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The narrative of evaluations: medically supervised injecting centers

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Medically supervised injecting centers, or drug consumption rooms are officially sanctioned places where people can inject or smoke illegal drugs in hygienic conditions and under supervision. Their ostensible purposes are to protect the health of drug users and contain the nuisance potential of open drug markets. This article argues that the debates and arguments supporting the establishment and existence of medically supervised injecting centers follow four interweaving narratives. These narratives can be characterized as (1) Caring and humanitarian (2) Elimination of public nuisance (3) Governance of the drug-using subject (4) Neo-liberal, utilitarian, and bureaucratic. These narratives alternatively combine and oppose each other. This means that the analysis of the benefits and problems with such initiatives depends on the perspective of the actors involved and the claims made for their effectiveness.

She can't be sure at first if the shade on the footstool is a trick of light or a trick of paralysis—wherein a certain floral slipcover or a love seat or a standing lamp resembles instead her fellow man. There are torsional shadows in her room. Revenants. Well, her glasses are splayed on the bedside table, atop an unopened book.

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Thus, this guest on the footstool is consubstantial with furnishings, with chairs, draperies, occasional tables. Edgeless and indistinct. A late Impressionist visitor. (Moody, 1998, p. 163).

In one sense all sociology is the "late impressionist visitor" as Rick Moody so eloquently puts it. His narrator is a woman dying of a debilitating disease which is gradually robbing her of her ability to distinguish reality from imagination, as well as her physical ability to respond to the world. In the narratives of illicit drugs policy and the experience of it, this description is particularly apposite. The intents and outcomes of policy becomes confusing when one reads the debates and arguments in the professional literature, the propositions and truth claims of policy documents and the outcome measurements of evaluations. All sociologists thus become late Impressionist visitors.

This article will look at the narratives and language of the medically supervised injecting centers (MSIC), or drug consumption rooms (DCRs) debate\(^1\) and the so-called evidence-base for their existence. It will argue further that there are five narratives which emerge from the debates and discussions of medically supervised injecting centers. None can be clearly delineated from another—they all contain elements of each other. There are four narratives that emerge openly and one which is never discussed, but exists as what some might call "the elephant in the living room." The overt narratives can be categorized as:

1. The caring and humanitarian
2. The elimination of public nuisance
3. The governance of the drug-using subject
4. The neo-liberal, utilitarian, and bureaucratic.

The final story is the pleasure narrative. Since this article will be concentrating on the first four (but touching on the hidden one), this article can be accused of also denying this fundamental drug story. I will have to plead guilty, but beg the
reader’s indulgence by noting that this is a narrative with a huge story to tell, and one which I will leave to another time. Pat O’Malley and Marianna Valverde (2004) however, attend to this particular one and its absence in the modern professional literature about drug use.

This article will develop the trajectories of each of these narratives through a discussion of the main reports and articles related to Supervised Injecting Facilities (SIFs). Although this is not an exhaustive trawl through the literature, it does choose such literature as illustrative of the argument. The main literature to be used is the evaluation report of the Sydney MSIC (MSIC Evaluation Committee, 2003), the European Report on Drug Consumption Rooms (Hedrich, 2004), and the Joseph Rowntree Foundation report (Independent Working Group (IWG), 2006), plus other professional articles in the area. The concentration on these three reports is because the MSIC Evaluation Committee report (2003), Hedrich (2004) and IWG (2006) are reasonably exhaustive. The outline of the development of the debate uses the Australian situation as an illustration because of the author’s background, but also because a medically supervised injecting center was established in Sydney and the evaluation report is comprehensive and intrinsically interesting. A side issue is also that English is the language of the author so, even though the European rooms are the longest established, most of the literature is unavailable, thus the reliance on Hedrich (2004).

**Narrative and the medically supervised injecting center**

Medically supervised injecting centers (MSICs) are part of the panoply of programs within the broader policy of harm minimization and include needle and syringe exchanges, drug substitution, and other such programs. Harm minimization can be described as a policy intended to reduce or ameliorate the harms associated with illicit drug use, without necessarily
reducing the use of these drugs (Single & Rohl, 1997). It is also a utilitarian, risk management-oriented policy (O’Malley, 1999, Miller, 2001).

All public policies have a metanarrative which deals with contradictions while attempting to maintain some form of coherence (Roe, 1994), so the objects of those policies, such as MSICs become part of the narrative structure. Harm minimization is a metanarrative of late modernity which attempts to deal with a series of competing discourses. On the one hand the state still treats the illicit drug-user as a damaging criminal in need of control, while on the other there is also the need to treat the drug user as a governable subject, amenable to the new technologies of the subject. O’Malley (1996, p. 27) refers to these new technologies of the self as “post-social rationalities” which:

Constitute their subjects not as members of an overarching social whole, shaped by social conditions and to be governed through social interventions, but as autonomous individuals, responsible for their own fate, invested with personal agency and thus with personal responsibility for their actions (O’Malley, 1996, p. 28).

At the same time, the New Public Health (Peterson & Lupton, 1996) orientation brings in new forms of surveillance over populations, including that population whose primary activity is taking illicit drugs via dangerous (albeit efficient) means such as injecting directly into veins. So the three competing directions of the harm minimization metanarrative are: 1) State control of drug users 2) Production of the governable subject 3) The public health imperative.

With the success in the late 1980s and 1990s in the fight to limit the spread of Human Immunodeficiency Virus (HIV) in the injecting drug-using population through the introduction of clean needle and syringe programs, other programs were then introduced in the hope of ameliorating other forms of drug-related harms. These include such experiences as overdose deaths and the spread of hepatitis B and C. These are
health problems for the individuals themselves. Thus we discern as the first narrative of the safe injecting facility the caring and humanitarian one. Its main characters are the intravenous drug users (IDUs) whose well-being is at the center of this particular story.

When we look at the definition of safe injecting facilities, the first blurring of the narratives becomes obvious. MSICs are state sanctioned rooms or clinics where people can inject illicit drugs.

Supervised injecting centers (SICs) are legally sanctioned health and social welfare facilities that enable the hygienic injection of pre-obtained drugs under professional supervision in a nonjudgmental environment (MSIC Evaluation Committee, 2003, p. 2).

Consumption rooms are protected places for the hygienic consumption of pre-obtained drugs in a nonjudgmental environment and under the supervision of trained staff (Hedrich, 2004, p.8).

Drug consumption facilities or rooms (DCRs) are legally sanctioned low threshold facilities which allow the hygienic consumption of pre-obtained drugs under professional supervision in a non-judgmental environment (Kimber et al., 2003, p. 227).

The term “drug consumption room” (DCR) is used to cover any room specifically set up for the supervised, hygienic consumption of pre-obtained, controlled drugs (IWG, 2006, p. 3).

Apart from what seems a very limited vocabulary, the above quotes have other common elements, in both language and intent. The word “hygienic” is an element in every definition, without exception. The protection of the consumer of (illegal) substances bought outside is another common idea, as is professional supervision and a nonjudgmental atmosphere. These official institutions are positively compared to the “shooting galleries” prominent in many U.S. cities and television programs which are not sanctioned by the state and are “unhygienic” (IWG, 2006; Wodak, 2004).
At least three of the four competing narratives described at the beginning of the article all make their presences felt in these quotes. There is the humanitarian impulse to protect people, and be respectful (nonjudgmental) while giving people safe places to inject. The governance of the drug-using subject involves the supervision of injectors by professionally trained staff. And of course, the risk-management, bureaucratic narrative exists with that same professional control. What does not appear is the nuisance narrative. There are about 65 drug consumption facilities in existence, the bulk of them in Europe with the only non-European rooms being one in Sydney and one in Canada. The earliest were opened unofficially in Holland in the 1970s, and were subsequently closed down because of local residents' complaints of nuisance. The first official room was opened in Switzerland (in Berne) in 1986, followed by the Netherlands in 1994 and about the same time in Germany (Hedrich, 2004, IWG, 2006, Kemmesies, 1999).

There are some common elements across all safe-using rooms, but there are also some culturally specific ones as well. The common elements include the targeting of a specific portion of the drug-using population; some professional overview of the operation and the distribution of clean needle syringes (in some programs to anyone, others only to those who use the injecting facility). While they all allow use of illegal drugs, they all fervently disallow the sale of these same drugs within the premises. The culturally-specific elements include the design of the buildings themselves, as well as their connections (or lack of them) to other health and welfare institutions.

The target population tends to be the one which is seen as the most problematic in the drug-using pantheon. This really means that person who is least amenable to individual governance. For example, the Swiss target group is the Schwars-tabhängige, or heavily addicted person who does not accept other forms of help; in the Netherlands it is the street drug
user that is not motivated to take up any other treatment, in Spain it is the socially excluded drug addict (Hedrich, 2004). In Sydney it is the drug user who injects in public around King’s Cross and tends not to be seen by other health services (MSIC Evaluation Committee, 2003).

The portion of the target population which is allowed to use the facilities depends very much on the reasons publicly espoused for the facilities’ establishment. In countries where public nuisance was the prime factor there are stringent requirements for those who are allowed to use them. In the Netherlands and parts of Germany for example, there are strict rules which allow only local residents (even those who are homeless) to use them. Identity cards are checked and registration procedures are strict. In Australia, Canada, and Spain, where the health of the user was deemed as important as public nuisance, there are no residency requirements and registration is anonymous existing really only for evaluation purposes. These requirements are important in understanding the priorities given to one narrative strand of the policy taking precedence over another. For example, we can trace how the nuisance narrative becomes more important than the humanitarian one, and how this is played out in the structure and functioning of the room.

In the next section this article turns to the narrative of crisis in Australia and the reasons given as to why these rooms were needed in the first place.

**The humanitarian narrative—the creation of crisis**

In common with the lessening of public nuisance (outlined below), the humanitarian narrative comes out of the narrative of crisis. This particular story is also an integral part of the sociospatial changes inherent in open drug markets. For as long as heroin overdoses occurred predominantly behind closed doors in private homes and apartments, their private
concerns were just that, private, and while they caused anguish and pain to the families and close friends of the dead user, without the pain becoming part of the public harms of intravenous drug use, the "crisis" could gain no traction. This section will concentrate on the situation in Australia to give a clear outline of the trajectory of the story and its development.

While illicit injection of heroin has been a feature (albeit very small) in Sydney and Melbourne since the 1960s, the late 1990s saw a massive rise in the number of injectors and drug overdoses from heroin. A campaign around the need for SICs (and a failed campaign for a heroin prescription trial) initiated by various groups, including drug and alcohol workers, became prominent with the claim that the overdose death rate would soon reach the road toll rate without drastic action (Linnell, 1998), since Australia (in common with much of the western world) was then in the thrall of a flood of cheap and high grade heroin. Safe injecting centers were seen as a natural extension of the harm minimization policies and programs that had been successful in minimizing the spread of HIV through the intravenous drug using community by the introduction of syringe exchange programs and other such interventions.

The state of New South Wales (NSW) was the center of the crisis where more than half the overdoses occurred, with the area in and around King’s Cross in Sydney accounting for 20% of all overdose deaths in Australia. There had already been established by this time a series of police-tolerated but private injecting rooms, many as part of the prostitution scene in King’s Cross. However, these produced so much public nuisance and police corruption that they led directly to a Royal Commission, and consequently the 1999 NSW Drug Summit recommending the establishment of SICs. There was a consensus (although clearly not unanimous) among many groups and individuals in the King’s Cross area that a SIC was worth considering and this was subsequently enshrined in law as a trial facility in May 2001 (Wodak, 2004). After the
evaluation committee handed down its report in 2003, the center was licensed for a further four years (van Beek, 2004b).

What was witnessed here was a moral panic, but from two very different groups. One was the group expected to run a moral panic, that is the conservative anti-MSIC line, the other the large group of advocates for the establishment of such a place like public health advocates, user groups, and direct service workers. This second group was worried by the fast rising overdose death rate. In the 1980s, Stan Cohen (2002) described a phenomenon which he called a "moral panic" in which certain people dubbed moral entrepreneurs came to see themselves as the guardians of public morality and used the media to whip up hysterical reactions to minor public nuisance problems against relatively powerless, outsider groups. I am not suggesting that the precipitous rise in overdose deaths was a minor public nuisance, but what happened in Sydney was the use of the media to influence policy by caring people who felt that otherwise the situation would have been ignored. Indeed, Wodak (2004) details how when a parliamentary committee declined to approve the establishment of a safe using facility, some well-known and concerned citizens determined to open an unofficial one as an act of civil disobedience.

This set up the caring and humanitarian narrative which provided the impetus for the establishment of the MSIC in Sydney and indicates the importance of this particular story in the evaluation report (MSIC Evaluation Committee, 2004). But the report also provides a subtle shift in emphasis. The pain for families of overdose deaths was made a prominent element in the campaigns leading up to the opening of the MSIC, but this group is absent in any of the reports and evaluations of existing centers. This shift is also evident in the IWG report (2006) and Hedrich (2004). The terms of reference of the MSIC evaluation (MSIC Evaluation Committee, 2003, p. 4) stipulate the impact on overdoses, blood-borne
viruses (BBV) incidence, prevalence and risk behavior in the immediate area of the center, and client health and use of other health services. From a sociological point of view, it would have been an interesting exercise to include in the survey of clients of the MSIC, as part of the evaluation, questions relating to contact with families, friends, and social support. From a public health aspect, it would have been even more important considering the importance for personal well-being that social support produces. It is notable that there is such a clear division between private (meaning individual, belonging within an individual body) and public (belonging to a wider, albeit not personally related community) harms. The IWG report (IWG, 2006, p. 109) does admit to some bleeding between the two distinctions "in that all private harms are likely to have public consequences. For example, overdoses will cost society money in terms of emergency services, hospital treatment, etc." The notion of social harms, beyond the nuisance harms of syringe litter and the cost to the public purse of illness, does not extend to pain and suffering to families and friends. The drug user is presented as an atomized individual, seemingly cut off from familial and community support by dint of their drug habits and lifestyles. In other words private harms cause biological, or viral, or health misery, but public harms have financial costs.

The concentration on personal health and well-being of the clients of SIFs is evident in the evaluation documents and reports, although it seems much closer to a description of avoidance of physical harm than to a positive production of well-being. Chapters on their impacts on overdoses, blood-borne viruses, and client health and referral uptake are part of all the main discussions, from the MSIC evaluations, to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and the IWG reports. Since all the reports and evaluations are produced for public policy purposes, it is not surprising that the happiness or satisfaction of IDUs is not uncovered.
The public nuisance narrative

The environment of crisis which gathered around the public drug markets and their consequent public injecting was also fueled by the loss of amenity felt by many residents and businesses around the markets. In Sydney, this was most acute in Kings Cross. This was also repeated around the world, in Europe and North America. Public injection led to overdoses (both lethal and nonfatal) among injectors occurring before the eyes of the public rather than behind locked doors. In Kings Cross, ambulance call-outs became commonplace. Public injecting also involved the littering of streets and parks with used syringes and other drug paraphernalia. Crime around the open drug markets is also perceived as an issue since it is assumed (sometimes quite correctly) that with the drug markets come the burglaries and petty thefts to pay for the drugs. Public disorder arising from users who are under the influence of various drugs adds to the atmosphere of insecurity and violence.

The public nuisance narrative was similar in all countries, from the Netherlands and other European countries, to Australia and Canada. However, its presentation as a first-order imperative for setting up DCRs is not evident in the same way across the globe. In Switzerland and the Netherlands, public order and amelioration of nuisance were paramount in the establishment of the DCRs. Hedrich (2004, p. 23) notes that in Switzerland, “the objective of reducing public nuisance was considered to be as important as improving users’ health.” In the Netherlands, the Dutch term “overlast” which means both objective and subjective experience of nuisance, was used when defining the population who was to be managed by the centers. The group was considered the most problematic in their resistance to treatment and in the very public nuisance they caused to local residents. This targeting of the population as the reason for the establishment of the Sydney MSIC was not as blatant.
While the humanitarian and public health imperative were presented as more important, the public nuisance narrative was just under the surface. It was important that the local public get behind the center and one way would have been to show how the MSIC would ameliorate the public nuisance that had been made so evident in the media and through various organized groups. The Sydney MSIC evaluation report set up a number of parameters and variables to test public reactions to the center and the amelioration of public nuisance or “annoyance,” as it is termed in the document. To do this, it counted the number of discarded syringes and concomitant drug paraphernalia, before and after the opening of the center, as well as the amount of drug-related loitering around the immediate area. Community perceptions of the center were surveyed and analyzed.

The acceptance of DCRs by the public is important because public nuisance is so central to the establishment of the centers. The narrative trajectory is not so obvious because, as was the case in Sydney, the drug and alcohol workers and others present the caring narrative as a moral crusade. But without the call to lower nuisance and raise community amenity, the alliances needed between local communities in the form of middle-class “gentrifiers” of inner-city areas, municipal councils interested in raising land prices and the rates that go with them, police and the representatives of the drug users (social and health workers), would never develop (Kubler & Walti, 2001). This is not an easy project, as can be expected. For example, there may be differences between residents and the business community in an area. The MSIC report (2003) found that residents in the Kings Cross and surrounding area felt that the five most important negative issues or annoyances in the area were discarded syringes, the negative image drug taking produced of the area, crime and safety, the tragedy of drug use, and harassment by drug users of passers-by. For businesses, the five top issues were negative image, crime and safety, discarded syringes, the way that the open drug scene attracted drug users, and harassment. Even
though four of the issues were common to each group, local residents were taken much more with the tragedy of drug use than were the businesses, whereas businesses objected to the way that the open market attracted drug users (and drove away customers, presumably). More interesting was the fact that overdoses, public injecting, and the spread of HIV/AIDS did not appear in either group’s top five.\textsuperscript{8}

The public nuisance narrative straddles the humanitarian narrative and the governance one. While the MSIC evaluation surveys found a greater acceptance of the center over time, local businesses became increasingly worried about crime, loitering and other annoyances they saw as driving away business. Local residents did partially subscribe to the humanitarian narrative, while the drug and alcohol workers, as well as users themselves shifted from the humanitarian and caring to a governance and public health narrative. Fischer et al. (2004) and Kubler & Walti (2001) illustrate how the various actors in the situation in Switzerland and Canada made alliances to ensure the continuation of the DCRs, but at the same time these alliances were fragile and needed to be negotiated and continually updated. To do this, the drug users’ advocates would cross the narrative line from humanitarian to governing and residents would move from nuisance to governing as well.

The importance of using public nuisance as the major reason for setting up safe using rooms illustrates the co-producing narratives of tolerance and control. While there may be strong moral arguments presented for tolerance, the public appeals are generally couched in terms of control of public nuisance, as we see here. Of course, one may not preclude the other, but they may become difficult to reconcile in cases of dispute. The importance of forging alliances and compromises between seeming competing interest groups becomes apparent here. To accommodate the compromises, the narrative transforms into one of governance, both self-governance of users and greater external control (Fischer et al., 2004;
O'Malley, 1996). Cohen's (2002) analysis of moral panics suggests that the process of moral panic inevitably leads to greater external regulation like greater policing and tougher sentences, while the situation described here also includes the (diminished) elements of tolerance and self-governance from those committed to the humanitarian discourse. However, the climate of crisis produced by such interventions in the media by various groups committed to establishing drug consumption rooms inevitably led to greater expectations of the effects of the DCRs than might otherwise have been the case.

Public nuisance and the use of public space is an area in which delicate negotiations are most likely to lead to success, at least in terms of being able to establish a supervised injecting room and keep the immediate community relatively satisfied with its existence. This was shown in the Sydney MSIC (Wodak 2004; van Beek, 2004b), as well as in the European experience (Kubler & Walti, 2001). Here we see two of the narratives being employed in the establishment of MSICs—public nuisance and humanitarian concern. The next section details how the programs of the MSICs add the other two narratives to the story—the utilitarian and the governance of the subject.

The Governance of the drug using subject

When discussing the Swiss situation, Walti & Kubler (2003) argue that the 1980s HIV epidemic opened up a "policy window" that allowed for a coalition of interests to pursue different and fruitful drug policies such as needle and syringe programs (NSPs), and SIFs. It also leads to collisions between the groups at various times which led to unexpected outcomes. One of these outcomes was the way that the governance of the drug user in NSPs and SIFs often produced greater state control of voluntary groups and thus greater policing of drug users by groups whose initial aim was to help and represent them. This was done by the incorporation
of drug services into a "uniform paradigm to which the participants have to subscribe . . . that of "social public order" (Walti & Kubler, 2003, p. 518), via state funding requirements and the desire to maintain positive relations with community groups and the police.

An analysis of the MSIC and other reports indicates a particular discourse of governance, similar to one described by O’Malley (1996) as the "audit" or "contractual" state. The contractual state exists where "models of market-like accountability are applied to state services (for example, audits, cost-benefit analyzes)" (O’Malley, 1996, p. 28). O’Malley (1996, p. 28) further argues that "post-social political rationalities" are no longer confined to the bureaucrats and their masters; those who see themselves as part of the defenders of the disadvantaged such as academics and community workers also buy into these discourses.

A common factor in all countries and facilities is the existence of explicit "use of service" rules. All centers have some rules, even if they are not all identical—rules such as no injecting in groins or necks (common to most), no injecting whilst drunk (common to most), no injecting of others (most), no smoking of heroin (chasing the dragon) in injecting rooms (in countries where this exists), and no injecting in smoking rooms. In Holland these last two requirements are very important. The clients are generally divided into those who smoke (heroin) or freebase (crack cocaine), and those who inject. The users are separated into rooms to stop trouble between them because of the established hierarchy and antagonism between users. In effect, the smokers look down on the injectors (Wolf et al., 2003). Sydney is the only place where the smoking of tobacco is banned and where pregnant women are not allowed in. One of the rules of the Hamburg rooms is "no sexism" (Zurhold et al., 2003, p. 668). All services reserve the right to exclude users who do not abide by the rules (Fischer et al., 2004).
While all the rules may explicitly claim a belief in autonomy and respect for the drug user, in fact there seems little belief in drug users being able to abide by conventional norms (Hedrich, 2004; Wolf et al., 2003; Zurhold et al., 2003; van Beek, 2004b). Instead the users are tightly controlled. Indeed, the Dutch services have explicit contractual arrangements with clients.

A systematic effort to increase and maintain safer use knowledge among clients of consumption rooms is made by some Dutch services. Permission to use the facility is given on the basis of a contract between the service and the user that obliges the drug user to attend safer use training courses (Hedrich, 2004, p. 43).

The differences in environment are very interesting. In Holland they describe a home away from home so that there is a café/lounge area where clients can mingle. In Australia:

Design features such as one-way flow through the premises and the installation of one to two person-injecting booths worked to minimize client interaction and allow for greater client privacy. These features in particular were believed to reduce the likelihood of intimidation or "standover tactics" from other clients. MSIC management suggested that had the MSIC adopted the typical European service model with a contact café, it might have been more difficult to regulate drug dealing on the premises (MSIC, 2003, p. 26).

In Sydney there is no talking between booths and staff watch while people inject themselves, at least until they prove they can inject safely to the staff's satisfaction (van Beek, 2004b). This is characteristic of the Sydney room with its hospital-like and highly controlled atmosphere. The medical director of the Sydney facility, Ingrid van Beek (2004b, p. 97), writes that she worries that the European social-welfare model serves to normalize injecting behavior, something she considers that the clinical environment in Sydney is less likely to do.

All the rules of service point to the governance of the drug-using subject narrative. They all describe the various technologies of self, designed to produce the "responsible" drug-using subject. Drug users enter the rooms as chaotic,
out-of-control subjects (those who are the most problematic) in need of persuasion and education, and exit at the other end as specialists in the harm reduction techniques of safer injecting. Fischer et al. (2004, p. 361) describe these facilities as “factories of health” implemented to contribute to the production of responsible citizenship in IDUs. To use Bunton (2001, p. 229), SICs can be seen as examples of the “pluralization of intervention technologies of governance.” The multi-sectoral approach involving numerous health and welfare professionals, the police and local municipal authorities leads to an effective management of the target populations (the most disadvantaged and homeless). However this has to be cloaked as examples of humanitarian caring, rather than control of problem populations.

The IWG (2006), distinguishes between a DCR and heroin prescription trials in terms of the clients of each. The authors argue that in a prescription heroin program:

The drugs are legal and prescribed and the user will have had a history of trying other treatments before receiving a heroin prescription. Before receiving a heroin prescription, the user will most likely have been treated with methadone (a heroin substitute) and, while failing to give up illegal drugs, will have kept in contact with treatment agency. Such “trusted” users are therefore less chaotic than the typical DCR clientele seen abroad, many of whom are homeless and experiencing a broad range of social and health problems (IWG, 2006, pp. 3-4. Emphasis added).

This is the baldest description in the literature of the “untrustworthy” and chaotic DCR client, although the rules of service and the general attitude in all the documents lend themselves to this description. This also points to the contradictions in the governance narrative. The client of a SIF needs to be taught self-care and to be trained in self-monitoring, but there is a question mark over the ability of the institution to train its clients in this since they are the least trustworthy of drug-using individuals. This is also the group of people who are least amenable to any rules that govern drug use.
As previously noted, pleasure, or the lack of it, is the elephant in the living room in the way SIFs and DCRs are written about. In Sydney, the descriptions belie any belief that people use drugs for pleasure—there is almost a desire to deny that pleasure exists at all. This can be related to the use of the language of hygiene and education. Here is the description of the Sydney room by its medical director, Ingrid van Beek, in a radio interview:

Well the first time that they come we take a full history, find out all about them, find out what sort of treatment they’ve had, what sort of history of overdose and so on, and once we’ve got these sorts of details, we find out what they’re going to use on this occasion . . . and then they proceed through to what we call the second stage and inject there, under supervision . . . and move to the third stage, which is particularly where our counselors are stationed and are able to engage people about the sort of broader reasons why people are using drugs and offer assistance. (van Beek, 2004a)

While there is no requirement to learn safer use, or a formal contract as in Holland, there is a presumption that the duty of the MSIC is to train its clients in the hygiene of "good" (but not enjoyable) drug consumption. In addition, the assumption behind the counseling stage is that there is an underlying negative reason why people use drugs, or at least why the sort of people who inhabit the MSIC would use drugs and why an investigation would lead to an amelioration of this drug use. This rationale is about drug use, not for pleasure, but as risk.

The use of drugs for pleasure is not mentioned generally in any literature about safe using rooms. Indeed, it is conspicuous by its absence. The language of the MSIC evaluation report and the EMCDDA report is about danger, risk, illness, and deprivation. A discourse of pleasure is what is missing from the modern discussion of illicit drug use, according to O’Malley & Valverde (2004) who write about the various discourses of pleasure available, but generally missing, in the debate. The liberal discourse is about pleasure and moderation; indeed in this discourse pleasure can only come from
moderation. The use of drugs like heroin and the way some people enjoy the procedure of injecting the drugs clearly confront this particular discourse since these imply not just a desire for risk, but also the abandonment of moderation.

This is especially true with respect to criminological analyses of illicit drug consumption, where discourses of “abuse” and “addiction” are associated in government with compulsion, misery, death, and disease, and the end of individual freedom (O’Malley & Valverde, 2004, p. 33).

Even the harm minimization discourse is not free from this. However much it would like itself to be, there is a tension between “presumptive right to pleasure and a duty to govern risks” (O’Malley & Valverde, 2004, p. 39).

The governance narrative links indirectly with the two narratives already discussed—caring and nuisance. The language of “safer using” presupposes concern for the user and a desire to help keep the user healthy and alive. It is also assumed that the responsible user will be more responsible in other areas outside of the center, thus producing a presentable face to the local community. As O’Malley (1996, 1999), Bunton (2001) and others argue, public health and harm minimization as policy also carry a neo-liberal tone, amenable to what O’Malley (1996) calls “actuarial risks” and assessment, linking this narrative to the final one to be analyzed below.

The neo-liberal, utilitarian and bureaucratic narrative

While outcomes relating to overdose deaths, amelioration of public nuisance and better health results for IDUs are the justifications for the establishment of MSICs, Australian public health rationalities demand an economic evaluation. The section analyzes the way that the MSIC evaluation report goes about producing this particular narrative. The introduction to the chapter in the MSIC report on the economic evaluation is telling. It aims to answer three questions which are:
1. What was the cost of the service?
2. Is there an economic justification for the service?
3. What would be the economic justification for opening new services?

The build-up to the establishment of the MSIC in Sydney was always couched in the language of the humanitarian and nuisance narratives. The EMCDDA report (Hedrich, 2004) outlines outcome measures in terms of expectations of the amelioration of public nuisance and public health. The IWG (2006) notes that the Sydney and Vancouver centers seemed quite expensive, but there were particular issues with their stand-alone situation that contributed to this. Interestingly, however, cost data on European services “are not readily available . . . as a result, at this stage, it is impossible to say anything certain about cost effectiveness” (IWG, 2006, pp. 63-4). This has not stopped the MSIC Evaluation Committee (2003) from trying. Considering economic evaluations as being fundamental to public health is a particular utilitarian view of the public health enterprise and one which, in the case of harm minimization, is ignored by the polemicists but avowed by the bureaucrats. Others who subscribe to the humanitarian view rarely comment in terms of economic evaluation.

As part of the neo-liberal, bureaucratic turn of harm minimization and its associated policies, economic evaluations make very specific choices about how and what will be counted. Such an evaluation does not cost quality-of-life issues like client satisfaction or happiness, for example, in favor of rather more easily enumerated costs and savings related to deaths, utilization of health-care services, policing, and the costs related to running the center itself. Neo-liberal social policy demands that all programs be costed, but those costings are limited to the cheapest (called “cost-effective”) alternatives. To this end, the evaluation committee used a cost benefit analysis (CBA) rather than a cost effectiveness
analysis (CEA). It is explained that “in CEA a single public policy objective is set (for example, a given reduction in heroin-attributable mortality) and various alternative ways of achieving this single objective are analyzed to determine which is the lowest cost” (MSIC, 2003, p. 181). A CEA finds the cheapest way of achieving a public policy outcome—not necessarily the most humane. A CBA uses an agreed value for a life and then examines “both the costs and benefits of alternative policies (so that) it permits rational choices to be made between different policies” (MSIC, 2003, p. 182, added emphasis). So basically, if the costs of implementing any particular policy are greater than the value of the lives it saves, the policy should be jettisoned. This is form of bounded rationality since it is internally coherent as an argument, but lacks a certain ethical engagement. It is also an extreme example of the utilitarianism of most public health policy, and harm minimization as part of that general health policy. The evaluation put a value on a life and implicitly argued that if the costs were greater than the savings, there would be questions about its very existence.

The report accepted that start-up costs were high, but costs into the future would likely be lower, particularly if the drought in heroin supply broke, falling from $63 per client visit to $30 per visit. In summary, the authors wrote that “A greater efficiency into the future may be achieved through some economies of scale, such as increases in client throughput, decreases in management costs and the amortization of the set-up costs” (MSIC, 2003, p. 205). Just imagine the scenario if there is a new flood of heroin and the room becomes particularly popular; the bean counters will force a cut in the time available for each hit to keep up “client throughput.” The economic evaluation becomes another narrative aligned with the risk management discourse, a narrative operating in contradiction to the humanitarian discourse of respect and care which is also presented as part of the general debate. However, the humanitarian discourse is not apparent in this part of
the evaluation at all. The economic evaluation does help shore up the governance discourse, in that if the users of the center can be persuaded or trained to use other health and welfare services less, thereby saving the state considerable resources, the MSIC justifies its existence. It also helps serve the amelioration of public nuisance if indeed the economic savings can be attributed to the existence of the center. However, as the effects of the heroin drought have shown around Australia, the costs of illicit drug use fall when there is a fall in supply.\(^{12}\)

**Conclusion**

While agreeing with Roe (1994) that public policy narratives are essentially metanarratives attempting to make contradictory tendencies somehow unite, the preceding discussion highlights the difficulty of this with the project of safe injecting centers. As outlined, these narratives are:

- The caring, humanitarian.
- The elimination of public nuisance.
- The governance of the drug-using subject.
- The neo-liberal, utilitarian & bureaucratic.

There is a glaring omission in these erstwhile contradictory narratives and that is the pleasure narrative. Ultimately, though, the dominant discourses are death and public nuisance. That is, the avoidance of overdose deaths, and the elimination of public nuisance.

In the moral panic of the 1990s the dominant discourse was the caring, humanitarian narrative. It was clearly an important element for most who worked at the coalface who were tired of seeing clients die through overdoses which they felt would be alleviated by the center (see van Beek, 2004b for an excellent illustration of this). However, as Kubler & Walti (2001) illustrate, this impulse is not necessarily what drives negotiations around such facilities in local communities. Rather, it is
narrative number two, the elimination of public nuisance, that dominates the establishment stage.

The governance of the drug-using subject tends to dominate at the operation stage but hits particular hurdles, not least the resistance of the clients themselves. To overcome this resistance, stringent rules are put in place in the effort to produce the self-governing subject. Instructing clients in safer, more hygienic use, moving them through efficiently and putting them in touch with other services become part of this. It is also apparent in the drive to produce a clinical rather than a comfortable environment at the Sydney MSIC. Fischer et al. (2004, p. 358) write “that rather than replacing existing punitive control of illicit drug use, these new and ostensibly more “progressive” practices of governance coexist alongside more traditional forms of repression (i.e., law enforcement), and indeed can be seen to mask and allow them to continue.”

The utilitarian impulse is clearly obvious in the Sydney MSIC trial and evaluation document with its cost-benefit analysis and cost savings. O’Malley (1999) argues that harm minimization, as a policy, is a series of risk discourses which use drug injection as a series of “actuarial risks”. Injecting itself is not the problem, but how much, where in the body (in the arm or groin) and where in space (in public, at home, at the MSIC). The neo-liberal narrative is not distinct from the humanitarian, self-governing or nuisance narratives in this respect. The humanitarian discourse worries about the body of the injector, the nuisance narrative wants the injector (and his/her paraphernalia) off the streets, the self-governing discourse wants the injector to learn responsible citizenship via safer injecting, and the utilitarian narrative wants to find the best way to count all this in the cheapest and most efficient way possible.

The narratives are produced by sometimes very different discursive communities. There are the various “stakeholders” such as local residents, businesses, the drug users, welfare
workers, et cetera. The outcomes for each of these groups could be very different, but the skill is in presenting these outcomes as identical, or at least not as antithetical to each other. Marianna Valverde (1998, p. 177) argues that modern alcohol/drug discourses are a "piling up of rationalities of governance on top of one another, rather than a shift from one to another". It is very useful to consider these narratives and their contradictions in this way, thus they have complementary, as well as contradictory effects.

It is at this point that I feel most like the late impressionist visitor. While the MSIC report (and others) attempts to define the sharp edges of the scientific, public health enterprise that is harm minimization, the voices of those it is intended to "help" are fuzzy indeed. In the pursuit of overcoming death and public nuisance, as the overarching policy metanarrative, the drug user becomes a client, and we are told the clients are respected even while they are herded and constantly monitored. The hard edges are maintained through economic rationalist arguments about cost-benefit analyses and complex statistical work and the utilitarian mindset is confirmed, at the same time as the policies are presented to the public as humane and life-saving.

Notes

1. I will be using the terms medically supervised injecting centers (MSICs), drug consumption rooms (DCRs), safe using rooms, or safer injection facilities (SIFs) and some others interchangeably since they refer to essentially the same types of institutions. Drug consumption rooms is a term with a wider meaning than MSICs, however, because in some places (particularly Holland), people are allowed to smoke or free-base cocaine and heroin, as well as inject. The only form of illicit drug consumption allowed in the Sydney MSIC is injecting. In the literature the terms used are all of the above, with their accompanying acronyms.

2. It is important to mention "shooting galleries" in this context because of the rhetorical use of them both by proponents and opponents of safe using rooms in the media scrum in the late 1990s in Australia (see the descriptions of the police-sanctioned, but still illegal rooms in King's Cross and a Melbourne one in a laneway near a church in Linnell, 1998).
3. In the Australian experience, the target population subtly changed. Initially, media attention was drawn to the rise of overdose deaths amongst IDUs, through the stories of grieving parents of users, who were often middle-class and young. Instead, the target population became the homeless (and aging) drug user or sex worker (cf. Linnell, 1998).


5. Bessant (2003) describes the flow-on from this particular moral panic in Victoria. In 2002 the media picked up on a situation where a child welfare institution was found to have allowed some young people to “chrome” (inhale volatile substances) on its premises. She argues that this would not have developed into the moral panic that it did without the debates about supervised injecting centers and the heroin flood. “Media workers tapped into a rich vein of vocabulary of images and categories that emphasized the deviant status of ‘drug addicts’ and plague-like status of the drug problem that experts, researchers and the media had been building up since at least 2000” (Bessant, 2003, p. 14).

6. I recognize that this is a novel use of Cohen’s (2002) argument which generally refers to the use of moral panics by political groups for conservative purposes. My use of the term also does not imply any criticism of the tactics used by proponents of the MSIC. However, the manipulation of the media and the escalation of the claims relating to future death rates from overdoses, thus claiming a high moral ground, falls within the parameters outlined by Cohen.

7. One explanation might be the difficulty of quantifying these types of harms, and this would clearly be a problem for an outcomes’ based evaluation such as the MSIC (2003). However, another explanation might be suggested by Room (1996) in his article regarding the social harms of alcohol consumption. In this article he argues that the very construction of social harms is culturally based, thus variable in many cases. The desire not to make negative moral attributions of drug users by the advocates of the humanitarian narrative would also play a major part.

8. As to the effects of the MSIC, while the hierarchy of residents’ annoyances stayed exactly the same over the survey period (prior to and after opening of the MSIC) while falling in overall percentages, business responses changed dramatically. Issues such as drug dealing, attraction of drug users, and crime and safety became more important to business after the MSIC opened than before. This has become more acute since the report was released, with more media attention to complaints from local business (see Mercer, 2005 & Cummings, 2006).
9. By the term “post-social,” O’Malley is using the argument adopted by Nikolas Rose (1996) to suggest that the world has moved from a consideration of the world as “social” or governed through communities and by the state, governance is now “post-social” through individuals and families via individual self-interest and contractual arrangements.

10. There is no evidence from the European literature that there are standover tactics or drug dealing on premises. However, there is drug dealing outside the Sydney MSIC premises (MSIC 2004, van Beek, 2004b).

11. This is common to many areas of public health. Evaluations of tobacco use almost invariably comment on the high financial cost to health budgets of smoking-related diseases; thus a clear financial benefit is claimed for smoking cessation programs.

12. Clarke (2001) used a number of models to determine the economic costs of safe injecting rooms. However, the models were predicated on crucial assumptions about the social costs involved in harm minimization as against drug abstinence as policies. A small change in one assumption about the value of a life made a large difference. “Here entirely different policies are optimal with a 1 per cent change in the social valuation placed on a user’s life” (Clarke, 2001, p. 60).

References


