hepatitis C; as opposed to *rationaly* considering the long term effects. It is claimed that withdrawal might be a factor that can account for the continued increase in prevalence levels of Hepatitis C. The experience of withdrawal, therefore, is not only considered as the cause of the lack of productivity in the drug user (Dole and Nyswander, 1966), but has become a high risk factor that can be governed through the choices made by the individual drug user.

5.3.8. Withdrawal and the dopamine hypothesis: reproducing the cannabis user

Just over half a century ago Charles Winick (re)articulated the point that “Abstinence symptoms are not found in users of cocaine, marijuana...because these drugs do not produce physical dependence” (Winick, 1957:11). Historically, the experience of

withdrawal has been confined to the domain of opiates with other drug users – ‘psyche’ and ‘body’ – being excluded from the category of withdrawal syndrome. This has become a familiar and powerful discourse on withdrawal. The truth that cannabis users do not experience withdrawal, however, has recently been contested with some success (Budney et al, 2003, Levin et al, 2010). Its success can be demonstrated by the fact that cannabis withdrawal has been recognised in the proposed *Diagnostic and Statistical Manual of Mental Disorders* due for publication in 2013 (Levin et al, 2010). It is not my intention to provide a comprehensive account of this recent development of the discourse of withdrawal, but only to link this new truth of cannabis withdrawal to a recent argument on the potential reunification of the drugs field (Courtwright, 2005, Seddon, 2010) and insights provided by those currently analysing recent reconfiguration of addiction within the biosciences (Keane and Hamill, 2010, Rose, 2007, Vrecko, 2010).

Courtwright (2005) and Seddon (2010) have both given accounts of a reunification of the ‘drugs field’. For Courtwright (2005), at the end of the nineteenth century and turn of the twentieth century various drug users (cocaine, opiates, and alcohol) were becoming grouped under the umbrella term inebriety. The inebriety concept was then dismantled because its advocates were unable to demonstrate a common mechanism. Over the last thirty years, developments in the neuroscience of addiction, however, have provided an alternative account of an underlying mechanism that operates at the neurological level for a range of psychoactive drugs (Courtwright, 2005). Because psychoactive drugs can mimic naturally occurring neurotransmitters they are able to hijack the brain’s reward system and produce an overproduction of pleasure (Keane and Hamill, 2010). The part of the brain affected by psychoactive substances is the mesolimbic dopamine system, which is part of a neural reward pathway linked to reward and motivation (Courtwright, 2005). The neurochemical dopamine has been proposed as the “common denominator of all compulsions” (Keane and Hamill, 2010, Vrecko, 2010:39). This is the dopamine hypothesis.

Seddon, in commenting on Courtwright’s (2005) account, situates this “long drift back” within the unfolding of neo-liberal forms of governmentality (2010:95). For Seddon, the practice of risk thinking, which is characteristic of neo-liberal government, supports a unifying trend and potentially suggests an opening up “of a fault-line underneath the ‘great regulatory divide’” (2010:96). Seddon, however, is sceptical about the wider

implications of a unifying trend for drug regulation (such as legalisation). However, this reunifying trend, which has been explained by developments in technologies of government, can provide a helpful way of explaining the new power-relations that have been implicated in the production of the truth of cannabis withdrawal and, in turn, the reproduction of the subject.

The truth of cannabis withdrawal, I have suggested, has been produced within this new configuration of biological psychiatry that has, in recent years, displaced psychological explanations in favour of neurochemical ones (Rose, 2007). This has included a new explanatory framework within the addictions field, within which concepts such as withdrawal and tolerance have been reconfigured. For Rose (2007), since the middle of the twentieth century, psychiatry has been mapping out what he refers to as a molecular style of thought (Keane and Hamill, 2010). The techniques of seeing the body as made up of organs, tissues and cells has given way to a new way of seeing mental pathologies in terms of an alteration in brain chemistry. These developments in biological psychiatry, Rose argues, are linked to new ways of seeing the brain. The brain has become one more “organ of the body to be opened up to the eye of the doctor” (Rose, 2007:196). This “psychiatric brain”, as Rose points out, is made up of chemicals, such as dopamine, and these chemicals influence conduct through acting upon the brains communication channels, such as its receptor sites and synaptic vesicles. New entities such as neurochemicals, receptor sites and receptor blockades have been brought into being within this style of thought (Rose, 2007). All, at some point, were disputed but are now taken-for-granted and treated as known entities that can be “written down or drawn in a graph” (2007:190).

On the one hand, these developments in biological psychiatry have been linked by Rose (2007) to the development of new techniques for visualising the brain and the expansion of the pharmaceutical industry. The crucial point is that the brain’s communication channels can be acted upon through fabricated chemical compounds – *pharmaceutical drugs* - which are believed to mimic brain chemistry. This new style of thought has welded “psychiatric etiology to psychopharmacology” and, moreover, underpinned the development and marketing of psychiatric drugs that claim to be therapies for all kinds of diagnoses (Rose, 2007:200). This can be put another way: Within the psychiatric institution, as we shall see in chapter 8, drug addicts were viewed as a drain on the national economy, whereas now, as Rose (2007) has pointed out in relation to mental

illness in general, they have become vital opportunities for the creation of private profit. The demand for profit has ultimately come to signify, he argues, what counts for our knowledge of mental disorders.

On the other hand, the formation of knowledge of addiction as a pathological state of brain functioning has been linked, not only to the above style of thought, but to an ‘addiction neuropolitics’ (Vrecko, 2010). Vrecko argues that research into the neuroscience of addiction has moved from a marginal field, as it was during the 1960s and 1970s in the United States, to a well funded and state sponsored speciality that has played an important role in the development of the above molecular style of thought (Rose, 2007, Vrecko, 2010). The formation of the Special Action Office for Drug Prevention by President Nixon allowed addiction science to form as a solution to the emerging drug-related problems of 1970s’ American society. For Vrecko, the formation of a state-sponsored addiction science explains how the scientist’s laboratory became an “obligatory passage point” for the production of truth of addiction (2010:58). The point that Vrecko is making is that the conditions required for the development of addiction neuroscience are historically contingent and dependent upon social, economic and political factors. The reunifying trend that has been made possible by developments in the neuroscience of addiction, in other words, is not politically neutral but has emerged and developed in tandem with broader strategies to control not only the heroin user, but also the cannabis user.

It is being argued here that one of these ramifications of the deployment of the dopamine hypothesis within the addiction field has been the (re)production of new subjects of withdrawal. Human experiences and processes such as dependency and withdrawal have been represented as neuroadaptations and are believed to result from the repeated excitation of reward pathways by psychoactive substances (Smith, 2002). Wickelgren, a scientist currently working in this field, has argued; “the active ingredient in marijuana...results in the same key biochemical event that seems to reinforce dependence on other drugs, from nicotine to heroin” (1997:1967). On the surface, and an experience that can be observable and measured, the substances produce a detectable level of anxiety; “this may be part of a common experience in withdrawal” (Wickelgren, 1997:1968). Most of these developments in the brain sciences, as Rose (2007) has suggested, are often hypotheses that soon establish a level of truth. Furthermore, these developments, as Smith points out, have opened up this area of research for

investigation and, importantly, the “potential pharmacological treatment” of cannabis withdrawal (2002:622). In many ways, this is one of the consequences of this reunifying process; the emergence of novel ways of governing drug users that have, up until recently, been out of the scope of conventional drug treatment technologies.

5.4. Conclusion

This chapter has attempted to ground the discourses of natural recovery, needle fixation and withdrawal within their historical context. The purpose of this chapter was to critically interrogate the historical formation of the discourses of recovery capital, needle fixation and withdrawal. A central theme of each of these genealogical investigations was the implication of power, knowledge and subjectivity in the government of the individual. In this respect, the genealogy of recovery capital argued that knowledge formed from natural recovery research into middle class drug users has recently been introduced into the recovery movement through the concept of recovery capital. Moreover, it was argued that this concept exercises power upon the treatment population through a dividing practice. In the second genealogical investigation into needle fixation, it was argued that needle fixation exists in tension with the dominant risk management strategies of harm reduction. In short, both discourses support and reproduce different subjectivities. In the final genealogy, it was argued that withdrawal was formed within the politics of health within the eighteenth century. The attempt to make withdrawal governable resulted in its transformation from a form of self-government to a biopolitical concern requiring expert intervention. The key theme is the formation of withdrawal as a dangerous experience. These genealogical analyses revealed similar themes and indicated important problems concerning the relation between discourses on poisoning and addiction in the eighteenth and nineteenth century. These will now be explored in more depth in the next chapter.

Chapter 6

Poisoning the body and population

6. Introduction

The previous chapter has raised some fundamental issues about the nature of withdrawal and the productive role of discourses on poisoning. For instance, how did it become possible to speak of the body of the morphine user as poisoned? How did it emerge? What has been the effect of this? Nonetheless, this chapter will also be analysing an historical period that has been discussed elsewhere (Berridge, 1999, Foxcroft, 2007, Harding, 1986, Seddon, 2010). In this respect, my intention is also to provide further insights to this historical period and demonstrate, in essence, what has been neglected. The argument that is developed in this chapter is that the rationalities and technologies that continue to have meaning within contemporary drug treatment practices are in fact embedded within historical processes concerned with the government of poison and poisoned bodies. First, this chapter will develop this argument by situating this poison-dynamic alongside the framework of sovereignty. Second, it will chart the transition from the sovereign axis of power to the governmental axis of power by situating it within a historical struggle between physicians and apothecaries and the emergence of biopolitics and a population-poison dynamic. Third, after establishing this ‘poison rationality’ it will then go on to highlight not only the link between its discursive practices and the addiction discourse (which is referred to as morphinism), but its productive impact on the objects and subjects of its discourse. The chapter will conclude with brief reflections on the Rolleston Report (Department of Health 1926) and ultimately on how the methods of detoxification and maintenance prescribing found in drug treatment is dependent upon this field of poisoning.

6.1.1. The sovereign-poison dynamic

The genealogy of withdrawal introduced the thesis of a poison-naïve population. Before I sketch out this argument I will discuss the threat from poisons within the context of sovereign power. Foucault defined sovereign power as “the right to decide life and death” or “the right to *take* life or *let* live” (1978:135-36) and argued that “this judicial

form must be referred to as a historical type of society in which power was exercised as a means of deduction...a subtraction mechanism” (1978:136). The objective of power was the “defence of the sovereign, and his own survival” (1978:135). This is the self-referential problem of sovereignty; a feature of this form of power (Dean 1999, Foucault 2007). An example from seventeenth century France - the ‘affair of the poisons’ - can be used as an illustration of this sovereign-poison dynamic. In brief, members of the aristocracy close to Louis XIV’s inner circle, including his mistress, were sentenced on charges of poisoning. This presented a threat to the life of the sovereign and his power to rule. It is not my intention to discuss this particular incident at any length (see Somerset, 2003 for a detailed discussion). I will only outline the techniques and objectives of power before they became re-centred onto the population-poison dynamic – *in terms of threat*.

The example contains two techniques of power that operated according to the rules associated with sovereign power (Foucault, 1978, 2007). First, sovereignty was exercised through the production of truth and judicial procedures; by his right to take life through various technologies of torture and punishment. Unlike the ‘public spectacle’ analysed in *Discipline and Punish* (Foucault, 1977), this torture imposed itself on the body of the poisoner - as a *judicial subject* - within the shadows of the *Chambre Ardente* (burning chamber). This was a room with all daylight excluded that functioned as a court of justice, initially for heretics. Similar judicial mechanisms of power were exercised on the victim of suicide – *the self-poisoned*. Taking one’s life, as Foucault notes in the last pages of *The History of Sexuality*, was a crime as it was a way to “usurp the power of death...which the sovereign alone...had the right to exercise” (1978:138). This can be contrasted with the victim of a heroin overdose where, in its contemporary form, power would operate to restore life.

Unlike this circular relation of sovereignty between the judicial subject, the law and the sovereign, in the seventeenth century the governmental technology involved the strategic arrangement of poisons, along with the production of knowledge of their existence and utility. Foucault described this type of governmental practice as ‘dispositional’:

“[I]t is not a matter of imposing laws on men, but of the disposition of things, that is to say, of employing tactics rather than laws, or, of as far as possible

employing laws as tactics; arranging things so that this or that end may be achieved through a certain number of means” (2007:99).

This strategic arrangement of poisons began with a ‘system of surveillance’ over and including apothecaries, fortune-tellers and alchemists. Strategically, apothecaries were prevented from selling poisons to anyone they did not know and the buyer was forced to sign a register stating its use (Thompson, 2003). The knowledge derived from this strategic arrangement of apothecaries and poisons initially served the interest of the sovereign – *his preservation* - and his immediate locality. This technology was initially concerned only with the ‘body’ of the sovereign. Only later would government technologies be deployed on the population in general. The previous genealogy on withdrawal made an important reference to the struggle for power between apothecaries, pharmacist and physicians for it is this struggle, which this chapter will now discuss.

In 1617 in England the Society of Apothecaries was granted a charter giving them the legal right to sell compound medicines within the city of London and the Suburbs within seven miles of the city (Ellis 1963). With an increasing demand for private medical care and no clear boundaries governing medical practice (Jewson, 1976), it is understandable how apothecaries came into professional conflict with the College of Physicians. This conflict began in the early sixteenth century when apothecaries moved away from physicians to practice independently of their assistantships (Bell, 1843). Jacob Bell was a key figure in the formation of pharmacy and provides commentary on this historical struggle. This professional conflict came to the fore with the developing political and professional concern for the unregulated circulation of poisons. Within this context, apothecaries were being accused of treating patients with large (poisonous) quantities of medicine for the purpose of profit, though with devastating consequences on the life of the patient (Anon, 1701, Corfield, 2009). This, as I pointed out in the previous chapter, raised questions on the topic of dosing. The apothecaries, however, were undermined by the physician’s legal position.

At the physician’s disposal the legal ‘*right to search*’ or “examine, survey, govern, correct, and punish...Apothecaries, Druggists...and sellers of waters and oils, and preparers of chemical medicines” (College of Physicians, 1553, quoted in Bell, 1843:6). This was the College of Physicians Act 1553. It can be argued that this regime was still caught within the framework of sovereign power, which is the “right of seizure; of

things, time, bodies and ultimately life itself” (Foucault, 1991:259). In light of the increasing threat from poisons towards paying customers, during the eighteenth century this Parliamentary Act was amended to include any medicinal compounds thought to be harmful to the “Health of Man’s Body” (House of Commons, 1724a: 3). Although this demonstrates an important shift in the economy of power, which was characteristic of the eighteenth century (Foucault, 1977), it is not until the nineteenth century that these ‘technologies’ shifted from preserving sovereignty and found their ‘reasoning’ and ‘deployment’ on the body of *population*. This is not to say that there were not medical concerns with population and poison, as the genealogy on withdrawal has demonstrated, but that an important shift can be detected in the nineteenth century.

6.1.2. *The population-poison dynamic*

In the first half of the nineteenth century, population, or the “species body”, as Foucault (1978:139) referred to it, emerged as a new object of concern with regard to the threat from the circulation of poisons. In fact, population provided a new conception of the governed in terms of health and mortality and essentially the rationale for the regulation of poisons. Population is

“imbued with the mechanisms of life and serving as the basis of the biological processes; propagation, birth and mortality, the level of health, life expectancy and longevity, with all the conditions that can cause these to vary” (1978:139).

As Dean points out, “members of a population are no longer bound together in a territory who are obliged to submit to the sovereign” (1999:107). In other words, it is not just a new conception of the governed that emerged at this time, but a new governmental rationality that no longer recognised the individual as just a judicial subject, but as a living, speaking member of a population. The development of this population, as *poison naive*, as I shall call it, owes its formation to economic, scientific and political processes.

From an economic perspective, the forces of the free market economy, within which poisons were not only being traded as commodities (Seddon, 2010) but re-categorised in terms of their monetary value and practical application, enabled the penetration of poisons into the very depths of medical, domestic and ultimately, biological life. Poisons had entered the home: They were used as pest control; they were used and kept

in the kitchen; purchased by young children; used as medicine; and used for interior decoration as well as to enhance women's bodies (Bartrip, 1994). Experts, moreover, were claiming that poisons in "moderate doses...may be entirely deprived of its poisonous qualities" (Christison, 1829: 213). This medicalisation of poisons resonates with the statements made by Jones (1701) and Mead (1747). The main point being made is that the free market economy and liberal medicine had filtered poisons in various forms from the medical to the cosmetic into the depths of population.

The nineteenth century, as Burney (2002) and Bartrip (1994) have pointed out, can be referred to as the poisoned century. The increased presence of poisons, it is argued, contributed to an increase in cases of accidental and intentional poisonings (Bartrip 1994, Burney 2002). Seddon (2010) has made a similar point regarding the problematisation of opium by the public health campaign which resulted in the emergence of a 'regulatory framework'; a point that is at the heart of his argument. For Seddon (2010), this problematisation was associated with the emergence of population; a theme that was crucial for the emergence of liberal forms of governmentality (Dean, 1999, Foucault, 2007). In a similar manner, it can be argued that the emergence of population allowed for these techniques of poison regulation, which once took the preservation of the sovereign as their objective, to be re-centred onto the health of the population. This begs the question; how was this problem space of population represented and made governable?

For Foucault (2007), the emergence of population was tied to the development of statistical modes of analysis. Hacking, furthermore, has argued that during the nineteenth century "there was an exponential increase in the number of numbers...The enthusiasm for numbers became almost universal" (1991:186). The answer to the above question lies with this technique for representing population; statistical representation spilled over into the domain of poisoning. Statistics revealed that levels of accidental and intentional poisoning existing – *separate from the sovereign* – in the population that were ultimately not reducible to the individual. This 'truth claim' of a 'poisoned population' enabled modern pharmacists (as opposed to the medieval apothecaries) to resituate their historical struggle with physicians away from the language of sovereignty and law and onto the language of bio-politics and expertise. This transformation of power would not have been possible without a new representation of 'population'.

6.1.2.1. Pharmacy and population; poison naivety and the poison book

Accounts of the history of pharmacy have been given as early as Jacob Bell (1843) and more recently by Holloway (1991). Berridge (1999) and Seddon (2010) provide important though different historical accounts of the development of ‘drug regulation’ and its relationship to the Pharmacy Act of 1868. This new conception of the governed that emerged in the processes identified above, I have given the label ‘poison naive population’. This is a way of thinking about population, not only as an object which can be poisoned, but as a form of poisoning which can be governed. As I have just noted, techniques of ‘seeing’ and ‘speaking’ about population can be traced to the bio-political practice of producing statistical truths of the levels of births and deaths and health and longevity associated with population (Foucault, 2007, Hacking, 1991). Arguably, it is with this bio-political practice - the collection of statistics - that incidents of poisoning became known through the techniques of writing, recording and explaining; furthermore, the reasoning given to this form of ‘problematic conduct’ constructing an image of population as poison naive. The following statements were provided by coroners within the House of Commons to explain the conduct:

“verdict accidental death, from ignorantly taking too large a dose of laudanum” (House of Commons 1839:4); “Accidentally poisoned in giving laudanum instead of tincture of rhubarb” (1839:6); “given in mistake of other medicine” (1839:12). *This list could go on.*

The Pharmaceutical Journal also repeated this statement - “administered in ignorance of its effects” (1865:37) - within parliamentary discussions; thus producing a new way of thinking about poison, *not in terms of a lack of rights, but in terms of a lack of knowledge*. For example, “as the law stands, any man, however ignorant-an individual unable to sign his own name-half whose shop is stored with butter, bacon, cheese...shall from the other half have the power of dispensing, to any person applying, preparations of mercury, arsenic, opium etc. etc” (Pharmaceutical Society, cited in Bartrip, 1992:60). To put this point another way, this naivety became an essential tool of the power of pharmacy.

This argument opened up a division between the ‘knowledgeable’ expert – *part of the emerging expert-population* - and the ‘irrational subject’; part of an emerging ‘population’ lacking in expert forms of knowledge. Developing this point further; the

domain of the pharmacists was unlike the domain of the apothecary for it was not engaged in a struggle with physicians and its ability to conduct itself was not caught up within, and disabled by, the framework of sovereignty. Instead, the domain of pharmacy was engaged within a bio-political struggle with the population and instead of rights, it found its power in knowledge; the Pharmaceutical Society informed its members that “knowledge is the true source of power, position and respectability” (The Pharmaceutical Journal, 1852b: 97). The ‘free’ subject of economic interest (Foucault, 2007) became problematised by his/her own ‘poison naivety’.

The meeting up of these two forms of subjectivity – *subject of interest and subject of naivety* – produced a tension between classical liberalism and biopolitics. This tension was summed up by John Stuart Mill;

“the sale of poisons, opens a new question...how far liberty may legitimately be invaded for the prevention of crime, or of accident. It is one of the undisputed functions of government to take precautions” (Mill, 1859/1974:165).

It is important to note that Seddon interprets the above quote by Mill (1859) as describing a point of tension that emerged “with the transition from a police economy to a liberal industrial one at the end of the eighteenth century” (2010:44). The technique that supported the objective of preserving the ‘subject of interest’, in light of the bio-political problem of poisoning, was the poison book.

The poison book, proposed in the Arsenic Act of 1851 (Bartrip, 1992, House of Commons, 1851), recorded the personal details of the individual, the reason for purchase as well as quantity sold; thus making the purchaser visible – as a ‘*case*’ - in the eyes of the pharmacist. The poison book was described by Mill (1859/1974) as a contract between the individual and society:

“Precautions of a similar nature might be enforced in the sale of articles adapted to be instruments of crime. The seller...might be required to enter in a register...Such regulations would in general be no material impediment to obtaining the article, but considerable one to making an improper use of it without detection” (1859/1974:167).

Mill understood the poison book as a way of promoting market freedom whilst at the same time overcoming the bio-political threat from poisons. The poison book, on the

other hand, was not a new technique but one that had previously functioned within the framework of sovereignty.

The technique of the poison book, however, became criticised by Taylor who argued it was ineffective because “the persons who brought the arsenic had not the ability of writing; they made a cross” (House of Commons, 1852: 96). His concern was with the cases of criminal poisoning associated with the lower classes. Instead, he argued that the “the dose should be swallowed in the presence of the druggist” (House of Commons, 1852: 102). Although this technique did not come into effect in the nineteenth century, it has become an essential (taken-for-granted) technique for governing the methadone client within the modern drug treatment system. Methadone subjects are required to consume their daily dose of methadone in front of the ‘expert’ arguably because they are excluded from being able to participate within a social contract like those illiterate untrustworthy subjects of Taylor (1852). This practice is the point at which most resistance against the power-relations within methadone maintenance occur and those who resist this power arrangement are problematised and normalised for not cooperating.

6.1.3. The body-poison dynamic; poisoned subjects and poison removal

The body of the poisoned subject first entered the machinery of knowledge production, not within the context of this ‘poisoning rationality’ but within criminal poisoning trials at the beginning of the nineteenth century (Christison, 1829). Criminal poisoning reached epidemic proportion during the nineteenth century (Bartrip, 1992, 1994, Burney, 2002). Burney, a commentator on nineteenth century poisoning, claimed poisoning was a “crime that exercised a peculiar hold on the public imagination” as it provided a theatrical relation between scientific forms of knowledge and acceptable evidence (Burney, 2002:292). Criminal poisoning occupied a prominent place within medico-legal treatises (Burney, 2002), most notably in the work of Professor Christison (1829) and his discursive construction of the body-poison dynamic.

The scientific accounts of truth of poisoning became subjected to problematisation within the court room. Previous forms of truth relied on the expert tasting and smelling for poison in the dead body, though in nineteenth century this failed to gain universal support (Burney, 2002). Christison also made important criticisms against the acceptable level of truth of poisoning:

“So lately as 1763, and even in Germany, the solemn opinion of whole colleges was sometimes grounded almost exclusively on the symptoms” (1829:32).

On the one hand, this problematisation of truth was raised by the demands of the law, and on the other hand, the emergence of the body as an object of medical and political discourse. In England, the law stated that any death resulting from the administration of a poison “must take place within a year” for it to be defined as a crime (1829:34). But Christison maintained that “a person may be carried off by a malady, the seeds of which have been sown by the operation of poison years before” (1829:34). Investigating and knowing the biological processes of poisoning enabled the expert to speak the truth of the crime through a new expert discourse of the body – and independently of earlier legal definitions.

The truth needed for trials became produced from two techniques of examination, which represented the body in different ways. The first technique for overcoming the problem of truth was the Marsh Test, which was developed in 1836 and was used for “detecting arsenic...white arsenic or arsenious acid” in the “body” (Marsh, 1836:229). The test became a valuable technology for producing scientific truth from the contents of the stomach. Essentially it allowed the body to speak through the discourse of the expert. The Marsh Test, however, was limited because it can only confirm the existence of poisons rather than the temporal and dynamic processes required by legal proceedings. This same limitation is traced to present day technologies of drug testing.

The second technique was the medical practice of mapping out the body of the dead which produced a detailed knowledge of the temporal processes, or the biological journey that poisons made through the body (Christison, 1829, 1850). Foucault defined mapping out the geometry of the body as the production of an “anatomical atlas” (1986:3). The atlas, Armstrong points out, “depicts the organisation and solidity of the three-dimensional body on the two-dimensional page...The atlas renders the body transparent; it is a means of making the body legible to an observing eye” (1983:1). The truth of taste and smell has no place on the atlas as truth. The atlas described how poisons entered the body and then moved to the stomach where, on occasion, because of the damage done to the inner surface of the stomach death by starvation would occur. Poisons moved from one organ to the next through “the sentient extremities of the nerves and conveyed thence along their filaments to the brain” (Christison, 1829:5).

This kind of knowledge enabled juries to make the distinction between what is true and what is false regarding the poisoned body and the conditions leading to the poisoning. It became a discursive practice.

The atlas which represented the ‘toxicological self’ or the ‘poisoned subject’ developed during the nineteenth century as toxicologists became more involved in criminal poisoning trials and the practice of pathological anatomy. It was during this process of construction that Christison was able to categorise the individual body in terms of their relation to poisons. In particular, he identified two biological features of this toxicological subject - *habit and idiosyncrasy* - and argued that they “are important in a medico-legal point of view...for they show how one man may be poisoned by a substance generally harmless, and another not be injured by a substance generally poisonous” (1829:27).

Habit explained the diminishing effects of poison or when it “loses its effect after a time, and required to be administered in a much larger dose” (Taylor cited by an anonymous author in *The Medical Times*, 1845:208, see also Taylor, 1861). Taylor later suggested that there is “a difficulty in assigning the tolerance of the poison merely to habit” (1861:694) for tolerance is a condition “in diseases of the lungs in reference to the use of antimonial medicines” (1861:22). Whereas, idiosyncrasy, Taylor claimed, “differs from habit...it does not, like habit, diminish the effects of a poison...some constitutions are observed to be much more affected than others by the use of certain poisons...thus opium, arsenic” (Taylor, 1861:21). The statements on habit, tolerance and idiosyncrasy formed a system of statements or an arrangement containing discursive rules of exclusion and inclusion, which, at this time, found their truth within the discursive field of poisoning as opposed to the discursive field of the opium eater / and later addiction.

The anatomical atlas representing the ‘poisoned body’ later found expression through the technologies used on those individuals accidentally and intentionally poisoned. When a person was poisoned, it was claimed that the “primary object is to remove the poison from the stomach” before it reached its destination (Christison, 1829:544). Christison claimed that the patient must be kept “constantly aroused” by dragging “him up and down between two men, who must be cautioned against yielding to his importunate intreatises and occasional struggles to get free and rest himself” (1829:545). On this point Dr Chowne suggested that “four to five hours” is an adequate amount of

time to walk for the body to be over the ‘coma like’ sleep (1842:706). To take a step closer to the experience of the withdrawing body, it is with this practice of removing poison from the body that Christison argued that an opium habit could be “broken off abruptly, without danger”; if the body is being poisoned then it is rational that the poisoning be stopped (Christison, 1850:537).

This ‘poisoning rationality’ became juxtaposed with the field which governed the treatment of opium eating during a debate between Christison (1850) and Little (1851) over the correct way to remove opium from the body. Christison, coming from the toxicological background, argued that the practice should be abrupt and his rationale was made from the poisoning registry. Little (1850), working as a medical expert in China, took a different perspective to curing the opium habit. From his observations of non-medicinal use of opium in China, which was his primary concern, he argued that “it is impossible to give up the habit at once with safety” and provided detailed instructions concerning the gradual reduction of opium with the help of various tinctures (1850:530). Interestingly, Little’s practice of removal was governed by a distinct medical reasoning which did not acknowledge Christison’s concern with poisoning; Christison’s approach predominated. *The argument being made is that the rationale of ‘poisoning’, a poisoning discourse, was brought to bear on the body of the opium habitué; or, it would be more right to say, produced the body of the opium habitué, when in the withdrawal phase, through the discourse of poisoning.*

6.2. Morphine and moral poisoning: liberty and upper-class society

In 1877, Edward Levinstein published the very influential *Die Morphiumsucht*, translated into English in 1878 as the *Morbid Cravings for Morphia*, in which he described the “ill effects which continued injections of morphia have upon the human body...the dangers threatening society...and...the remedies for the redress of this abuse” (1878: preface). Unlike the incidents of accidental and intentional poisoning found within the population this form of poisoning involved habit and pleasure and threatened the medical, moral and political processes of society. The medical critique problematised the misguided freedom of the liberal citizen by arguing that the public were free to use their “liberty” to poison themselves (Sharkey, 1878:342) and, in particular, the public were unknowingly “allowed to poison themselves without let or hindrance” (Sharkey, 1887:342). For Hickman, this modern medical technology

threatened “the bourgeois subject’s” sense of “autonomy, will power, and self-mastery” (Hickman, 2004:1274).

The object of this problematisation was the “higher and more educated classes of society” (Levinstein, 1878:4). Sharkey, for instance, claimed that “people will be startled to hear...London society resorts freely to the use of morphia injections for the purpose of killing time or of producing certain vague and pleasurable sensations” (1887:336). These views were expressed by physicians in London, Paris and Berlin and were directed, in particular, at “ladies, even belonging to the most elegant classes of society” (Levinstein, 1878, Sharkey, 1887). It is worth citing the liberal philosopher John Stuart Mill on the importance of morality and the authority of the ruling class:

“Whether there is an ascendant class, a large portion of the morality of this country emanates from its class interest and its feelings of class superiority. The morality between Spartans and Helots, between Planters and Negroes, between princes and subjects...and men and women” (1859/1974:65).

Underpinning this criticism was that through poisoning the nervous system with morphine the bourgeois liberal citizen would become a “moral paralytic” (Sharkey, 1887:339). Poison paralysed the morality of the individual because it imposed itself on the nervous system (which regulated moral energy).

These links were made possible not only by discourses of poisoning, but interests in the medical concept of neurasthenia towards the end of the nineteenth century. It was claimed that nervous exhaustion was brought on by the “changing modern environment” (Hickman, 2004:1281). I have already discussed neurasthenia in the previous chapter. The links with this discourse, on the other hand, allowed for statements such as that “neurotic subjects” were predisposed to developing morphinism (Anon, British Medical journal, 1880:668) or to suffer from incidents of poisoning (Harrison, 1989). Lead poisoning at the end of the nineteenth century is an example of a form of poisoning which was described as a disorder affecting the nervous system (Harrison, 1989). In this example, the biological concept of idiosyncrasy, found in the work of Christison (1828), explained why more females were poisoned by lead than males. In summary, by aligning itself with the liberal agenda, the medical profession pushed forward the argument for greater control over self-poisoning by syringe. This

was an argument developed earlier in this thesis, where I analysed needle fixation in terms of medical power and knowledge.

Not all citizens (mis)used their liberty and risked poisoning themselves. However, it became essential for all citizens, for society itself, that the potential be removed from the hands of the public. In principle, the medical profession were allowed to poison society with the syringe, though society was not authorised or knowledgeable enough to poison itself. Statements of this kind also appeared in Allbutt (1871), Anstie (1871), Levinstein (1878) and Sharkey (1887). At the heart of this intervention is the idea that the poisoned subject is produced through poisoning alone; and, in the same way other dangerous subjects, becomes a “quantum of uncertainty” (Castel, 1991:283) and unable to make a rational decision to detach from the syringe. As a medical subject, they become intertwined with the demands of medical and political power; their subjection was a necessary condition of their liberty.

6.2.1. Creating a ‘type’ of poisoned subject: the morphinist

What happened when these individuals continued to (mis)use their liberty and resist medical and political power by poisoning themselves? How were these individuals to be known and made governable? In the context described above, medical power first assigned these individuals to a patient group and then objectified them through the medical concept of morphinism (Levinstein, 1878, Sharkey, 1880). The practice of opium eating was problematised at the beginning of the nineteenth century in the context of life insurance and longevity (Seddon, 2010). Researchers have tended to investigate the shift from habit to disease from the perspective of class tensions and medical and pharmaceutical regulation (Berridge, 1999); wider transformations in the conception of freedom (Seddon 2010); and pathologising of the soul (Harding 1998). Although important works, *this thesis will draw attention to the permeation of this poisoning rationality and its subjects into the discourse of dependency and addiction treatment practices.*

The first point to note is that Levinstein articulated the medical concept of morphinism as a form of “morphia poisoning” (1878:2). It has already been pointed out that this statement can be located in the early nineteenth century. This discursive field of poisoning provided statements from which concepts such as morphinism, addiction and dependency were formed. This poisoning rationality has had a lasting effect on the way

in which we think about and act upon problem drug users. To take an earlier example, such statements were produced and deployed by Levinstein (1878) and later in Crothers (1893). In relation to treatment, Crothers urged that if the “patient is being poisoned...the poisoning must be stopped...were it arsenic instead...no one would dispute this” (Crothers, 1893:197, Levinstein, 1878). The discursive field of poisoning provided the rules in which such statements were not only possible but made sense. Similar statements on poisoning were also made in relation to the alcohol user.

Morphia poisoning was identified through two separate types – *acute and chronic* – with both being identified by Christison (1829). It was not just the subject of morphia poisoning that was divided and produced through these categories in the nineteenth century; “Lead poisoning was seen as having either acute or chronic forms” (Harrison, 1989:174). Acute referred to accidental and intentional cases of poisoning. Chronic morphia poisoning, on the other hand, was understood as a “diseased state of the system...caused by the injudicious use” of morphine (Levinstein, 1878:3). The “cerebrospinal and sympathetic nervous system” (Levinstein, 1878:11) became the object – the final destination – or site within the human body that became *chronically* poisoned. The terms *acute* and *chronic*, which belong to this poisoning registry, continued to be used during the nineteenth century as a way of identifying and producing poisoned subjects. For instance, in relation to morphinism, “chronic opium poisoning...is characterised by repeated nerve excitations” (Crothers, 1893:317) and “the repeated poisoning culminates in chronic poisoning” (Kerr, 1894:345).

The genealogy of this poisoned subject, along with its associated rationalities and objects can be traced back then to toxicological discourse (Christison, 1828, 1850). Poisoning became represented in what can be described as a bio-journey - the temporal processes through which poisons move in and around the body. Chronic poisoning, it was claimed, became noticeable only after a period of four to six months, with some signs showing up after years of being poisoned. It was understood and mapped out as a biological process and the longer the poison circulated around the body then the more poisoned the body became. With particular reference to the present, researchers continue to ‘think’ and ‘speak’ within this registry of poisoning when they ask pertinent and critical questions; such as *How quick to dependence?* (Coomber and Sutton, 2006). Interestingly, Levinstein arranged this condition alongside other “mental diseases following intoxication, such as chronic intoxication with alcohol, lead, arsenic, and

oxide of carbon” (1878:7). Later in the nineteenth century experts began to use the ‘problematising framework of addiction’, which developed from the conditions of poisoning, to question the practice of arsenic eating (Kerr, 1894).

6.2.2. Arsenic and the arsenic eater: A poisoned subject

So far I have demonstrated how morphinism became constructed, in part, through a discourse of poisoning. The historical link between opium and arsenic also allowed statements, which were applied to the consumption of opium, to be applied to the consumption of arsenic. The discursive fields of poisoning and morphinism were mutually conditioning. The truth of the arsenic eater emerged as a defence within judicial proceedings. It was used in court by those accused of poisoning as a form of defence. They claimed they did not poison the person. He was an arsenic eater and poisoned himself. This raised the question of whether an arsenic eater really existed. The following newspaper article provides an excellent illustration of the practice of arsenic eating and its resemblance to the dependency syndrome, as described in the International Classification of Diseases.

“At the meeting of German naturalists and physicians held in Graz in 1875 two arsenic eaters were produced, who consumed-one thirty centigrammes of yellow arsenic, the other forty centigrammes. A dose of six centigrammes would to most men be poisonous...Indulged in as a remedy then as a pleasing stimulant, it comes gradually to be taken as a matter of habit and cannot be discontinued with impunity. Strange to say, all the symptoms of arsenic poisoning become apparent in those who leave off the drug suddenly. The body wastes away, a feverish thirst sets in, the limbs lose all their force, the skin dries up, the gait becomes unsteady...There are of course remedies which can alleviate the pain...but fail to cure...the body can only be restored to its former condition by a renewed indulgence in the poison” (quoted in the New York Times, 1889).

Norman Kerr, a leading figure of addiction/inebriety, claimed that the “practice of arsenic taking is spreading slowly among us, but yet at a more rapid rate than is generally supposed” (Kerr, 1894:151). In reference to the arsenic question – is it an addiction? - Kerr answers no. The answer is not important; it is the conditions which make this question possible that is important. For Kerr, as well as for Crothers (1893), the “general rule” of exclusion and inclusion into the category of addiction was based

on “the thinking power and moral sense”, which with arsenic, “are...not at all directly affected” (1894:153). It has nothing to do with the “demand for fresh increasing supplies” or the impression made on the “human economy” (Kerr, 1894:153); in other words, arsenic does not attack the soul. This criterion is important as this marks a radical break with morphinism.

6.2.3. Poison removal technologies: The abrupt withdrawal of poison from the morphinist

Levinstein (1878) advanced the first expert arrangement of practices to treat chronic morphine poisoning. Levinstein’s work was very influential and provided an important starting point for what followed (Berridge, 1999, Seddon, 2010). It is possible to identify a particular ‘way of thinking’ about the practice of de-poisoning; a political conception of the subject being governed; and, techniques for restraining the individual. The rationalities were, in part, embedded within this discursive field of poisoning which regulated what could be said and done regarding the government of this ‘poisoned subject’ (Christison, 1829). Informed by poisoning rationalities associated with this poisoned subject, it was advocated that de-poisoning should follow the abrupt method which was highlighted above, because if the body is being poisoning then it is only rational that the poisoning must be brought to an end (Crothers, 1893, Levinstein, 1878).

With regards to the individual, there is a particular conception of a subject accorded with the rights and responsibilities needed to become a liberal citizen. Furthermore, as demonstrated above, the way in which this subject conducted themselves needed to be in line with the broader political and social order. In reference to this point Mitchel Dean notes that

“Within liberal forms of government...there is a long history of people who, for one reason or another, are deemed not to possess or display the attributes (e.g. autonomy, responsibility) required of the political subject of rights” (1999:134).

It would be inaccurate to claim that the morphinist, as one of *those people*, permanently occupied this ‘irrational space’ in a similar way to other irrational or abnormal subjects from the nineteenth century, such as the deviant, criminal and the feeble-minded (Foucault 2006). It is more precise to suggest that the conduct and subjectivity observed within the abrupt de-poisoning phase – *represented as a place caught between reason*

and unreason - belonged to this irrational group (Foucault, 2006). This particular experience can be illustrated by Levinstein, in which he observed the following: “quarrelsomeness, want of sleep, hallucinations...trembling of the hands, and increased reflex action” (1878:11). The patient even “runs around the room, cries and screams” (1878:51). The individual is commanded by a “passion” caused by the insidious use of hypodermic morphine (1878:112). It was thought rational then that governing the withdrawing subject – *the subject incapable of rational control* - must be performed within an institution (Levinstein, 1878).

Confinement and restraint were important political technologies used in the exclusion of certain types of humans from the category of the rational individual during the nineteenth century (Castel, 1991, Dean, 1999). Removing freedom and responsibility from the individual ensured they would not compromise the de-poisoning process as they were considered a hindrance. Foucault’s *Madness and Civilisation* and *Discipline and Punish* are good examples of how certain individuals within society come to be judged and excluded from what it means to be a normal citizen. The link between power, knowledge and the production of the subject can be further illustrated by making reference to what Foucault referred to as ‘dividing practices’. Dividing practices are when

“The subject is either divided inside himself or divided from others. This process objectivises him. Examples are the mad and sane, the sick and healthy, the criminals and the good boys” (1994c:327).

This dividing practice divided the individual inside him/herself as a ‘withdrawing subject’; an experience of being de-poisoned. This subjectivity is qualitatively distinct from other forms of subjectivity associated with the morphinist, and even the addict, and has its own forms of government. Abrupt poison removal found expression as a rational practice within the confines of a hospital or similar institution (Levinstein, 1878). Importantly for the genealogy, this is a practice which has continued to be an influential way of dealing with the withdrawing subject to this day.

The procedures incorporated into the confinement of the subject resemble those that still operate within residential rehabilitation centres and detoxification centres. First, the individual’s belongings were searched for morphine (nowadays, heroin and crack) and syringes as part of a preventative measure. In this respect, Levinstein (1878) was clear

that morphia poisoning reduced individuals to common liars and cheats and would attempt to pull the wool over the eyes of most. The truth provided by the morphinist was invalid. In addition, physicians were also confronted with another problem; some patients still required the “*morphia syringe*” (original italics Levinstein, 1878:111) for additional ailments. In this example, because the problem was understood to be formed from the improper use of the syringe, patients were displaced, by a power-knowledge arrangement, from an active position into a passive one on the ‘correct’ side of the syringe (though the neo-liberal subject, in contrast, has today been given the syringe back to use correctly). From a technical perspective, this expert strategy forms a “manoeuvre of creating an imbalance of power” (Foucault, 2006:146) within which the syringe became part of the techniques used for producing individuals as *medical subjects*.

Confinement, as a technique for regulating the conduct of irrational subjects, became strengthened and maintained through various techniques used for restraining the individual. It is possible to identify two techniques that were used for regulating the conduct of the *withdrawing subject*. First, force was imposed on the movement of the body by physical objects. For the purpose of restraint, Levinstein argued, “Doors and windows must not move on hinges...that the patients can neither open nor shut them”; this was considered as the essential conditions for regulating the conduct of this particular subject whilst within the de-poisoning phase (Levinstein, 1878:113). Second, patients were also subjected to the surveillance which functioned through assistance of a nurse or medical attendant. Resembling modern day ‘drug workers’ in some respect, these individuals regulated the space between doctor and patient with the aim of keeping constant watch over each and every individual within the hospital. Levinstein claimed that the “treatment is more agreeable...if the first nurse is an educated person, well acquainted with the requirements and wants of the higher classes” (Levinstein, 1878:114). Towards the end of the century Crothers (1893) maintained that the success of treatment depended solely on the watchfulness and efficiency of this medical assistant. Watchfulness, in part, has become embedded in the technologies which form the basis of modern day drug treatment practices; though in different forms.

6.2.4. Poison removal technologies: From gradual reduction to continuous regulation

Abrupt withdrawal continued to gather momentum through the inebriety movement (Crothers, 1893, Kerr, 1894) and has continued to have relevance in today's system, alongside maintenance prescribing (Ministry of Health, 1926). Withdrawal became problematised, however, because it failed to provide the 'right conditions' needed for removing poison from the body of the morphinist (Jennings, 1890, Mattison, 1892). Such a critique became possible, on the one hand, because of an emerging set of governmental practices concerned with re-establishing the 'essential conditions' of liberal rule within this field of governmental practice; and on the other hand, because of the emergence of the discourse of collapse which became associated with the practice of poison removal. Ultimately, it created two ways of thinking about withdrawal. This *technology of government* can be found in the work of Jennings (1890) and Mattison (1892), which addressed the conduct of the morphinist rather than addressing morphinism as a sub-heading within a text book on inebriety like Crothers (1893) and Kerr (1894). For Jennings (1890) and Mattison (1892) it is possible to identify liberal subjectivities; a new emphasis on techniques of restriction rather than restraint; and a new way of thinking which, through the productive workings of power, opened up further directions for government to address – notably, in light of collapse, the direction of maintenance prescribing.

This critique of abrupt methods and the restraint of the morphinist in an institution (Jennings, 1890, Mattison, 1892) can be conceptualised as the liberal critique of too much government, which is a concern with the power authorities have over the freedom of the individual (Dean, 1999, Foucault, 2007, Rose and Miller, 2008). Liberal forms of government depend on the freedom of its citizens, as Foucault notes; "liberalism is not just an acceptance of freedom; it proposes to manufacture...to arouse it and produce it" (2008:65). It is the role of experts to provide the right conditions which are needed for liberal rule to be effective. Within this critique, there is a shift in the 'style of thought' from the practice of (first) restraining and (second) removing opium to the overall objective of recovering "their liberty" (Jennings, 1890: preface). In other words, Jennings seeks to not only recover what Levinstein (1878) removed and saw as problematic (liberty), but produce it and put it to use as a governmental intervention. By doing this Jennings introduced the liberal notion of freedom as an essential construct in the art of governing the morphinist. It would be a mistake to suggest that freedom itself

is unregulated as Foucault argued that freedom becomes introduced through “additional control and intervention” (2008:67).

On this last point, the conditions of liberal rule became provided “with the understanding that they are to exact nothing and to do nothing during the course of treatment” (Jennings, 1890:30). With this in mind, it is logical to argue that this subject has moved from one ‘system of power’ into another ‘system of power’. This feature of liberal rule can be summed up by Rose and Miller:

“[t]hat subjects are individuals whose freedom, liberty and rights are to be respected by drawing certain limits...goes hand in hand with the emergence of novel practices which seek to shape and regulate individuality in particular ways” (2008:205).

The governmental conditions of liberal rule were provided by imposing “method and order” onto the conduct of the morphinist (Jennings, 1890:37). This emphasis on method and order as a solution to previous forms of government, interestingly, went hand in hand with the move out of the hospital or special institution and into special establishments where “every one is free to come and go” (Jennings, 1890:35) as well as “attend entertainments and engage in social pleasures” (Mattison, 1893:15). Arguably, as we shall see, this demonstrates that class interests were reflected in the treatment practices. Jennings had a further reason against confinement: Certain morphinists tempted others back into the practice of self-poisoning, a point that will be returned to in the next chapter.

The techniques of method and order that were implemented by Jennings (1890), along with this characteristic shift in the economy of power-relations, resemble Foucault’s often cited description of the emergence of the political technology of the body:

“[i]t was a question not of treating the body, en masse, ‘wholesale’, as if it were an indissociable unity, but of working it ‘retail’, individually; of exercising upon it a subtle coercion, of obtaining holds upon it at the level of the mechanism itself” (1977:136-137).

With reference to this new governmental intervention of method and order, which implements a liberal political rationality, Jennings argued that this form of treatment required the “condition of the greatest docility” in all matters (1890:37). Docility “joins

the analysable body to the manipulable body” (Foucault, 1977:136). The body of the poisoned subject – the morphinist - began to enter the machinery of disciplinary power, which was at the same time a “political anatomy”, “that explores it, breaks it down and rearranges it”; moreover, “it defined how one may have a hold over others’ bodies, not only so that they may do what one wishes, but so that they may operate as one wishes” (1977:138). In order to transform the individual into a liberal subject, there “must be regularity as regards medicine; regularity with respect to meals; and last but not least regularity also with respect to repose” (Jennings, 1890:38). Ultimately, these practices had the aim of producing a “methodical mode of living” (Jennings, 1890:37); a subject capable of exercising ‘freedom’.

However, before these techniques and their consequences are explored in more detail, it is important to situate this *statement* on regularity, medicine, food and rest identified in the above paragraph within its broader medical and political context, in particular, in the curative technologies for the ‘modern condition’ of neurasthenia. The term was developed by Beard (1878), who understood neurasthenia as “the cry of the system struggling with its environment” (Cited in Hickman, 2004:1281). He argued that progress in civilisation had brought with it various conditions, including neurasthenia, whose symptoms reflected the darker side of our modern society. Among the symptoms were drug use, hay-fever and hysteria (Wiener, 1956). The curative technologies for regulating the nervous system included “rest in bed...forced feeding...regulated muscular exercise”; “all these measures in combination...were supported in their contention of many successful results” (Drummond, 1906:13). For rest, Mattison suggested cold showers or baths; “patients who dread it at first soon come to appreciate it highly” (Mattison, 1892:10). As a way of calming the system, Jennings suggested motion treatment, in particular, the “use of the hammock” (1890:18). Diet had “great value in the remedying of nerve starvation” (Kerr, 1894:355). Abstinence also draws support from this discourse. Kerr claimed that alongside opium and alcohol, they “should altogether abstain from tea and coffee” (Kerr, 1894:151). It was feared that such things would excite the system. This combination of statements on treatment can be found articulated in the work of Crothers (1893), Jennings (1890) and Mattison (1892).

The disciplinary mechanisms of political power that took hold of the morphinist during the last decades of the nineteenth century sought to transform these disordered and

useless bodies into ordered productive ones. The conduct of the morphinist became transformed through “fixing the hours”, not within the institution but within their daily lives (Jennings, 1890:37). The timetable is one technique from the disciplinary apparatus and was originally used in monastic communities to prevent idleness (Foucault, 1977). It later became deployed to “establish rhythms, impose particular occupations, regulate the cycles of repetition” in schools, workshops, prisons and hospitals (Armstrong, 1983, Foucault, 1977:149). The fixing of hours supported the aims of political power and addressed forms of conduct that appeared problematic to the nervous system, such as eating at unseasonable times - the “washing down lobster salad...with copious libations of brandy and champagne” in the middle of the night and reading before bed, for example (1890:38). It is the “programme of reduction” (1890:38) which regulated the nervous system during the poison removal process which has had a lasting impression on contemporary drug treatment in terms of detoxification or maintenance regimes.

The regulation of the nervous system was not only complicated and shaped by the wider bio-political concerns with neurasthenia, it was shaped by the medical concern with the system itself collapsing. Due to the concerns raised over the circulation of the morphinist during the de-poisoning process, the body of this individual became subjected to the practices of the medical examination (See Armstrong 1983 and Foucault 1989). The medical examination, according to Armstrong, “enabled the interior of the body to be differentiated and deciphered to the point at which an observer – from the outside without dissection – can read the internal structures and their changes” (1983:1). The type of medical examination used by Jennings (1890) was the sphygmograph, a device to measure the pulse. It provided a novel way of ‘seeing’, ‘measuring’ and ‘recording’ the pulse of patients. Although part of a medical intervention, such techniques of examination were able to transform this “field of visibility into the domain of power” (Smart, 1985:87). In other words, it produced a form of knowledge which enabled physicians to make judgments based on what was a normal and abnormal pulse. Regarding the exercise of power, it provided the essential truth for determining the ‘regularity’ and future direction of the practice of poison removal:

“The study of these tracings suggested the use of cardiac tonics and stimulants as substitutes for the morphia during the progressive reduction...A hypodermic

injection of morphia given at this moment re-establishes the normal state of circulation” (Jennings, 1890:2-3).

The sphygmograph provided the ‘rationality’ needed for directing the ‘conduct’ of poison removal (what produced the image of a normal pulse) away from the dangers of collapse. It also enabled Jennings to make the assertion that the craving found its home in the internal workings of the pulse. Heart tonics, such as sparteine, trinitrine, bromide of sodium, bromide of potassium, were advocated and used by a number of physicians from late nineteenth century for normalising the pulse (Crothers, 1893, Jennings, 1890, Mattison, 1892). Furthermore, the practice of normalising the pulse helped introduce the practice of a ‘continued dose’:

“[l]et it be understood that we refer entirely to the influence of the *continued dose*, by which we mean giving it twice in the twenty four hours, at regular intervals, so as to keep the blood constantly charged with the drug” (1892:2 emphasis not added).

This marks a conceptual move to the present as it points to the importance of regulating the system through establishing a ‘normal rhythm’ of circulation. Even though what the observer would see in the readings from the sphygmograph is only a representation of the pulse rather than the pulse itself. Importantly, it enabled truth claims concerning the introduction of continued dose into the technology of poison removal. In other words, it is one of the conditions for today’s maintenance and substitution prescribing.

The sphygmograph, on the other hand, provided another function. Armstrong points out that the “various techniques that invested the body all involved surveillance: bodies had to be inspected to judge their status, they had to be analysed to identify their deficits and they had to be monitored to evaluate their functioning” (1983:3). The sphygmograph was not just used to produce the truth that informed the removal of poison from the body. It enabled surveillance to extend beyond the confines of the hospital space and across boundaries of time by making moral claims about past conduct. For example,

“the sphygmographic examination of the pulse is, as I have always taught, the best way of telling whether a patient is honest or not in carrying out a prescribed reduction. If the plateau is not obtained, when the patient ought to be in a state

of want, there is no hesitation – he takes morphia secretly” (Jennings, 1890:9-10).

This medical practice provided an essential technique of surveillance over the conduct of the morphinist; a technique which is characteristic of the political regulation of individuals (Rose and Miller, 2007). The use of the sphygmograph, however, raised the possibility for ascertaining truth through physiological means. Lombroso, in particular, claimed that the sphygmograph could be used for medico-legal purposes (Inbau, 1953). Although developed by a heart specialist, the sphygmograph has since found its deployment within a legal domain, mainly through the work of Marston, as an essential method for detecting deception; the polygraph (Keeler, 1930).

The introduction of continued dose has arguably manifested itself in maintenance prescribing which has become associated with the Home Office commissioned Rolleston Report (Ministry of Health, 1926); a report that has ”set the course of twentieth-century opiate addiction treatment policy in Britain” (Ashton, 2006:4). I would argue that conditions needed for maintenance prescribing to be possible owe their ‘emergence’ to the poisoning and political rationalities which developed throughout the nineteenth century. Before concluding this chapter, it is important to make two points regarding this important governmental technology of maintenance prescribing. In support of this option, and with respect to the abrupt method, the report put forward that withdrawal “might cause not only intense suffering, but even fatal collapse” (Ministry of Health, 1926:4). On the second point we can identify the move towards a permanent cure only in the conditions of social forms of liberal rule:

“A permanent cure will depend in no small measure upon the after-education of the patient’s will power, and a gradual consequent change in mental outlook...education of the will is the improvement of the social conditions of the patient” (1926:9).

The important point to make regarding a step towards the present of contemporary drug treatment is that the idea put forward that the “minimum dose” in a continued or maintenance style can help keep the “patient in a condition in which he can lead a useful life” (1926:10). It is this condition that has become the means and end of governmental intervention.

6.3. Conclusion

The aim of this chapter was to give further attention to poisoning discourse that was identified in the previous genealogical analyses of recovery capital, needle fixation and withdrawal. My interest was with the productive role of the poisoning discourse on the practices used to govern the body of the opiate user. The central theme explored in this chapter concerned the danger associated with an open circulation of poisons and the techniques and rationalities that have emerged as a result of its government. The terms sovereign-poison dynamic and population-poison dynamic were developed using primary sources in order to demonstrate how, through a historical struggle between apothecaries and physicians over the right to practice medicine and the emergence of a new economy of power, a set of discursive practices emerged that took as its object the health of the population. The problem space and strategies used to govern this space, ultimately, shifted from protecting the sovereign to directing a population. From here, a third axis was developed on the body-poison dynamic. This concerned the discursive formation of a poisoned subject, knowledge of the poisoned body, and a set of discursive practices through which this subject could be governed and reproduced. The argument of this chapter is that the formation of this discursive field of poisoning and its convergence with the practices for treating the body of the opiate user are important historical conditions of maintenance prescribing.

Chapter 7

Dividing practices: separating the poisoned from the problematic

7. Introduction

The aim of this chapter is two-fold; to trace the discursive strands of the poisoning rationality in twentieth and twenty first century and investigate its impact on discourses of addiction and problem drug use. The second aim is to trace the historical trajectory of the ‘dividing practice’² identified in the genealogy of natural recovery outlined in chapter 5. This chapter will be covering historical events that have been analysed elsewhere (Berridge, 1989, 1999, Lart, 1998, Seddon, 2007, 2008, 2010). My intention will be to move along similar historical lines though provide further insights to this historical period and analyse problems, subjects and practices that have been neglected.

The first section will explore the emergence, and constitution, of the dividing practice in the early twentieth century that was developed in the genealogy of natural recovery from chapter 5. It will be argued that the British System advocated this ‘maintenance technology’, as opposed to other methods, as legitimate medical practice which promoted liberal forms of citizenship. The second section will make genealogical links with the American clinic experiment and the subsequent psychiatric reconfiguration of subjectivities and treatment practices. Here the aim is to investigate the productive power of this ‘dividing practice’ in relation to the production of ‘normal’ and ‘abnormal’ drug addicts. The third section will explore the British clinic system, highlighting neglected links with the American case. This section will also explore the emergence of a new type of drug user as a result of new truth producing practices from biological psychiatry. The final section will demonstrate the impact of neo-liberal rationalities on drug treatment practices and subjectivities since the emergence of neo-

² For Foucault, the dividing practice is a way in which subjects are produced through power relations. The dividing practice is defined as when the “subject is either divided inside himself or divided from others. This process objectivizes him” (1994e: 326). In the genealogy of natural recovery and recovery capital, dividing practice was used to explain the way in which the abnormal drug addict was separated from the normal drug addict.

liberalism, and the most recent problematisation of drug treatment from the recovery movement.

7.1. The British System, liberal citizenship and technologies of the body

In a Norman Kerr memorial lecture on drug addiction delivered before the Society for the Study of Inebriety, Sir W. H. Willcox (1923), a medical advisor to the Home Office and member of the Rolleston Committee (Department of Health, 1926) stated; “I am of the opinion that drug addiction is rare” in Britain; although he acknowledged that “no statistics are available” (1923:1013). This statement on the rarity of addiction is also made by the Rolleston Committee a few years later (Ministry of Health, 1926). Berridge has also drawn attention to the decline of use opium during the early years of the twentieth century (Berridge, 1999). The memorial lecture, however, identifies two groups within *society* that have become victims to addiction: The “citizen class” and the “Vicious Group” (Willcox, 1923:1013). This ‘Vicious group’ are found in London and other “great cities” and “devote their lives to so-called pleasure seeking” (1923:1013). Importantly, the group is small and their “influence is not extensive” (1923:1013). The vicious group resonates with the “dope fiend” described by Kohn (1992:2). Willcox (1923), like Kohn (1992), note similarities between the vicious groups in Britain and the drug addicts of the American underworld.

The citizen class, in contrast, became victims of addiction as a result of medical practice and “through no fault of their own” (1923:1013). These individuals were described as having the virtues of good character – honesty, self-reliance, respectability – but were unfortunately “afflicted with “addiction disease”” (1923:1013). Stimson and Lart have referred to this group as the “respectable and deserving addict” (1994:332). In many ways, these subjects resemble late nineteenth century subjects of morphinism (Jennings, 1890, Levinstein 1878, Mattison, 1892). These drug users were divided into two groups – two types of addicts - by medical and political rationalities. In relation to the then citizen class, Ernest Clarke claimed that “eye-strain may lead to a neurosis and so pave the way for drug addiction” (Willcox, 1923:1014). It was the psychoneurotic, the successor to the neurasthenic (Armstrong, 1983) that was predisposed to this addiction disease (Ministry of Health, 1926, Willcox, 1923). In light of these concerns, as pointed out in the genealogy of withdrawal, drug regulation was aimed at reducing level of addiction within the population.

The ‘citizen class’, unlike the ‘Vicious group’, were important to “national well-being” (1923:1013). It is worth pointing out that fear over national degeneracy was also in the background. As Seddon (2010) notes, women’s bodies became the site of intervention for population management. These were part of the group that used drugs for pleasure as well as having a predisposition. The link between citizenship and national well-being has been made by Rose (2007) in what he refers to as ‘citizenship projects’. These concerns

“the ways that authorities thought about (some) individuals as potential citizens, and the ways they have tried to act upon them in that context. For example: defining those who were entitled to participate in the political affairs of a city or region...Such projects for creating citizens were central both to the idea of the national state, and to the practical techniques of the formation of such states” (2007:131).

The problematisation of addiction, or ‘addicts of the citizen class’, can therefore be understood not only as part of the “political history of citizenship projects” (Rose, 2007:131), but also as a threat to the liberal social order. It was through the deployment of ‘technologies of citizenship’, to borrow a term from Cruikshank (1999), that the state could intervene and repair “these abnormalities of character which hampered their capacity to meet their obligations of citizenship” (Seddon, 2010:61, Valverde, 1998, 2008). As a consequence of the threat of addiction (Willcox 1923), and international pressure, the prescribing of opiates to drug addicts became problematised by the Home Office (Berridge, 1989, 1999 Mott and Bean, 1998, Seddon, 2010, South, 1989).

The Departmental Committee on Morphine and Heroin Addiction was set up in 1924 in the aftermath of the Dangerous Drugs Act 1920 (Berridge, 1989, Seddon, 2010). The DDA, it has been argued, was a “major landmark in the regulation of heroin” (Berridge 1989, 1999, Seddon 2007:147, 2010). It situated the penal response at the heart of British drugs policy through creating a divide between the regulation of drugs, on the one hand, and the regulation of medicines, on the other (Berridge 1999, Seddon 2007, 2010). It was the prescribing of opium and cocaine to drug addicts and the self-prescribing by doctors that the Rolleston Committee, chaired by Sir Humphrey Rolleston, was asked to consider. It was asked,

“to consider and advise as to the circumstances, if any, in which the supply of morphine and heroin...to persons suffering from addiction to those drugs may be regarded as medically advisable” (Ministry of Health 1926).

Its formation has been described as the result of a ‘power-struggle’ between key individuals from the medical profession and the Home Office (Berridge, 1989, 1999, South, 1989). Rolleston, it is argued, defended the interest of the medical professions against the penal line being pushed forward by Sir Malcolm Delevingne (Berridge 1989). Seddon, in contrast, has put forward a new perspective in which he argues that the British System, and its “medico-legal alliance” (2010:75), can helpfully be understood as part of broader mutations in liberal governance. This “medico-legal alliance”, he argues, was part of the reconfiguring of the relation between doctors and the state under welfarism (2010:75).

The methods of treatment advanced by the Rolleston Committee for treating the body (and character) of the drug addict, it can be argued, can be analysed in terms of their political rationality, such as the production of a liberal citizen, and the type of individuals excluded from participating. The Committee recognised the “existence of two classes of persons” that required the long term maintenance of morphine or heroin. The “Vicious Group” (Willcox, 1923:1013), who used drug for pleasure and not relief, are excluded. In prison these were treated by the abrupt withdrawal method. In doing so, no “alarming symptoms occurred” (1923:1016). The ‘citizen class’ of the Rolleston Report, in contrast, are

“(a) Those in whom a complete withdrawal of morphine or heroin produces serious symptoms which cannot be treated satisfactorily under the ordinary conditions of private practice; and

(b) Those who are capable of leading a fairly normal and useful life so long as they take a certain quantity, usually small, of their drug of addiction, but not otherwise” (Ministry of Health, 1926)

The committee recommended both ‘gradual and abrupt methods’ for the citizen class, however, it has been the maintenance or ‘continued dose’ that took primacy and has underpinned the approach to withdrawal in the contemporary drug treatment system. This is further evidence by the ‘parking people on methadone debate’. This will be

discussed at the end of this chapter. For Ashton, this emphasis on maintenance prescribing is the Rolleston legacy; a report that “set the course of twentieth-century opiate addiction treatment policy in Britain” (2006:4). Indeed, however, it does not explain how it became possible for the Committee to ‘see’ and ‘think’ about maintenance prescribing as “medically advisable” over the abrupt method (Ministry of Health, 1926).

The statements that form the above recommendations are, it can be argued, inseparable from the historical conditions in which they were formed. They are also embedded within a liberal political framework. The ‘medical’ and ‘political’ rationalities that produced the above discourse were described in the previous chapter. The claimed danger and irrationality of the *withdrawing subject* have no place within liberal society: it “might cause not only intense suffering, but even fatal collapse” (Ministry of Health, 1926); in certain subjects complete withdrawal produced “severe distress or even risk of life” (Ministry of Health, 1926). In the Rolleston Report, the practice of maintenance – which is the regulation of the nervous system - served to keep the “patient in a condition in which he can lead a useful life”. In order to do this, the social conditions of the patient needed to be improved (Ministry of Health, 1926). The conditions of treatment, in this context, were very much aligned with the conditions of liberal rule. This reference to the social in terms of ‘practice’ resonates with what Rose and Miller (2008) refer to as ‘governing from the social point of view’; the goal of establishing ‘social conditions’ as the mechanism of liberal rule (Rose and Miller, 2008). In this respect, my argument moves along the same trajectory as that of Seddon (2010); that the British System, and most importantly its ‘practices of maintenance’, is part of a reconfiguration of the relation between doctors and the state under social forms of government.

We will now move on to make important genealogical links with the strategies, techniques and rationalities for governing the addiction problem in North America. The main reason for this is because influential figures like Edwards (1967) and Bewley, who were involved in the development of drug treatment in Britain, visited America with the aim of learning from its experimental period with the clinic system. This was so Britain did not repeat the same mistakes that led to the clinics’ failure. This connection between America’s clinic system and Britain’s is seldom recognised. Overwhelmingly, discussions appear to be preoccupied with the differences between the American and the

British approach to drug policy rather than treatment practices (Schur, 1963). Webster (2007) has also acknowledged the globalisation of drug treatment approaches.

7.2. The American case: The clinic experiment and psychiatric power-knowledge

In North America, the drug addicts from the ‘Vicious group’ were represented as a “dangerous menace to human civilisation” (Hickman, 2002, Weber, 1918a:129). These *non-medical addicts* were from a minority group and were predominately young, male, lower class, and used heroin intravenously (Courtwright, 1982, Schur, 1963). In contrast, those from the ‘citizen class’ - categorised as *medical, therapeutic* and *professional* – were, it was claimed, on the decline and therefore not a threat (Courtwright, 1982, Musto, 1973). Their decline was linked to the passing of the Harrison Act in 1914, which imposed tighter regulations on the prescribing of morphine and heroin with the expectation that addiction would retreat or dissolve under the force of America’s legal system (Aurin, 2000, Musto, 1973).

This tactical manoeuvre was an attempt to prevent addiction from eroding the social order by restructuring its unregulated medical treatment into the apparatus of the state. For Aurin (2000), this was a move from cure to legislation. Kolb (1922, 1927), who was a psychiatrist, claimed this reduced the number of medical and professional addicts, but was ineffective for non-medical ones. In defending their position, the medical profession expressed concern that forcing drug addicts into withdrawal without proper medical support was dangerous (Musto, 1973). The treatment of the drug addict and the control of prescribing were therefore placed under state control through a clinic system; an existing interventionist program “set up by health departments to treat tuberculosis, mental illness, or syphilis” (Musto, 1973:151). Clinics were established in most major cities by federal and local governments (Bishop, 1919, Sandoz, 1922).

The mobilisation of narcotic clinics can be understood as part of wider transformation in medical power and knowledge that provided a new way of seeing illness in terms of relations between people rather than relations between people and the changing environment (Armstrong, 1983). This intervention was also tied to the language of epidemics. Epidemics have historically served as moments when “existing conceptions of the body, the family and social life...and purpose of political authority are thrown into total confusion” (McKinlay, 2009:169). Foucault has argued that during epidemics the state will exercise a greater level of power over the population through an

intensification of surveillance technologies (Foucault, 1977). Undoubtedly, for Foucault, the plague epidemic served as a vital historical bridge between disciplinary power and biopower (Foucault, 2003, McKinlay, 2009). The clinic system, ultimately, was part of a historically constituted bio-political practice through which the state, in times of crisis, acts upon the conduct of its citizens. This can be compared with Rose's citizenship projects (Rose, 2007).

The objective of the clinic was to reduce the spread of addiction and support the transformation of drug addicts into productive citizens. By stabilising them on their prescription, thus preventing withdrawal, it was claimed they would then fulfil their social obligations. As Dr Buchler pointed out

“Some who came to the clinic ragged and filthy left with decent clothes, a bank account, and a sense of having been a part of the machinery of production”
(cited in Howe, 1957:136).

This ‘stabilisation’ was preparation for being moved into one of the state hospitals to be cured. Curing addiction, up until this point, had become almost synonymous with the removal of poison from the body (Jennings, 1890, Ministry of Health, 1926, Musto, 1973). In other words, the problem of addiction was tied up with the problem of poisoning.

The dominant patient group were from the lower class. Those that could afford it purchased prescriptions, at a high cost, to avoid publicising their addiction (Musto, 1973). Interestingly, addiction occupied two positions: It was a vice, a demonstration of a weak-will; and, for others, it awkwardly fitted into the medical model of a disease (Berridge, 1999, Bishop, 1919, Musto, 1973). This can be compared to other late nineteenth century social problems such as syphilis and alcoholism (Musto, 1973). Although a tension existed between its medical and moral dimensions this only enhanced its ‘applicability’ (Seddon, 2010). It is also worth pointing out that at this time divisions were being constructed between true addicts and ordinary habitués.

7.2.1. Psychiatry, dividing practice and the subject of relapse

The clinic experiment, however, was short lived (Howe, 1957, Musto, 1973). Los Angeles Clinic, for example, was opened on 8th March 1920 and, by order of the federal authorities, was closed on 17th August 1920 (Howe, 1957). The Albany clinic, New

York, was established by the New York State Narcotic Commission on 18th April 1919 and then closed in September 1920 (Musto, 1973). The closure of the clinics, it is suggested (Musto, 1973), resulted from the transfer of the prohibition unit to the Justice department. Narcotic affairs then became invested in the Federal Bureau of Narcotics, headed by Anslinger. Developed in 1930, the Federal Bureau of Narcotics enforced the measures contained in the Harrison Act and as such addiction became the responsibility of the Public Health Service (Kolb, 1922, Musto, 1973).

The Public Health Service (PHS), under the guidance of psychiatrist, Lawrence Kolb (1922, 1927), took on the task of transforming the drug addict, ending his “continued menace to the city and make him a self-supporting, productive citizen” (Kolb, 1927, Lambert et al, 1930:448). Physicians were also reluctant to treat them because of the complexities of the Harrison Act. In becoming the “step-child of the neurologist and psychiatrist” (Somerville, 1924:108), it opened up a new power-relation between the drug addict and the psychiatrist; a relation of responsibility inherent within social forms of government (Dean, 1999, Rose and Miller, 2008). In this context, psychiatry operated as a political technology for regulating various *problematic groups* deemed unable to be integrated into the social order (Gordon, 1986, Rose, 1986). Unlike neurasthenic discourses within which individuals were represented as passive objects infected by their environment (Armstrong, 1983, Jennings, 1890), psychiatry represented the citizen as an active agent in the spread of ill health (Gordon, 1986, Rose and Miller 2008). The Public Health Service encouraged citizens by organising educational campaigns promoting personal responsibility for health (Rose, 1986). In other words, the population became mobilised in the national fight against addiction.

The ‘visibility’ and production of individual cases by the clinics revealed that certain ‘types’ of drug addicts were incurable through withdrawal alone. This enabled experts to make truth claims about the medical professions struggle to cure addiction because of the ‘cases’ returning to the clinic following cure (Lambert et al, 1930, Musto, 1973). Kolb (1922, 1927) referred to this type as the *repeaters* and arguably found his terms of reference within the discourse of psychiatry.

Nineteenth century explanations for relapse came from the discourse of neurasthenia, in particular, the relation between nutrition and nervous energy; “diet becomes then of the greatest importance...More early relapses are brought about by indigestion than by any

other cause” (Jennings, 1890:80). Relapse, in this historical context, was a failure to complete the ‘de-poisoning phase’ of treatment (Mattison, 1892). In the nineteenth century, the character of the individual had also served as an explanation for relapse. Jennings argued that the “argumentative *habitué*, who knows more than any doctor living” were prone to relapse (1890:41). These problems of conduct - *or resistance to power* – were recoded as problems of poor character. This recoding of problems into the character of the individual was an essential feature of moral technologies of the self that operated during the nineteenth century (Foucault, 2006, Rose, 1999). It was through the self that the virtues of good character - *normal citizenship* - such as self-reliance, sobriety, respectability and self-improvement could become a reality. The character of the person, who relapsed, in this respect, was a challenge to liberal citizenship.

The ‘visibility’ of the clinic system identified above gave way to Kolb’s (1927) psychiatric diagnosis and the psychiatric hospital. The Bellevue Hospital in New York (Shultz 1930) and the Lexington Public Health Service Hospital in Kentucky (Kolb, 1927), are examples. The psychiatric hospitals, according to Ausubel, provided an “experimental laboratory” (Ausubel, 1948:219) for the study of addiction. For Rose, institutions have, since the nineteenth century, acted as “observing and recording machines, machines for the registration of human differences” (1989:133). They also provided the links between the “political problematisations of conduct” and the “spatial fixing and regulation of the person” (Rose, 1999:105). Foucault (1977) made a similar point about the function of the prison in disciplinary society.

At the Bellevue Hospital, drug addicts were admitted through the “psychopathic admitting office”, before being searched for narcotics (Shultz, 1930:466). The ‘all male’ patients were provided with washing facilities and with a hospital uniform as their “street clothes” were removed (Shultz, 1930:466). For Foucault (2006), in the asylum clothes allowed the patient to recreate their outside life. Torn and shameful clothes were considered humiliating: “Something must be found between the ornaments of delirium and obscene nudity” (Foucault 2006:154). The uniform removed their ‘outside’ identity and supported the power-relation and the construction of a patient.

In the psychiatric hospital, an addiction became diagnosed by ‘observing’ the body for “hypodermic marks” which thus ensured they were “*bona fide* drug addicts” (Shultz, 1930:466). These were the marks of the subcultural subject (Howard and Borges, 1970).

In addition, the information provided by the ‘confession’ or ‘assessment’ allowed the individual to be measured ‘physically’ using Kretchmer’s body types (Schultz, 1930). This information on individual height, weight, temperature and respiration, allowed for statistical comparison against normal functioning during treatment. As I have pointed out in the previous chapter, this enabled Himmelsbach (1941) to construct the truth of an abstinence syndrome and instil it into medical discourse. This also reflects wider shifts in the production of knowledge from hospital medicine to laboratory medicine (Jewson, 1976).

The information collected from each case became used to categorise the personality of the individual through personality reaction techniques (Schultz, 1930). Interest in the personality developed during the Second World War when a concern for manpower led to the promotion of research into the assessment of the personality and aptitude of soldiers (Rose, 1989). Psychological testing meant that large populations became subject to analysis through advanced statistical techniques (Armstrong, 1983, Rose, 1989). The deployment of personality reaction techniques within the hospital enabled drug addicts to be divided and organised “into two classes, the curable and the incurable” (Lambert et al, 1930: 462). In the context of early twentieth century psychiatry, these two groups were reproduced as the non-psychopathic and psychopathic as well as the normal and abnormal personality type (Lambert et al, 1930, Kolb, 1922, 1927).

From an historical perspective, separating patients into two groups was not for therapeutic reasons, but related to their suitability for the work they were offered in the workshops (Foucault, 2006) or within the military service (Rose, 1989). The rationale for separating normal addicts was because they can be “reconstructed if separated from the abnormal” because in both normal and abnormal drug addicts the “herd instinct is powerfully developed” (Schultz, 1930:461). Normal addicts were the ‘therapeutic’, ‘medical’ and ‘professional’ drug addicts – *the citizen class* - and were not a serious problem to treat because most “seek to rid themselves of it” and are often deterred from continuing by the “physical suffering connected with withdrawal” (Kolb, 1925, Lambert et al, 1930:460, Schultz, 1930). The psychopathic addicts, in contrast, forget “the punishment of yesterday in the desires of tomorrow” (Lipton, 1950:585). The reduction of normal drug addicts was also attributed to the Harrison Act. This left to be treated a class of addicts peculiarly liable to relapse (Kolb, 1927, Schultz, 1930).

The psychopathic personality type was believed to be at 87% (Lambert et al, 1930) and even as high as 90% within the drug addict population (Kolb, 1927). These claimed figures prompted addiction experts to argue that psychopathic types become drug addicts not because of being ‘chronically poisoned’ (like normal addicts) but because of an underlying personality defect (Kolb, 1927, Lambert et al, 1930, Schultz, 1930). Or, to put another way,

“a certain number of psychopaths, in order to escape difficult situations, resort to alcohol...morphine and other narcotic drugs” (Lipton, 1950:585).

This reversal of perspective indicates an important shift in the discourse; a move away from somatic explanations towards psychological explanations of addiction developed from psychiatry’s attempt to explain relapse. *The division between the two groups was the outcome of ‘government’*.

The discourse of psychopathy situated the addict alongside the emotionally unstable, pathological liars and sexual psychopaths (Lipton, 1950). Ausubel, in his paper *The Psychopathology and Treatment of Drug Addiction*, suggested that his paper might better be entitled *The Mental Hygiene of the Inadequate Psychopath* (1948). The psychopath began life as a problem child: Reacting rebelliously to a dominating parent; suffering from “enuresis” (bed wetting); and, going through life reacting to situations in an exaggerated manner (Lipton, 1950:584). Relapse and addiction was no longer a reaction to environmental factors, but the consequence of a type of personality (Kolb, 1927).³

The treatment of the psychopath first required that the individual be “unpoisoned from his narcotic” (Lambert et al, 1930: 463). The treatment of the addict-psychopath, for Lipton (1950), required an exploration of childhood relationships as this provided both therapist and patient with a sense of how the self and conscience developed and the

³ Some have objected (Lindesmith 1940, Amsel et al 1971) to this claim by arguing that this ‘division’ was based on a person’s unfavourable position in the class hierarchy, where it was more tempting to call the “underworld character a psychopath than call a reputable physician by that derogatory name” (Lindesmith 1940:920). The drug addict, Lindesmith passionately argued, should be regarded as sick. The label of psychopathy was based on a moralistic judgement.

emotional conflicts that continue to persist. By overcoming these ‘emotional hurdles’, the psychopath could mature and develop “new habits of work” and “orderly living” (Ausubel, 1948:241). However, some were extremely sceptical regarding the treatment of this type of addict; this type “give very poor hopes for rehabilitation, as no drug treatment can change a fundamental personality defect” (Schultz, 1930:481). Winick (1962, 1964) later made the claim that drug addicts, and psychopaths, mature out of their addiction.

In addition to the treatment of the ‘psychopathic personality’, experts were pursuing alternative substances to morphine that could aid the removal of the poison from the body. Isbell and Vogel (1949) argued that in certain dose methadone produced a greater feeling of euphoria than that produced by morphine, though because of its pharmacological likeness to morphine it was a perfect substitute for morphine during the withdrawal phase (Wikler, 1952). The main issue raised was that “people with neurotic and psychopathic personalities will abuse it” (Isbell and Vogel, 1949:913). This was because of the euphoric experience, which they measured against the normal functioning of intelligence; “there was a loss of 6.8 IQ points in the week prior to withdrawal” (1949:910). Regarding the management of the abstinent syndrome (Himmelsbach, 1941), withdrawal was considered to be mild and barely registered (Isbell and Vogel, 1949). Although methadone became placed under the Harrison Act (Isbell and Vogel, 1949), it found its place as an indispensable tool in hospital detoxification (Gossop et al, 1987, Wikler, 1952). More specifically, at that time, methadone became trapped within a style of thought associating practices confined within the hospital setting.

From a historical perspective, methadone operated within two related domains; the management of pain (Tainter and Buchanan, 1949) and the management of the morphine abstinent syndrome (Isbell and Vogel, 1949). Methadone proved attractive in the clinical management of pain because in an analgesic dose it avoided the euphoric reaction commonly associated with addiction. Furthermore, the use of methadone in non-addict patients, or those without personality defects, was relatively free from the dangers of addiction (Isbell and Vogel, 1949, Tainter and Buchanan, 1949). Pain management, however, has produced its own understandings of the relation between drugs, addiction and pathological behaviour (Keane, 2010). Pain management, as Keane (2010) observes, relies on the distinction between physical dependence and addiction.

Physical dependence is a natural biological response to opiate therapy. In this respect, opiate drugs are effective, safe and unfairly stigmatised by their association with addiction. *It is worth putting this point another way; the division between physical dependence and addiction produced by the dividing practice – ‘by their own government’ - separated the non-psychopath from the psychopath; the normal from the abnormal; the citizen class from the vicious group.*

7.3. Liberalism and the British clinic.

In 1958, the Interdepartmental Committee on Drug Addiction, chaired by Sir Russell Brain, was set up by the Home Office to revisit the Rolleston recommendations of prescribing addictive drug to drug addicts as legitimate medical practice (Ministry of Health, 1926) because of a slight increase in the number of drug addicts (Lart 1998, MacGregor, 1989, Ministry of Health, 1961, Mold, 2004, Spear, 2005, Yates, 2002). It concluded that it was not significant enough to make changes. The Committee reconvened in 1965 because between 1959 and 1964 the number of drug addicts increased from 68 to 342 (Ministry of Health, 1968). The use of amphetamines, hallucinogens and cannabis had been steadily increasing during this period (Plant, 1994), though an increase in heroin addicts provoked concern over an emerging youth drug subculture (Lart, 1998), like that seen in North America (Courtwright, 1982, Musto, 1973). These concerns, expressed by the media and the public (Plant, 1994), included both drug taking and sexual conduct. Underlying this issue, which was debated “almost to saturation point” (Boyd, 1972:540), was the belief that “neurotic and socio-neurotic” trends were “too common among adolescents” (Harms, 1973:122). Furthermore, these trends, as pointed out by Winick (1962, 1964), were linked to developmental problems or issues of maturation.

Knowledge of an increase in the drug addict population, it has been argued, was linked to the Addicts Index; a surveillance technique set up by the Home Office (Lart, 1998, Ministry of Health, 1968, Mold, 2004). The Addict Index dates back to 1934 when the Home Office Drugs Branch began to collect statistics on known drug addicts from the medical profession (Mold, 2004, 2007). From 1961, however, out of the 342 drug addicts documented, 328 became objectified through the new classification of the *non-therapeutic addict* (Ministry of Health, 1968). In the genealogy of natural recovery in chapter 5, links were made between visibility and the subjectivity of the ‘maturing’

addict (Winick, 1962, 1964). Instead of ‘active’ and ‘inactive’ drug addicts, the Index organised ‘cases’ into ‘professional’, ‘therapeutic’ and ‘non-therapeutic’ addicts (Stimson and Oppenheimer, 1982). Non-therapeutic addicts were under the age of 20, with one being only 15 years old (Ministry of Health, 1968). The existence of *non-therapeutic addicts* fed into wider anxieties concerning the conduct of young people. These were also the undeserving addicts; the antithesis of the deserving addicts of the Rolleston era (Stimson and Lart, 1994).

The Interdepartmental Committee on Drug Addiction made recommendations on how best to govern the emerging drug problem (Ministry of Health, 1968). The perception of the drug addict as a sick person remained, however, addiction was reconceptualised as a socially infectious condition (Ministry of Health, 1968). This statement was supported by the epidemiological evidence, which was given greater weight (Lart, 1998, Ministry of Health, 1968, Mold 2004, Seddon, 2010). The committee recommended that suitable institutions needed to be developed:

“Each centre should have facilities for medical treatment including laboratory investigation and provision for research. A centre might form part of a psychiatric hospital or of the psychiatric wing of a general hospital” (Ministry of Health, 1968).

The clinics formed part of out-patient facilities of London undergraduate teaching hospitals and regional “mental hospitals” (Mold, 2004, Bewley, 1967:498). The majority of non-therapeutic addicts were found in London so attention focused on the capital (Lart, 1998). This ‘rationale’ for deciding the geographical location was, in part, determined by an epidemiological rationality that supported the new definition of addiction as contagion (Ministry of Health, 1968). It is important to point out, briefly, that self-poisoning, or suicide with pharmaceutical drugs, was also emerging as a ‘problem’ and in the same respect, became treated through a similar clinic system. This issue will be returned to later in the chapter.

Doctors were required to notify the Home Office of new cases of addiction (Lart, 1998, Mold, 2007). The public health discourse was further emphasized by the fact the treatment clinic was referred to as a ‘containment unit’ (Mold, 2007). In unpicking this image, the addiction epidemic, it was claimed, could be governed by disciplining the prescribing of opiates to addicts through the new power and knowledge arrangements

within the clinic (Lart, 1998, Mold, 2004). It is worth reflecting back on Foucault's (1977) point that during epidemics the state will exercise a greater level of power over the population through an intensification of surveillance technologies.

The political objective of the clinic was two-fold; treating the individual drug addict and controlling the spread of addiction (Connell and Strang, 1994, Lart, 1998, Mold, 2007). The source of the contagion, it was claimed, was irresponsible prescribing practices (Lart, 1998). The power to prescribe heroin and cocaine, therefore, was removed from the hands of the general practitioner and placed in the hands of consultant psychiatrists, who became authority figures within the specialist treatment clinics (Glanz 1994). This transfer of power from the generalist to the specialist was part of wider changes in the exercise of medical power (Stimson and Lart, 1994). Statements concerning the objectives of treatment were clearly being articulated prior to its opening;

“if there is co-operation between the clinics it should lead to a standard practice in deciding which patients are otherwise incurable or untreatable, but thought to be capable of leading a more normal life with long term drug taking” (Bewley 1967:498).

The ‘words’ incurable and untreatable resonate with the American case discussed above (Kolb 1922, 1927). The consequence of new social control policy on the addiction concept (Lart 1998, Mold 2007) meant that within the psychiatric unit addicts were separated into two groups as a technical means of preventing “spreading the addiction to other patients” (Connell 1967:499).

The issue facing the clinic was the “two extremes of prescribing” (Bewley, 1967, Connell and Strang, 1994:171) or the “prescribing tightrope” (1994:170). This is the problem of under prescribing and withdrawal and over prescribing and the spread of addiction. This is an historical and ‘biopolitical’ problem that was first raised in the eighteenth century in relation to poisoning by apothecaries. At the centre of these poles are the correct dose and the desired effect. It is also the management of addiction within population. The problem was articulated in North America by Dole and Nyswander (1966). If given too much, the addict is high and euphoric; if not enough, the addict becomes sick and desperate for the drug. Addiction, therefore, leaves little time room for normal life because the addict oscillates between ‘high’ and ‘abstinence’ (Dole and Nyswander, 1966). In this position, the individual “is unable to behave rationally”

(Connell, 1969, cited in Strang and Connell, 1994:170). For Dole and Nyswander, it “seemed reasonable” to search for a medication that can block the abnormal reactions of addicts to heroin and prevent the abstinence syndrome (1966:304). The aim was to create “socially productive...normal citizens” (Dole and Nyswander, 1967:20). It can be argued that this resembles the subject position of nineteenth century morphinism and the problems of ‘liberty’ and ‘collapse’; the new element is the notion of ‘block’ or a ‘blockade dose’ associated with methadone.

7.3.1. A new subject of addiction discourse: ‘chippers’ and the ‘pseudo-junkies’

The problem of prescribing or the “prescribing tightrope” (Connell and Strang, 1994:170) involved the government of a new subject of addiction. The problem was advanced in an article in the *British Medical Journal*:

“One particular perplexing problem which will face the new prescribers is the identification of the heroin user who is not an addict but a so-called “chipper”. These are a subgroup of heroin users, sometimes adolescents still living with their parents, and generally stable and socially integrated...prescriptions of heroin to them might simply push them deeper into addiction” (Anon, 1968:719, see also Marks et al, 1969).

The chipper has a short history. They are also known as pseudo-junkies (Gay et al, 1973), or a type of pseudo-heroinism (Primm and Bath, 1973) and also the occasional and controlled user (Blackwell, 1983). The chipper showed signs of opiate withdrawal; they walked and talked like a drug addict and some of them even believe that they have a physical dependency (Blachy, 1973). Blachy (1973) proposed naloxone, the opiate antagonist, in this endeavour. He concluded a third of his sample showed no evidence of physical dependency whatsoever. This also comes back to the problems raised by Glaser (1974) and Primm and Bath (1973) on whether street heroin can actually cause physical dependency because of the varying levels of purity and the sporadic ways in which it is used. Coomber and Sutton (2007) have also criticised the lack of clarity of the dependency syndrome. It also raises ethical implications over the use of pharmacological interventions with individuals that are not physically dependant upon heroin. This begs the question; how has it become possible to speak of the ‘chipper’? What reconfigurations have made this subjectivity possible?

The psychiatric investigative techniques of observation and interpretation were previously used to diagnose an addiction. For example, in the psychiatric hospitals ‘observing’ the body for “hypodermic marks” ensured they were “*bona fide* drug addicts” (Shultz, 1930:466). The personality reaction techniques also supported a diagnosis. The subjectivity of the chipper could not exist within this particular arrangement as the truth of physical dependency was not accessible through this psychiatric discourse. The truth of whether the individual was physically dependent upon heroin or a pseudo junkie, with a “psychological interest in the junkie identity” (Gay et al, 1973:287), proved problematic for psychiatric diagnostic techniques. The emergence and the possibility of identifying the chipper indicate a shift in the addiction discourse. The exclusion of the chipper, it can be argued, relates to new conceptions of addiction within biological psychiatry and new truth technologies of diagnosis (Rose, 2007).

The introduction of urine testing into the practices of the clinic, it can be argued, allowed for the production and exclusion of the chipper from treatment practices. The regular meetings between those responsible for running the clinics during the early years contributed to the development of “substantial agreement on styles of treatment” (Connell and Mitcheson, 1984:767). These styles of treatment, as Lart (1998) has pointed out, developed from the scrutiny of prescribing practices. The agreed guidelines of the clinic stated that before considering a prescription

“at least two urine samples showing positive results for an opioid should be obtained” (Bewley, 1984:768).

Urine testing operated within a ‘political rationality’ that rebrands social and political problems as technical matters (Campbell, 2005). The objective was to overcome the uncertainty of the word of the drug addict, reduce the time spent using psychiatric assessment forms, and exclude the chipper from the clinic (Marks et al 1969). This truth no longer involves the psychiatrist, but a range of actors from addiction counsellors, toxicologists and administrators. The new investigative technologies of biological psychiatry (Rose, 2007) opened up new power relations for the drug addict to resist, as well as measures to counter this resistance. Marks et al (1969) raised the concern that some drug addicts brought clean urine samples with them to prove they had not been taking street drugs. Bewley (1984) later overcome this problem by supervising urine

testing; a practice that soon became normalised into the assessment practices (Bewley, 1984).

The introduction of urine testing into psychiatric practice can also be mapped onto this shift in biological psychiatry and its new investigative and truth technologies. The truth of addiction was no longer found on the surface of the body or within the psyche, but in the biological body of the citizen. Psychological truth, in this context, could not dispute the biological truth. Biology, however, could provide truth concerning the ‘character’, past, present, and future, of the drug addict. The key spaces are the use of drug testing in the courtroom, prison, sport, child protection meeting and work place. Campbell (2005) has argued that they are better thought of as suspect technologies, in that they reproduce drug addicts as untruthful citizens. As a responsible and participating citizen, the drug addict came to recognise (and resist) this level of truth by not meddling with the process. Ultimately, urine testing has become stabilised within the drug treatment system (Department of Health, 2007) to the point where it determines life changing decisions about individual liberty and parental responsibility.

The World Health Organisation’s committee on Addiction-producing Drugs emphasised this biological basis of addiction when it advanced two diagnostic categories in 1958; drug addiction and drug habituation. Drug addiction signified the presence of both physical and psychological addiction and drug habituation signified only the psychological. Keane points out that this distinction reflected an “enmeshment between the biological and the political” as it was an attempt to justify the subjection of some drugs and not others to international state control (Keane, 2010:55). As a governmental technique, addiction proved inadequate because of the erroneous attempts to grasp the multifarious drug taking patterns and types of drugs abused around the world. The term drug dependency, in contrast, allowed for this diversity and for subjects of drug taking to be made up through the categories of ‘psychic’ and/or ‘physical’ dependence (World Health Organisation, 1964, 1965). The chipper, as we have seen, has been excluded from the category of physical dependence.

7.4. Neo-liberalism: Drug-related problems, public health and self-poisoning

The preceding paragraphs have explored, against the background of the development of drug treatment practices, how a ‘dividing practice’ emerged and functioned within the above (liberal) configuration of treatment practices. It operated as a strategy that

produced fixed subjectivities moulded onto the personality. They were part of “highly differentiated populations...addicts, the mad, the bad or the sad” (Bunton, 2001:227, Dean, 1999). In the 1980s, however, Britain experienced a new type of drug problem. Unlike earlier epidemics it was not thought of as an ‘extreme group’ of ‘dangerous individuals’ who were excluded from society (Kolb, 1922, 1927). Instead, it was the issue of poly drug users and their related problems located within the population. It moved beyond London and into numerous regions of the country (Bunton, 2001, Ghodse et al, 1985, Hartnoll et al, 1987, Lart, 1998, MacGregor, 1989). As such, the gaze of the clinic and Home Office Addict Index appeared redundant (Ghodse, 1977, 1994).

Parker’s (2005) argument is that the act of drug taking became normalised (FN); or as Strang put it, the “drug problem has changed with the times” (1989:144). According to Strang,

“Originally, drug taking was associated with certain distinctive groups within the overall community...As the behaviour has become more widespread...individuals with less extreme characteristics are more likely to be found in the population of drug users” (Strang, 1989:146).

The perception of drug taking in the population can also be understood as resulting from the emergence of neo-liberal forms of government that proposed solutions to the ‘problematics of the welfare state’ (Bunton, 2001). The practices of exclusion became criticised for being too costly and dependency producing (Dean 1999, Rose and Miller 2008). Instead, neo-liberalism, it is claimed, operated through inclusionary practices. The drug addict, rather than excluded, was integrated back into the community (Bunton 2001). With the emergence of ‘inclusionary practices’ responsibility is transferred from the state to the individual through notions of self-responsibility, freedom, autonomy and risk (Bunton 2001, Rose and Miller 2008, Seddon 2010). The dividing practice outlined above begins to dissolve and breakdown within this configuration of treatment. This is not a permanent breakdown of this mode of power; as we shall see it is taken back up in the recovery movement.

7.4.1. The new ‘art’ of seeing and knowing: ‘self-poisoning’ and ‘drug-related problems’

The new drug problem challenges the existing surveillance technology, as the Addict Index only provided a distorted picture as it was limited to notifiable drugs, such as heroin and cocaine (Ghodse et al, 1978, Ghodse, 1994). The Index had revealed an important pattern and problem; an increasing number of poly drug users attending general and private medical practice outside of the capital (Bewley, 1980, Bewley and Ghodse, 1983, Connell, 1982, Department of Health and Social Security, 1982, Marks and Leavers, 1982). Private Doctors, according to Bewley and Ghodse (1983), could, it was argued, receive over £100,000 a year by prescribing controlled drugs to drug addicts. However, the Index failed to capture the true threat to public health (Ghodse, 1994).

It has been pointed out elsewhere that public health strategy had a significant role in responding to this drug use epidemic (Lart, 1998, Seddon, 2010, Yates, 2002). It resituated the focus of government from the individual and substance and onto the ‘related problems’ experienced by the drug user and society. For Ghodse (1994), this allowed indicators of drug use to be used in determining the level of drug use within the population. Among the indicators were

“an incident of drug overdose, a road traffic accident in which drugs were implicated, a septic complication of drug injection, or death due to drug abuse...If all this information is present then it is possible to establish prevalence rates” (Ghodse, 1994:67).

It was claimed that this data produced a significant picture of “drug abuse within the community” (Ghodse et al, 1978, Ghodse, 1994:66). Grounding truth in an associated factor was not new. Kolb (1927) relied on observations of the individual. Injecting marks on the body were also helpful (Howard and Borges, 1970), and even the detection of quinine in the urine proved a valuable indicator of heroin use. *The concept of drug-related problems, in this respect, was not deployed as a therapeutic tool, but as a new way of seeing addiction.*

This concept of drug-related problems, instead of being applied to drug users, can in fact be traced back to the mid-1970s when expert and political authorities were

problematizing the human and social consequences of a developing market in pharmaceutical drugs. The permeation of these drugs into medical practice, it was claimed, contributed to an increase in what became known as “drug-related deaths” (Anon, British Medical Journal, 1977:1492). Questions were also being raised over the accountability for “drug-related injuries”, especially following the birth defects caused by the prescribing of thalidomide (Anon, British Medical Journal 1979:1674). The growing issue of “drug-related problems” associated with pharmaceutical drugs presented authorities with a new public health problem (McNulty, 1977:576). Because healthcare specialists were anxious over the liability of drug-related problems “drug information centres” were opened in order to improve the circulation of knowledge among experts (McNulty, 1977:576).

This growth in pharmacological interventions, according to Rose (1989), paralleled the move from the psychiatric treatment of mental illness within the hospital to community-based interventions. The community focus of the clinics resonates with this reconfiguration of psychiatric power. The rapid expansion in the pharmaceutical market and general acceptance of pharmacological interventions have not only provided vital opportunities for the creation of private profit (Rose, 2004), but have reconfigured the way in which medical problems are understood and treated (Rose, 2008). As psychiatry moved out of the hospital and into the community, there has been a “massive psychiatrisation of everyday worries” with, by 1984, nearly ten million people in Britain having taken tranquilisers for ills ranging from broken homes, nerves, unemployment and worry (Rose, 1989:69).

The “attitude” of using “pharmaceutical crutches for all crises” was said to have contributed to an increase in self-poisoning (Smith, 1972:159). This resonates with the iatrogenic poisoning and addiction problems found in the late nineteenth and early twentieth centuries (Courtwright, 1982, Musto, 1973), and with the observations of Rose (2004). A glimpse into this problem is given by Kessel:

“The effects of this medical revolution have been to make poisons both readily available and relatively safe. The way has thus opened for self-poisoning to flourish, since few who practise it have their minds set on dying. Facilitates for self-poisoning have been placed within the reach of everyone” (Kessel, 1965:1265).

In 1972, the use of pharmaceutical drugs for deliberate self-poisoning accounted for “1 in 10 of all medical admissions and 1 in five of all medical emergencies” (Ghodse, 1977, Kessel, 1965, Proudfoot and Park, 1978, Smith, 1972:157). In the same year, it was even predicted that by 1984 every acute hospital bed would be filled with a “self-poisoner” (Brewer 1985:391). On the back of this increase in self-poisoning, special treatment clinics were set up in psychiatric wards of hospitals, such as in Sunderland (Burstons, 1969) and Sheffield (Jones, 1977), to govern this bio-political problem. Here, echoes can be heard and parallels can be made between the drug treatment and self-poisoning clinics.

Links have been made with the new public health movement and the links between smoking and cancer (Seddon, 2010). To develop this point further, the public health discourse of self-poisoning, interestingly, permeated the medical knowledge of the smoker. It was argued that the “smoking of tobacco produces a multiple, complex (self-) poisoning” (Johnston, 1978:700). In this respect, cancer was considered as a ‘drug-related problem’. Furthermore, this also suggests that the argument that drug-related problems had been worked out for alcohol (Seddon, 2010) is limited, and can be located within a much broader field.

Ghodse, who was an influential figure, argued that those presenting to emergency departments suspected of deliberate poisoning can be seen as “two separate populations” (1977a:806) - *suicidal individuals* and *drug dependants* – and can be set against the “wider background of other drug-related problems” (1977a:806). This is not to suggest that the two groups were indistinguishable before this, only to point to the fact that they were brought together through a common organising principle; *drug related problems*. Ghodse (1977b) argued that the hospital records of self-poisoning, most importantly, could compliment the figures collated by the Home Office Addict Index. When considering that out of the 395 drug addicts studied only 134 were known to the Addict Index, he argued that these hospital records could form a more accurate picture of drug addiction within the population (1977b, Ghodse et al, 1978). The inclusion of mortality studies, it was consistently argued (Ghodse, 1977a, 1977b, Ghodse et al, 1978, Ghodse et al, 1985), was (internationally) recognised as an effective tool for measuring trends in drug addiction.

7.4.2. The neo-liberal subjectivity: the problem drug user

This new technology of surveillance, made possible by epidemiological use of the notion of drug-related problems, revealed the addict population not as addicted subjects with an abnormal personality, but as normal individuals whose drug use produced a series of related problems. This dissolved and removed the power inherent in the psychiatric dividing practice previously described. This new subject, referred to as the *problem drug user*, was defined by the ACMD as

“Any person who experience social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption and/or dependence as a consequence of his own use of drugs or other chemical substances” (ACMD 1982:34).

The opening-up of the definition of drug user to potentially include ‘any person’ from the population cannot be separated from the neo-liberal project of producing “self-determining and risk-managing” citizens (Bunton, 2001:225, Rose and Miller, 2008). Bunton (2004) has argued that this flexibility given to the neo-liberal subject provided the conditions needed for the subjectivity of the ‘problem drug user’.

Neo-liberal rationalities have transformed the individual into an active, responsible and autonomous individual who can be deployed as a technical instrument in the achievement of political objectives (Dean, 1999). This understanding of the citizen is bound up with critiques of the welfare state (Dean, 1999, Rose and Miller, 2008), such as the freedom of the individual being penetrated to the point of hindrance by the ever expanding domain of expertise. The government of the liberal citizen was not conducive to the freedom of the individual required for civilisation (Rose and Miller, 2008). The neo-liberal citizen must

“become ‘experts of themselves’, to adopt an educated and knowledgeable relation of self-care in respect of their bodies, their minds, their forms of conduct” (Rose and Miller, 2008:215).

Essentially, the neo-liberal citizen is encouraged to take responsibility for governing their own lives and the role of authority is to provide the individual with the information and skills needed to make this possible (Cruickshank, 1999, Dean, 1999, Rose and

Miller, 2008). The subjectivity of the neo-liberal citizen and its reconfiguration of the problem drug user can be seen most clearly in the government of HIV and AIDS.

7.4.3. HIV and risk: harm reduction and the hidden population

HIV produced a significant reconfiguration in the way in which the liberal state thought about and governed its problem drug users (McKeganey, 2006, Zibbell, 2004). This point has been explored in the genealogy of needle fixation in chapter 6. Since the first incidents of AIDS were reported in America in 1979-1980 it has become a global epidemic. This epidemic has not only “exposed the hidden vulnerabilities in the human condition” (Fineberg, 1988: 128), it has affected how political power and scientific expertise organise the conduct of individuals and society (Herdt, 1992). Indeed, HIV and AIDS have problematised the body in new ways and have challenged our “basic assumptions” about the relationship between “culture and deviance” (Herdt, 1992:4). In particular, it has raised new questions about the relationship between the individual and groups of drug users.

The government of HIV and AIDs further emphasised the limitations in modern forms of power. Foucault (2007), post-Foucauldians (Dean, 1999, Rose, 2007, Rose and Miller, 2008), and Deleuze (1988) have pointed to the links between political powers and surveillance and the regulation of individuals and populations. It has been acknowledged that deviant populations are hidden (Biernacki and Waldorf, 1981) and, drug users in particular, are therefore “concealed from the view of mainstream society and agencies of social control” (Watters and Biernacki, 1989:417). In relation to drug use and HIV, epidemiological studies have overcome this limitation through including HIV, as well as more recent blood borne viruses, within the concept of ‘drug-related problems’. “HIV carriers”, it was argued, can be used in epidemiological studies “as an indicator of drug abuse by injection” (Frischer et al, 2001, Ghodse, 1994:73). Knowledge of HIV, in this respect, has revealed the characteristics of a typically hidden group of individuals.

The reconfiguration in the government of problem drug users can be seen in the report on *Aids and Drug Misuse* by the Advisory Council on the Misuse of Drugs:

“HIV is a greater threat to the public and individual health than drug misuse.
The first goal of work with drug misusers must therefore be to prevent them

from acquiring or transmitting the virus. In some cases this will be achieved through abstinence. In others, abstinence will not be achievable for the time being and efforts will have to focus on risk reduction” (1988).

This statement indicates an important shift in the object of government from the body of the ‘poisoned’ or ‘addicted’ subject, like that found in psychiatry and the clinic, to ‘drug-related problems’, such a crime and disease, which link the individual to new ways of seeing and knowing the biological processes of population.

The uptake of harm reduction in British drug policy has been described as a challenging process. The ACMD had rejected the proposed needle exchange scheme in 1986 due to no evidence that the sharing of syringes between drug users resulted from a shortage of syringes (Stimson, 1994). The mobilisation of the gay community in the fight against AIDS, however, proved encouraging and prompted the ACMD to carry out a pilot project (Stimson, 1994). It has been argued that acceptance of harm reduction practices is associated with the expansion of services within the voluntary sector, encouraged by the Central Funding Initiative (MacGregor, 1994, Stimson and Lart, 1994). The Central Funding Initiative provided funds to improve drug treatment services in England so they could better respond to the growing threat of problem drug use (MacGregor, 1994).

During the 1980s drug treatment was provided through an uncoordinated and dispersed network of power made up of techniques and strategies deployed through voluntary services, community organisations and general practitioners. The earliest non-statutory services were linked to Christian churches, parent-groups and concept houses (Turner, 1994). Elements of this network were already in place since the 1960s though the Central Funding Initiative in the 1980s, and their location within the community, encouraged their growth. The shift from the specialist to the generalist is also significant here. The specialist services provided by the clinic had already been declining due to the lack of direction and lack of appropriate funding. As Russell put it, “money, under this government, is tight” (1985:1994). However, the “reinstatement of the GP” (Glanz, 1994:155, ACMD, 1982) and their flexibility regarding the prescribing practices, coupled with the input from the voluntary sector, provided an important working relationship that the ACMD supported. The rapid uptake of harm reduction, it has been argued, was supported by the previous expansion of the voluntary sector (MacGregor,

1989) and their frustration with dominant abstinence policies of the clinic system (McDermott, 2005).

In contrast, the development of this new network of non-specialist services can be situated within the wider context of neo-liberalism; in particular, with what Rose and Miller (2008) refer to as a pluralisation of technologies of government (Rose and Miller, 2008). Rose and Miller (2008) have argued that over the twentieth century the social technologies of welfare were being reconfigured by neo-liberal rationalities. The technologies of power that once supported the 'social' were detached from their central point and are now located within an autonomous network of voluntary agencies, organisations and communities. The transformations and mutations in political power have produced an important reconfiguration in the way the individual has come to relate to society through the self-governing community (Rose and Miller, 2008). In addition, the treatment of the problem drug user has followed a similar pattern to the development of mental illness; "from the corporal, to the carceral, to risk management" (Miller, 2001:168, Mugford, 1993). Drug services were to take on the role of producing what Stimson and Donoghoe referred to as the "health-conscious drug user" (1996:18).

This emergence of HIV has arguably transformed the landscape of drug treatment from a policy and treatment infrastructure based on abstinence to a system dominated by risk management strategies, such as the needle exchange (Stimson, 1995, Zibbell, 2004) and safer injecting environments (Rhodes et al, 2006). This is still the dominant configuration of drug treatment up until the present. One of the consequences of this reconfiguration is that the expert, the one providing guidance through the expertise of the *psyche*, "finds themselves now cast in a subordinate role" (Castel, 1991:281). This is because the task of governing risky populations has become an administrative one, involving a range of generalist services from needle exchange schemes and outreach workers to community prescribing interventions (Strang, 1994).

The new discourse of problems has re-envisaged the problem drug user in a way that does not "automatically assume their rationality and freedom are to be diminished" (O'Malley, 2004:157). This can be contrasted with the concept of the drug addict, who is an out of control subject with an abnormal personality, whose government depends upon the removal of freedom. This has involved a re-thinking of the activity of government in terms of choice:

“It restored free will to new categories of ‘dependant’ or ‘problem’ drug mis/users and understood the process of becoming a drug user as involving rational decision making” (O’Malley, 2004:158).

These elements of choice, freedom, and rational decision making are part of the neo-liberal citizenship project. The change in individual behaviour was reconceptualised as a form of personal responsibility and amenable through an emphasis on freedom and self-government (Bunton, 2001, Dean, 1999). Alongside the need to equip problem drug users with syringes and knowledge of risk, in order to navigate risky environments, additional techniques have been used to reduce factors that are liable to produce risk. In fact, withdrawal is no longer a dangerous experience, which is life threatening, it has become a ‘risk’ factor. This was argued in the genealogy of withdrawal in chapter 5.

7.4.4. Methadone maintenance: from ‘danger and collapse’ to ‘risk and BBVs’

The use of methadone had been in decline during the 1970s as abstinence models informed drug treatment policies and practices (MacGregor, 1989, Preston and Bennett, 2003). Following the HIV epidemic, substitute prescribing was transformed from a “shady pastime” to a “well-supported clinical priority” led by physicians and psychiatrists (Robertson 1994:97). In fact, it has become a “central pillar of the prescribing response” to problem drug use (Preston and Bennett, 2003:19). Instead of providing the conditions for the ‘irrational subject’ to lead a productive and normal life (Doyle and Nyswander, 1967), it has been argued that

“prescribing may serve two wider purposes directly related to our goal of containing the spread of HIV...*Attracting more drug misusers to services and keep them in contact...Facilitating change away from HIV risk practices*” (ACMD, 1988:47-48).

The political function of methadone has dramatically shifted from the management of danger in the body to the management of risk through improved retention figures. The information used to determine a ‘correct dose’ is no longer the management of the nervous system or promoting productivity and normality in the individual. The ‘correct dose’ of methadone has been linked to retention, with doses of between 60 and 120mg of methadone being linked to positive outcomes (National Treatment Agency, 2005). Ultimately, as a pharmacological intervention methadone has been aligned with the

political desire of bringing hidden populations into agencies of social control. As Foucault has pointed out, modern forms of power are dependant upon forms of visibility for governing citizens and population. Since this statement was made (ACMD 1988), retention has become a preoccupation (National Treatment Agency, 2005). In fact, the key objective of the Government's ten year drug strategy *Tackling Drugs to Build a Better Britain* (1998) was to double the participation of problem drug users within treatment between 1998 and 2008.

The key documents that have informed and organised the use of substitute drugs such as methadone and buprenorphine are the *Drug misuse and dependence: UK guidelines of clinical management* (Department of Health, 1999, 2007). In 1999, out of 138 pages the guidelines mentions the word risk 79 times. In 2007 the guidelines are eleven pages shorter but risk appears 260 times. The risks include

“risks related to overdose, polydrug and alcohol use, unsafe injecting practices and unsafe sex...self-harm or harm to others. Risks to dependant children should be assessed...normally include all clients asked about their children, their age, and the level of contact they have with them” (Department of Health, 1999:26).

Methadone still targets the dependency upon opiate substances, but only insofar as this ‘drug-seeking behaviour’ is considered to be a risk factor. The oral administration of methadone reduces the risks associated with injecting and heroin withdrawal. The structured approach of methadone thus allows “increased calculability of lifestyle” and the “normal patterns of work” to become possible (O'Malley, 2004:163). It is through the logic of substitution that the problem drug user can become a responsible drug user and a calculating risk taker (O'Malley, 2004).

The personal experience of methadone has been captured in the ‘liquid handcuffs’ phrase (Southgate, 2003); a metaphor used to articulate the power methadone has over individuals (Southgate, 2003). The words of a methadone subject are offered by Fraser and Valentine (2008). Cameron is a 42 year old methadone user:

“Methadone just allows us to be normal, that's all. It's no different from a diabetic taking insulin. No different. Best analogy...a vampire taking his blood every night...we just need to stay normal, and that's it, we're poisoned, so we

need the poison, and that's all it does, it's just the same as heroin. Except the only difference is you don't get a rush...you're just normal" (2008:1).

This statement is interesting because it makes two comparisons. One with diabetes, which, in terms of substitution, is a dominant comparison between insulin and diabetes and methadone and dependency (Fraser and Valentine, 2008, Lart, 1998). The other is from the perspective of 'poisoning'. Here the body is represented as 'poisoned' and requires a continuous flow of this particular poison within the body. Tober and Strang have also put methadone in a similar context; "It is a life-saving treatment, but it is also a life-threatening poison" (2003:3). *The methadone subject is a poisoned subject.*

7.4.5. From parking people on methadone to sending them on a recovery journey

In this final section, the most recent problematisation of drug treatment practices in terms of the recovery movement will be briefly described. The criminal justice turn is important, however, this has been investigated from the governmentality perspective elsewhere (Seddon, 2010). In a recent meeting held to discuss the current direction of drug treatment Ian Wardle, Chief Executive of Lifeline, made the claim that:

"There is a fundamental debate taking place out there about our work and values...Is it fair to say our field is in crisis at this point in time? Unfortunately, I believe it is. I believe this is because of two things. First, I think we are divided within. Second, increasingly there are attacks on drug treatment from the outside" (2009:7).

The outside attacks on drug treatment resonate with the neo-liberal economic argument (Rose and Miller, 2008). Up until now, this has been kept at bay by the National Treatment Centre's powerful mantra of £1 spent on drug treatment is £7.50 saved from the economy. This has been reframed as a £2.50 saving. In an article published by the Daily Mail, however, Mark Easton criticised this 'mantra' by putting forward; "£1.9m bill to help just one addict kick the habit". It was also claimed in the Sun that "the NHS blows £130m curing 70 junkies" (Roberts 2009:10).

In addition, Rose and Miller argue that the economic argument "chimed with a range of criticisms of social government...government overreach" (2008:210). This is at the heart of the liberal thesis (Dean, 1999, Foucault, 2007). In the above meeting, it was also argued that

“it's one thing to get nearly 200, 000 people into drug treatment (and not keep them waiting for it), but how many are coming out, and what sort of outcomes are being achieved?” (Roberts, 2009:10).

The argument concerning too much government has extended beyond recovering individual freedom from drug dependency to recovering it from ‘drug treatment dependency’ (Gyngell, 2007) and for “merely sustaining addiction” (Roberts, 2009:11). In this respect, drug treatment has been ‘parking people on methadone’ (Ashton, 2007). In a recent meeting on the future of drug treatment it is was put forward that

“we have become very risk averse in substance misuse. We have got to a point, because people say detoxification kills, where we are not prepared to let people try and come off drugs because we are terrified that they are going to die” (2009:24).

This problem of ‘parking people on methadone’ forms one of the arguments emerging from what has been referred to as the New Abstentionists (Ashton, 2007). The argument made at the end of the last chapter and the beginning of this chapter helps explain this problem. The New Abstentionists is a movement calling for the reinstatement of abstinence as the goal of drug policy and practice.

The Conservatives report *Breakthrough Britain: Addictions: Towards Recovery* (Gyngell, 2007) underpins the Coalition Government’s attempt to reform British drugs policy and practice. It is not my intention to analyse this in depth, as this event is still unfolding, only to point to a new ‘subject’ and ‘technology of power’ (re) emerging within this space. The term problem drug user features only four times in the one hundred and twenty six pages of this policy document. Addiction, in contrast, is used over three hundred times and addict/s over one hundred. The general tone of this re/emerging discourse on addiction can be put into context using a quote from the report:

“Addiction is a progressive disease, which means the drugs that keep me happy today won't keep me happy in a week's time or a month's time so I need to continue to take more and more. It's not only the physical addiction that gets (progressively) worse, but it's a sort of emotional crisis that is being pushed away. My belief is it's a spiritual crisis that is being batted away by taking drugs.

And the trouble is, the more drugs you give an addict, the more drugs an addict needs” (Former addict and repeat offender, cited by Gyngell, 2007:10).

The discourse is also a return to the incurable figure found in Narcotics Anonymous. On this point, the report recommends locating 12-step programmes within prison and directing addicts towards AA and NA groups.

The National Treatment Agency (2010) has recently begun reconfiguring their ‘models of care’, which were outlined in the introduction chapter, according to neo-liberal and recovery rationalities. Recovery, however, is a contested concept (Bonney and Stickley, 2008, Collier, 2010). The concept of recovery operates within a variety of contexts including substance misuse and addictions field (Best and Laudet, 2010), the mental health field (Bonney and Stickley, 2008, Carpenter, 2002) and eating disorders (Malson et al, 2011, Strober et al, 1997). The meanings given to recovery vary from an idea, a policy, a personal journey, a movement, a paradigm, and an instrument for change and self-formation (Best and Laudet, 2010, Bonney and Stickley, 2008, Carpenter, 2002, Rethink, 2011). Jacobson and Curtis suggest recovery is also understood in the same sense as people recovering from physical illnesses; the “restoration of normal health and functioning” and “strength of character” (2000:1). For Jacobson and Greenly, because of its application in various arenas such as “outcome research, personal narrative, service design and provision, and system reform” this has led to confusion over exactly what is to be “experienced, promoted, or facilitated” (2004:482).

The recovery movement can be located along two separate, though at times overlapping, historical trajectories (Jacobson and Curtis, 2000). The first is the consumer/survivor/ex-patient movement that emerged during the 1960s and 1970s. This particular social movement can be mapped onto wider social movements that emerged at this time that called for greater acknowledgment of civil and human rights (Carpenter, 2002, Cruikshank, 1999, Jacobson and Curtis, 2000). The second trajectory is the *grassroots self-help movement* (Jacobson and Curtis 2000) such as Alcoholics Anonymous (1963) and Narcotics Anonymous (1982). The two recovery movements differ in their structure, organisation and relationship with professional bodies; however, a commonality is the rejection of the medical and psychiatric models of disease and treatment and the premise that people “can and do recover” (Carpenter 2002: 88, Narcotics Anonymous 1982). This is at the heart of the recovery movement.

The concept of recovery has operated in the mental health field since the 1960s and 1970s. However, it has only recently been introduced into the substance misuse field. Because of philosophical differences between the abstinence model, underpinned by the twelve step fellowships, and the substance misuse treatment system, underpinned by harm reduction model, the objectives of recovery have been seen to be at odds with public health and the needs of the drug using population. The criticisms alluded to above have provoked a reconfiguration of the fundamentals of drug treatment in Britain (Aston 2007). The New Abstentionists have criticised the harm reduction model as failing to tackle public health issues and instead advocate recovery-orientated systems (Best and Laudet 2010, DrugScope 2009). In taking a broader picture, this move can also be seen as an attempt, demonstrated in the coalition Government's *2010 Drug Strategy consultation paper*, to realign the Drug Strategy, and in turn the drug treatment system, with the *Big Society* agenda.

The recovery process is not only nurtured internally by their own experiences and skills, it is also encouraged externally by 'a' supportive relationship (Best and Laudet 2010, Carpenter 2002). The supportive relationship within the mental health field is "a professional, friend or family member" (Carpenter 2002:89). In contrast, in the substance misuse field it is another recovering person (Best and Laudet 2010). The twelve step fellowships also operate a similar model in which the person is called a sponsor (Narcotics Anonymous 1982). The person involved in this mentoring role is called a recovery champion. Best and Laudet define recovery champions as "charismatic and connected community figures who are visible examples of success...for those who claim recovery is not possible" (2010:5). The increased visibility of recovery has also been sought through various recovery walks and marches in England, Wales and Scotland over the last year or so. In some ways, this resonates with the wider aims of the recovery movement identified above and their mantra: People "can and do recover" (Carpenter 2002: 88, Narcotics Anonymous 1982). It is worth pointing out that recovery not only opens up the possibility for new forms of subjectivity, it also produces new relationships of power with a 'recovery champion'.

The notion of a recovery champions has also been linked with recovery capital. The visible demonstration of recovery champions, for Best and Laudet, may be the "key contagion that allows the 'viral spread' of recovery capital" (2010:5). The discursive

elements that make up the concept of recovery capital, it was argued in chapter 6, can be traced to the domain of natural recovery research (Biernacki 1986, Granfield 1996). The introduction of neo-liberal rationalities through the concept of recovery capital, on the one hand, reduces the excessive cost of drug treatment by displacing responsibility for recovery onto the individual in the form of self-care. In this respect, as a ‘technology of the self’ recovery capital directs individuals towards certain goals or the attainment of recovery capital in order to produce ‘neo-liberal subjects’ or ‘subjects of recovery’. The deployment of recovery capital, on the other hand, objectifies the problem drug user as an individual lacking in recovery capital and in terms of a new problem space based on this lack of middle class resources. *This arguably returns to the ‘dividing practice’ within drug treatment which was started by Kolb (1927) based on normal/abnormal, curable/incurable, psychopathic/non-psychopathic, mature/immature, those that have / those that have not.*

7.5. Conclusion

The aim of this chapter was to give further genealogical attention to the themes identified in previous two chapters regarding the productive role of discourses on poisoning and the dividing practice identified in the genealogy of recovery capital. The genealogical background to this chapter was the formation of drug treatment practices from the Rolleston era through to the recent configuration of drug treatment within the context of changing manifestations of scientific and political power. The central theme has been the formation of a dividing practice that has taken on several configurations within the history of drug treatment practices. In particular, this chapter has demonstrated not only the class dynamics and productive outcome of this practice, but that it is ‘configuration’ specific. The concern raised in this chapter is that the introduction of recovery capital into the ‘recovery’ configuration of drug treatment system has introduced this dividing practice into the recovery movement. The consequence, it has been argued in chapter 6 and in this chapter, is that the dividing practice inherent in the concept of recovery capital produces two groups of individuals and risks further marginalising an already marginalised group of individuals.

Chapter 8

Conclusion

By way of conclusion, I will first return to the research problem that was set out in the introduction to this thesis. Second, I will look at how the thesis has provided an alternative perspective from that contained in the current academic literature. Third, I will then provide an overview of the thesis, from introduction to analysis, and draw out the main steps that were taken in the development of the argument. Fourth, I will look at the policy implications of this thesis and the future direction of research opened up by this thesis. Finally, as I began the thesis with a personal account of my own experiences with the research problem, I wish to reflect upon these experiences again using Foucault's notion of 'thinking otherwise'. In other words, I want to reflect on my own position, and how that has changed, following the experience of studying a topic that I was a part of.

8.1. The research problem

At the heart of the research problem, which was outlined in the introduction to this thesis, was the complex multitude of power-relations that operate across the contemporary drug treatment system. In many subtle and intriguing ways, the population, body and subjectivity of the drug user have become the objects of a multifaceted set of discursive and non-discursive practices that extend well beyond drug treatment organisations and into the life of the individual. The experiences of withdrawal, as we have seen, once evaded power-relations with the medical expert; but, since the middle of the nineteenth century, have produced not only new relations with the self but also new relations with a range of medical and drug treatment specialists and institutions. These forms of government have extended into and beyond the body of the individual drug user where they have focused upon various domains including health and illness, disease, criminal behaviour, relations with other drug users and individuals, education and employment and other behaviours deemed problematic. This has been made possible by a range of governmental rationalities and technologies that are directed towards the management of the health, fitness and productivity of the

population. These practices, as I have argued in this thesis, have been formed by conditions that are historically contingent and, furthermore, dependant upon various social, scientific, cultural and political influences for their existence.

8.2. Seeing things differently

While there have been recent analyses of the historical development of drug policy and practice, these, with the exception of Seddon (2010), have arguably neglected the importance of broader social, scientific, cultural and political processes. Seddon (2011) has recently acknowledged this gap in the academic literature and proposed further historical sociologies of drug policy. Furthermore, Zajdow (2005) had also acknowledged the absence of sociology in debates on drug treatment and policy. This thesis, therefore, has addressed this gap in the academic literature and, I would argue, contributes, also, as a historical sociology of drug policy and drug treatment.

The historical studies that have attempted to provide insight into nineteenth and twentieth century ‘drug issues’ have arguably been limited by their refusal to problematise (or their method of problematising) the ‘addicted body’ within this historical context. For instance, it has been argued (Berridge 1999, Foxcroft 2007, Harding 1986, Parssinen and Kerner 1980, Seddon 2010) that there was no drug problem as such in the nineteenth century and the first problematisations of opium were related to life insurance and then public health. The concept of addiction, however, has been conceptualised as a product of liberal forms of government (Seddon 2010, Valverde 2008), religious discourse (Harding 1986) and by drawing on changes in the dominant medical paradigm (Parssinen and Kerner 1980). This revealed the addicted body, how it is irrational or immoral or sick, as embedded in religious, medical and political discourse.

There has been a general failure to question the taken-for-grantedness of the experience of withdrawal. For instance, Berridge (1999) and Harding (1986) claim that people in the nineteenth century only realised they had a dependency when opium became controlled and they were forced to withdrawal. The general acceptance of these concepts is problematic. Indeed, I am not suggesting that an experience never took place though I have argued that this experience has been reproduced by the many attempts to make it visible, knowable and governable. In this sense, my argument concerning the

poisoning discourse allows us to see the nineteenth century construction of the ‘addicted body’ from a different perspective, one of poisoning, which is also complimented, in terms of its governmental objectives, by its relation to political power (Seddon 2010).

The work of Lart (1998), MacGregor (1989) and Mold (2004) has provided an important insight into the emergence and wider social and political functions of the British drug dependency clinics. Stimson and Oppenheimer (1982, 1994), in particular, provided an effective ethnographic account of the inner workings of the clinic and which subsequently underpinned the analyses of others (Lart, 1998, Mold 2004). These revealed how the prescribing and therapeutic practices within the clinic developed within the context of social control policies and how through the objectifying power of the Home Office Addict Index and psychiatric discourse a new type of drug user emerged (Lart 1998). This literature, however, had failed to make links with the American clinic experiment and the types of power-relations that operated and the subsequent reconfiguration of the practices of the clinic by biological psychiatry. The subjectivity of the pseudo-junkie, in part, is the product of this reconfiguration and their attempt to separate out the true object of the clinic. The thesis, in this respect, demonstrated the importance of not only changes in political rationalities, but also the reconfiguration of scientific rationalities for the production of the subject of drug treatment.

The development of the concept of drug-related problems through the alcohol field and the application of the inebriety concept to drug problems had revealed the importance of seeing ‘practices’ from the drugs and alcohol field as mutually conditioning (Courtwright, 2005, Seddon, 2010, Valverde, 2008). Courtwright (2005), Seddon (2010) and Valverde (2008) have made important links with nineteenth and twentieth century discourses of inebriety. I would not dispute this link with alcohol, though I would argue that this thesis adds a new angle on the development of the concept of drug-related problems by pointing to the practices of self-poisoning and the biopolitical problematisation of pharmaceuticals. Moreover, it was also revealed in this thesis how the drug-related problem concept provided a new way of seeing the ‘addicted population’, as problem drug users. The neo-liberal subjectivity, as others have pointed out (Bunton 2001, O’Malley 2004, Seddon 2010), was also key to the emergence of the

problem drug user. This can be seen as an attempt to align the individual drug user with the neo-liberal agenda.

The final attempt to realign the individual drug user with the broader social and political order, I have argued, has been through the recovery movement. The recovery movement has received attention from academics that are participating in its development, though it has received no critical analysis from sociology. Unlike the numerous papers that have advocated recovery and recovery capital, this thesis expresses a ‘critical attitude’ towards recovery capital. This is primarily because of its link to natural recovery research on middle class drug addicts and how it operates as a dividing practice on the recovery population. In this respect, this thesis builds on the work of Miller (2001) who criticised harm reduction’s middle class agenda. In developing this argument, this thesis reveals the inherent ‘dividing practice’ that can be found in the operation of recovery capital that divides and reproduces this middle class agenda through the recovery movement.

8.3. Reviewing the thesis

In the introduction, this thesis set out the research problem before providing an overview of the drug treatment system. My intention in providing this overview was to introduce the reader to the notion of the ‘drug problem’ and how we think about the problem drug user and then demonstrate the complexity of the drug treatment system. The complexity existed in the various agencies, institutions, pathways, journeys, interventions and experts that confront the individual when they either go voluntarily or are coerced into the system for ‘help’ with their ‘problems’. The theoretical and methodological orientation of the research pulled the needs of the literature review in the direction of academic literature on the historical constitution of drug policy and the drug treatment system. The aim of the review was to outline the dominant narrative of how this system and its objects developed. The work of Berridge (1999), Courtwright (1982) and Musto (1973) proved useful by covering relevant literature across this same historical period in Britain and the United States. The literature, as pointed out in the above section, revealed a lack of historical sociologies and the neglect of important themes including the body itself.

Chapters 3 and 4 provided an overview of the governmentality perspective, drawing on Foucauldian (Foucault, 2007, 2008) and post-Foucauldian (Dean, 1999, Rose and Miller, 2008) literature, and the genealogy approach. The governmentality perspective was used by Seddon (2010) to structure his genealogical analysis of the mutually conditioned relationship between freedom and drugs. This thesis followed a similar trajectory though gave attention to both scientific and political rationalities. The governmentality perspective provided a new way in which to think about the complexities of the drug treatment system. For instance, how the objects of the system were formed through governmental problematisations rather than having an existence independent of their government. Thinking about drug treatment as governmentality opened up the possibility that the universal concepts such as withdrawal and dependency, for instance, were formed through historical attempts to make the body governable and were not, as often assumed, ahistorical; even withdrawal has a history. This perspective moves counter to the dominant understandings of withdrawal found in the academic literature.

In chapter 5, the analysis moved from the present and onto the history of these practices. In using the genealogical method, my intention was to question the “primacy of origins, of unchanging truths” (Dreyfus and Rabinow 1982:109) of the ‘practices’ and understandings of the ‘body’ that circulated within the drug treatment system. The discourses of natural recovery, needle fixation and withdrawal were selected as they were problems identified within the academic literature (Lindesmith, 1938, Fraser et al 2004). These genealogical analyses revealed a similar picture and indicated important links and overlaps with the way in which the body and self of the drug user within the eighteenth, nineteenth and twentieth century were problematised and governed through medical power-knowledge.

The experience of withdrawal and earlier accounts of needle fixation emerged through the medical profession’s concern with governing the health and morality of the population. These initial genealogical excavations revealed that these practices, and even the addicted body, were in fact produced within a broader discursive field of poisoning that developed within the early part of the nineteenth century. The poisoning theme also continued when psychiatry emerged as the political technology for governing the ‘drug addict’. In contrast, the genealogy revealed how this ‘poisoned body’ became marginalised by a dividing practice which relocated the problem within

the personality of the individual. The poisoned body, it was argued, became the normal middle class drug addict. The genealogy of natural recovery revealed how this normal 'poisoned body', supported by the neo-liberal subjectivity, formed the criteria for the concept of recovery capital. The question was raised as to whether a 'position' existed outside of the treatment system in which one could break free of their drug use without the involvement of the power-relations described in this thesis. I was aware of the arguments made by Biernacki (1986) on the idea that recovery without treatment was possible. In fact, I found this notion an attractive proposition and alternative to the agencies of social control. The genealogy of natural recovery revealed, on the contrary, that an alternative form of recovery was something of a play of mirrors and was only visible through mutations in political and scientific rationalities.

The genealogical work carried out in the genealogies constructed in chapter 5 opened up a broader field for historical analysis. Chapter 6, therefore, developed the discursive strand of poisoning by locating its 'emergence' within a play of forces, on a battle field, between physicians and apothecaries. The concepts of sovereign-poison dynamic and population-poison dynamic were developed in order to draw attention to the shifts in the economy of power from the body of the sovereign onto population. The argument was put forward that the emergence of 'population', as an object which needed to be governed, with respect to poisoning, allowed for the discipline of pharmacy to emerge and the pharmacist to take on the role of *pastor to the poison naive*. In many ways, the pharmacist whose job it is to supervise the consumption of methadone by the problem drug user can be understood as a contemporary manifestation of this form of 'pastoral power' that emerged during the nineteenth century as a technique for reducing incidents of poisoning. The pharmacists as pastor can be understood in the broader context of biopolitics. This point, compliments the work of Southgate (2003) and the notion of methadone as liquid handcuffs. This point has enabled a reflection on the current discursive field of drug treatment.

The discursive practices used in the treatment of the poisoned body were then applied to the body of the opium user which revealed the body as a poisoned body and morphine withdrawal as a body in a state of 'de-poisoning'. The work of Berridge (1999) and Seddon (2010), in this respect, only offered us a partial picture of how a system of practices formed which took as their object the body of the drug user. The link with the

biopolitical problem of neurasthenia, furthermore, constructed this experience and mode of government as dangerous. Ultimately, this resulted in maintenance prescribing as the priority not only because of its link with overcoming this danger imposed on the nervous system, but because it supported the 'productive' objectives of liberal citizenship. This was an important event in the historical formation of the discursive practices for treating heroin withdrawal, and, as we have seen, it opened up the space in which maintenance prescribing became not only possible, but essential, for the life and liberty of the citizen. The 'poisoned' body, under the continued dose, could be normal and productive. Most importantly, it demonstrated how these practices were not only applied to the field of morphinism, but how the field of morphinism and ultimately the two dominant methods of detoxification and maintenance in drug treatment, are dependent upon them. The British System, therefore, reproduced this discursive practice as a way in which to promote liberal forms of citizenship.

In the same way as chapter 6 developed the poisoning theme from chapter 5, chapter 7 further explored the development and operation of a dividing practice whilst at the same time continuing the historical narrative of drug policy and treatment. The theme of dividing practice, although developed in the genealogy of natural recovery, became more explicit when the analysis turned towards the early years of the British System and in particular its reconfiguration in North America when psychiatry took over responsibility of the drug user from the physician. Commentators (Berridge 1999, Seddon 2010) have acknowledged the dominance of the 'citizen class' (Willcox 1923) in the Rolleston era, however, the dynamics between this class and the 'vicious class' has been neglected. What was interesting was in North America, the same two groups were discussed in relation to addiction and national well being though it was the reverse. The dynamics have, in part, been discussed by Courtwright (1982) and Musto (1973) though Foucault's concept of dividing practice proved effective in understanding how these two groups were dividing through psychiatric concepts of normal and abnormal. The genealogical analysis of psychiatric practice revealed that as the poisoned subject became divided from the 'problematic personality', for the purpose of government, the relapsing subject emerges as the true object of psychiatric discourse. The links between the American clinic and the British clinic proved fruitful in this respect.

The remaining sections of chapter 7 explored the transition from the liberal configuration to the neo-liberal configuration of treatment practices with the emergence of the voluntary sector, in which the drug treatment agency of this research can be located, and the shift towards the problem drug user and harm reduction. The argument was that the (re)construction of the drug addict as problem drug user also depended on the practices of self-poisoning and the biopolitical problematisation of pharmaceuticals. The concept of drug-related problems therefore emerged within a broader context than already acknowledged elsewhere and further enhanced the potential for surveillance over the problem drug using population. Part of my argument was that within this configuration of drug treatment practices the dividing practice broke down and dissolved. However, it is through the recovery movement, also arguably aligned with the neo-liberal project, and the concept of recovery capital in particular that this dividing practice has resurfaced. The sections below will go on to discuss the policy implications concerning the introduction of recovery capital.

8.4. Policy Implications: the recovery movement and recovery capital

When I started this doctoral research project the theme of recovery was just beginning to take shape within mainstream drug treatment. The way of thinking about the solution to drug problems from the perspective of 'being-in-recovery' had, to a large extent, mostly been associated with the twelve-step movement. The principles advocated by twelve-step groups were often seen as existing in opposition (and tension) with the harm reduction philosophy. During the early phases of my research I was still actively working as a drug treatment practitioner for a local organisation. It was only because of my academic life that I had an awareness of the potential changes in the direction of drugs policy and practice. In fact, I can remember thinking how detached and uninformed our team of practitioners were about these macro changes. As I became more involved in this research the recovery movement was starting to be talked about by senior managers. From my own observation, the agencies and practitioners were becoming abruptly aware that drug treatment was about to be going through some significant changes.

The recovery movement is now beginning to gather momentum amongst policy makers, academics, practitioners, agencies, service users and other interested groups. This can be demonstrated by the recovery academies and organisations that have developed in

England and Scotland over the last few years. Furthermore, there have also been a series of recovery walks that have taken place in England and Wales over this period. The aim of the walks has been to challenge the stigma associated with drug problems and provide a visual demonstration that recovery is possible for those with drug problems. In other words, by forming a collective, through association, recovery can become tangible. The social networking site *Wired into Recovery* has become a hub of activity for not only drug users, recovering drug users, service users and family members, but also for academics and professionals working in this particular field. This is giving birth to an interesting mix of subjectivities and spaces within which they can be practised.

The purpose of this thesis has been to strategically use the genealogical insights to probe the way the present of the problem drug user is taken-for-granted. The present of problem drug users entering within the drug treatment system is currently in the process of being reconfigured. The transformations witnessed in this particular field of practices cannot be explained by simply pointing to the problems within the drug treatment system itself. These changes can be explained by pointing to the broader social, economic and political processes. As a result, we have come to ask questions again about this particular field of government. What does it mean to govern problem drug users? What ends should they be directed towards? What is the most economic way of doing this? This is an essential feature of liberalism, which Rose and Miller refer as the “recurrent diagnosis of failure” (2008:206). The solution to this recent diagnosis of failure, the critical reflection on governmental practice, has taken the form of the recovery movement.

My ‘policy implication’ might seem slightly premature given the fact that the recovery movement is still unfolding. Nevertheless, in the process of unfolding regimes of government are in the process of being reconfigured, transformed and strengthened as they draw support from other discursive practices. These regimes, as Dean (1999) has pointed out, tend to support each other because they tend to promote the same types of subjects or problematise the same objects. In this respect, the recovery movement, much like harm reduction, aligns the individual with the neo-liberal agenda by reproducing rational forms of subjectivity. The concept of recovery capital, I have argued in this thesis, is one such discursive practice incorporated into the recovery movement in order to make this space visible, thinkable and ultimately governable.

In terms of the recovery movement we need to view recovery capital as a mode of government – a way of exercising power - which not only ‘governs’ a problem but is involved in its production. The problem space produced arguably functions as a way in which this population can be acted upon, organised, divided and reproduced through a middle class paradigm. Recovery capital, in this respect, is a dividing practice that divides up the recovery population into two groups; those that have recovery capital and those that do not. This is not the first time class has been implicated in the make-up of governmental tools. Miller (2001), as I have mentioned, revealed how harm reduction enacted a middle class value system. This value system prioritised certain needs over others. This ‘Othering’ of need further marginalises the problem drug user. In light of my findings on recovery capital, my conclusion is that we need adopt a critical attitude towards concepts like recovery capital that are brought into the tool box of the drug treatment system for the purpose of acting on the conduct of others.

8.5. Future research avenues

A future research avenue would ask questions about the way we think about the body in withdrawal. In this section, my intention is not to go into any further exploration of withdrawal but to advance a possible future direction for research. In many ways, this ‘diagnostic’ of the (poisoned / addicted) body is at the heart of the genealogical project. The genealogy of withdrawal, as I have demonstrated, revealed that this concept, which is fundamental to drug treatment, has a complex history. It has proceeded from its emergence, where it was self-governed and known as ‘leaving off’, to becoming associated with death and nervous conditions, and then denial, to more recently becoming a diagnostic criterion for an addiction itself. The genealogy revealed that experts have not only located withdrawal in the physical body, but also within the psyche and behaviour of the individual. More recently, withdrawal has come to be described through a molecular style of thought (Rose, 2007). In turn, each of these ‘events’ have situated the individual within a system of power-knowledge. It has also not managed to escape from its discourse of panic and fear.

As Foucault (1978) has pointed out, power-relations are unavoidable, but we need to be vigilant and proactive in criticising their manifestation and operation. We could ask, is it possible to completely do away with the concept of withdrawal and go back to the eighteenth and nineteenth century notion of ‘leaving off’? This is a radical question. It is

a question, however, that can now be asked. It makes sense. What alternative ways are there of thinking about the withdrawing body? This is an important question that goes against the dominant discourse of withdrawal. In addition from this approach to the thought of being 'in-withdrawal', the broadening of the discursive field of withdrawal – *its wider deployment* - by the dopamine hypothesis has also highlighted a potential area for future research. In this respect, it would be important to question the impact of recent developments in the biosciences on our understandings of withdrawal and what new withdrawing subjects have been produced by these new understandings?

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