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Reducing risk, producing order: The surprisingly disciplinary world of needle exchange

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Abstract

Emphasizing the reduction of risk over the cessation of drug use, needle exchange in the United States is often condemned for coddling its participants. Declining the punitive measures or unwavering teleology of criminal justice and drug treatment approaches, harm-reduction measures in general are faulted by naysayers for their refusal to establish clear normative boundaries for behavior modification. This article will seek to subvert such critiques by describing the ways in which disciplinary technologies suffused one needle exchange program in New York City. Drawing upon 1 year of participant observation at "Bronx Harm Reduction," this article will consider how the "minor procedures" of disciplinary power first characterized by Foucault (1977) worked to shape and organize different user bodies in needle exchange; it will further employ the work of Mitchell Dean to reflect upon the connections between program-level "technologies of agency" and government-led "technologies of performance." While conceding the overarching disciplinary transformation of late harm reduction, this article is specifically interested in the ramifications of this trajectory within one specific time and place. Namely, it postulates that attempts to "raise the bar" within a low-threshold program may serve to alienate or explicitly exclude certain service users.

Keywords

Harm reduction; needle exchange; Foucault; discipline; governance

Bronx Harm Reduction cleans up

When asked their first impressions of Bronx Harm Reduction, many newcomers expressed their surprise at how clean it was, like a clinic. Others used the words "orderly" and "peaceful" to describe the drop-in center with astonished approval. On one level, such remarks revealed common preconceptions of what a space populated by illicit drug users might look like—dirty, chaotic, and disorganized, like the lives of users themselves. Yet, these unlikely adjectives also praised Bronx Harm Reduction's ongoing efforts to remake itself into an exemplary needle exchange program that had successfully integrated a "medical model" of care.

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All reported names of workers and service users at Bronx Harm Reduction are pseudonyms.

The aesthetic overhaul of Bronx Harm Reduction's drop-in space represented the first step in an ongoing organizational makeover. Walls were repainted in soothing shades of blue and green, and flat-screen televisions were installed in the main space. While the administration joked that the makeover was inspired by New York's famous "W" Hotel, a new bathroom for program participants was explicitly modeled after those found at a luxury gym and spa. Imposing an atmosphere of calm, if sterile, competence, the renovation presaged the installation of an actual medical center set to open the following year. Employees often quipped that their chosen field was as "raw" or as "grimy as it gets," yet their work environment itself increasingly betrayed this description.

Few might imagine a needle exchange program in the South Bronx to so closely resemble an upscale doctor's office in appearance, let alone in organization and atmosphere; yet, this article is precisely concerned with exploring the imposition of order, and the salience of disciplinary power (Foucault, 1977), within a realm that is both celebrated and disdained for being outside social control (see, for example Tammi & Hurme, 2007). To be sure, needle exchange in its inception bore little resemblance to other institutions charged with the criminal or medical rehabilitation of drug users, spaces more directly implicated by Foucault's 1977 *Discipline and Punish.* In New York City, syringe exchange claims a rich pedigree in radical organizing and guerilla social service provision. As in other large, coastal United States cities, needle exchange here owes its legality to a successful, once controversial harm reduction movement, itself a branch of the larger activist campaign around HIV/AIDS. Led by groups such as the AIDS Coalition to Unleash Power (ACT UP) and the Association for Drug Abuse Prevention and Treatment (ADAPT), the decade-long struggle for syringe exchange in New York City precipitated numerous arrests, a failed pilot program, and denunciations from public officials and community leaders across the political spectrum (Anderson, 1990; Sullivan, 1991; Watters, 1996). Vindication arrived only with the 1991 criminal trial of eight ACT-UP volunteers, whose illicit distribution of clean syringes was pardoned under the banner of medical necessity, a ruling that paved the way for the decriminalization of needle exchange statewide (Sullivan, 1991).

Twenty years after the exoneration of the "Needle Eight," syringe exchange has gained worldwide recognition as an evidence-based public health intervention and the local endorsement of important state actors and institutions, such as the New York Department of Health and current New York City mayor Michael Bloomberg; support here is not merely political or moral, but overwhelmingly financial, with the state and city government providing the vast bulk of funding for syringe exchange. In turn, the administration, staffing and service environment of harm-reduction programs have shifted starkly since the 1980s, and not only in New York City. Several commentators have previously weighed in on harm reduction's changing identity as a "mature paradigm," characterizing its increasing institutionalization as a survival tactic demanded by hostile funding environments (Lune, 2001; Heller & Paone, 2011). Comparing New York's syringe exchange campaign with other effective social movements, Howard Lune writes that harm reduction's (limited) acceptance required compromises between founding advocates and public health guarantors (Lune, 2001.) Others have noted more critically that harm reduction's revolutionary spirit

and social agenda have been defused in the name of political palatability and bureaucratic compliance (Roe, 2005; Smith, 2012).

This article is less focused on the explanation or evaluation of the "institutional turn" within harm reduction, and will instead describe its ultimate effects in terms of participant management at one particular syringe exchange. While linking the disciplinary procedures undertaken by Bronx Harm Reduction to the reporting mechanisms demanded by its state regulators, this article will function more as a microlevel exploration of overarching trends in harm reduction, further grounded in the specific history of my research site. Noting earlier efforts by Bourgois (2000) and Moore (2004) to escape the "paralysis" often implied by a poststructural perspective, I here attempt to locate my critique within a specific historical and spatial harm-reduction context, which is neither inevitable nor unchangeable. It is not the intention of this article to simply dismiss syringe exchange for its complicity with power, but rather, to bring attention to the ways in which the harm-reduction experience has become more rigidly administered in one particular time and place.

Drawing upon 1 year of participant observation in diverse realms of Bronx Harm Reduction, I will first describe the ways in which all program participants (also termed "service users") were disciplined through techniques of case making, surveillance, and confession; I will also discuss more generally the ways in which BHR's administration sought to impose more structure, rules, and formality upon the agency as a whole, which took on a noticeably clinical appearance over the research period. Beyond the early writings of Michel Foucault, this article will also mobilize the work of Mitchell Dean (1998) to reflect upon the connection between the program-level "technologies of agency" directed at Bronx Harm Reduction's service users, and the government-led "technologies of performance" that drove them. Moving to more practical concerns, the final section will consider how efforts by Bronx Harm Reduction (and similar programs) to "tighten the reigns" might further alienate the multiply-marginalized populations who patronize such spaces of last resort (see also McLean, 2012). At the same time, this discussion will concede the essential "productivity" and pleasures of disciplinary power, experienced by some service users as an opportunity for personal reinvention and self-care.

Research site and methods

I arrived at Bronx Harm Reduction in the summer of 2010 during a period of ongoing change within the organization. Following multiple crises in leadership, funding, and facility maintenance, the agency had stabilized somewhat after the appointment of a new executive director in the previous year; however, tensions between new and old staffers erupted throughout my research period, expressed in a steady outward trickle of veteran employees. Founded in 1996 by a user-artist affiliated with ACT-UP, Bronx Harm Reduction had expanded markedly since its days as a mobile outreach team, to become one of the busiest storefront syringe exchange programs in New York City. Many staff members described needle exchange as the "heart" of the organization, but this core service had been supplemented by many ancillary amenities over Bronx Harm Reduction's 15 years in operation. In addition to syringe exchange, all registered users were able to attend educational and support groups, access showers and do laundry, eat lunch and dinner, and

receive free HIV testing and referrals for health care and other social services. Funded through separate state budget lines, case management, mental health, housing placement, and medical escort services were available to HIV-positive clients exclusively. All participants, regardless of HIV-status, were invited to sit in the first-floor drop-in for the entirety of opening hours, where they might sleep, socialize, watch television, or simply be, with minimal interference. On average, about 200 participants passed through the drop-in each day, a small, if significant slice of a registered user population exceeding 3,000. Nearly a quarter of Bronx Harm Reduction's users were known to be HIV-positive, while 60% described themselves as past or present illicit drug users. Poverty and homelessness were more uniformly distributed traits, with 75% of users homeless at intake, and nearly all reporting yearly incomes below $10,000. A majority of the service population claimed Puerto Rican heritage, and fully one-third of all participants had recently arrived from the island. Interestingly, many such individuals explained that they had been sent to New York to receive drug treatment, essentially evicted by frustrated family members and local government officials exhausted by the social burden of addiction. Arriving in New York without a job, money, or slot in a legitimate treatment program, these individuals often found their way to Bronx Harm Reduction, where they faced less explicit exhortations to get clean.

As with all unstably housed participants, these (in)voluntary migrants were more likely than their apartment-dwelling counterparts to occupy the drop-in or attend available support groups at any given time. By extension, their experience is perhaps disproportionately represented within a project that relied heavily on participant observation in Bronx Harm Reduction's public spaces. While also conducting semistructured interviews with a small sample of service users, I here draw largely on 1 year of field notes that reflect the everyday activities of both program participants and staff. For an average of 20 hours each week, I worked as a "researcher-volunteer" at Bronx Harm Reduction, a role that allowed me access to most of the organization's areas and actors. As a volunteer, I found myself both serving food in the drop-in, and photocopying forms in the administrative offices, among other tasks. The only activity I did not assist in during my research period was syringe exchange itself. A self-imposed restriction stipulated within my application for ethical review (approved by the City University of New York Graduate Center Institutional Review Board), I refrained from syringe exchange out of concern that it might undermine participants' informed consent to participate in my research, by effectively forcing some individuals to interact with me. In general, I did not approach participants at the agency unless already acquainted with them, while pursuing an extremely passive method of subject recruitment for interviewing. This is not to deny the potentially disruptive, coercive, or simply uncomfortable effect of my presence in the drop-in center. Over the course of my research, it became clear that many users of Bronx Harm Reduction were accustomed to the objectifying gaze of outsiders, whether researchers, writers, case workers, or doctors. While I constantly denied any interest in individuals' past or present drug use, I found myself a frequent recipient of spontaneous "confessions" from participants, a phenomenon that belied the power asymmetry characterizing even our most casual interactions. Given this paper's interest in the disciplinary effects of Bronx Harm Reduction, it is necessary to recognize

myself as part of the surveillance apparatus, an approach discussed by other addiction researchers (Campbell & Shaw, 2008).

As noted above, data analysis for this article focused primarily upon 1 year of field notes gathered through participant observation, while interview references are minimal. On one level, such methodological bias reflects this particular article's desire to show how disciplinary procedures were deployed "from above," as opposed to how they were received, interpreted, or embodied by their targets. At the same time, the larger project from which this article is drawn may also be seen as privileging the collection of ethnographic (over interview) data, at least among service users. Before embarking upon this study, I was aware that Bronx Harm Reduction was a frequent site of clinical and public health research; indeed, the beginning of my fieldwork coincided with the second phase of a longitudinal study on hepatitis risk, conducted by the federal Substance Abuse and Mental Health Services Administration. While acknowledging my perhaps inevitable identification with disciplinary power, this project attempted to avoid the overinterrogation of a highly-researched population, many of whose members participated in other interviews and focus groups on a near weekly basis. As suspected, the data gathered from 11 interviews with service users struck a much more formal, or performative, tone, with multiple participants leaning away from my recorder to first confirm the propriety of their answers. Coding was guided by a set of established, if abstract concepts, such as "surveillance," "confession," and "technologies of performance." Field notes were coded iteratively using TAMS Analyzer, an open-share qualitative analysis package, while printed program materials (e.g., pamphlets, annual reports) were read and coded for relevant content by hand.

Producing "safe" bodies: Harm reduction as a site of discipline

Among the many definitions of "discipline" that Foucault offers throughout his oeuvre, it may be most useful to conceive of discipline as a "physics" or "economy" of power within the context of harm reduction (Foucault, 1977). Misconstruing the peculiar meaning of discipline indicated here, defenders of harm reduction might protest that such programs offer a nonpunitive, nonjudgmental approach to drug use, in effect constituting a "third way" between established criminal justice or treatment-oriented responses that seek to deter or cure such behaviors. Yet, it is precisely the "non-coercive" nature of harm reduction that implicates it within a larger field of disciplinary power encompassing not only service users, but also service providers, and state apparatuses. Operating "without recourse…to excess, force, or violence," disciplinary power, Foucault writes, does not seek to repress certain behaviors or peoples, but rather endeavors to train and organize bodies; moving beyond the binary of il/legality employed by the criminal justice system, harm reduction instead seeks to "separate, analyze, and differentiate" a multiplicity of drug use and drug users, with the intention of stemming the danger or disorder therein posed. Overall, Foucault pens discipline as a "modest" power that operates in the interstices of human behavior—a definition that strongly resonates with harm reduction's own mantra of "little by little" or "baby steps" (Foucault, 1977, p. 170).

This article is hardly the first to assert the relevance of Foucauldian theory to the critical analysis of harm reduction. Once accepted as an unequivocal good, the lines of support for

harm reduction in the social scientific literature have only recently been complicated by the application of poststructural analyses calling for more reflexivity around the implementation and underlying theory of harm-reduction technologies. The concepts of biopower and governmentality lie at the center of such studies, which speculate upon the potential of harm-reduction programming to function as a "better mousetrap"—a less obtrusive, and thus more effective, means of managing drug users (Miller, 2001). Other critical takes tie harm reduction to the rise of a "new public health" and the growing dominance of neoliberal governance in general (Petersen & Lupton, 1996). Unlike modalities of drug control founded in prohibition or treatment, harm minimization delegates responsibility for safe consumption onto the individual user, thereby recognizing the role of choice and freedom in the more efficient government of drug use (O'Malley, 1999). Where Steven Mugford (1993) has situated the growing popularity of harm reduction within a general transition to postmodern forms of population control, Moore and Fraser (2006) have problematized the ways in which harm reduction discourses assume and inscribe a neoliberal subject, autonomous and rational, and thereby neglect the material constraints faced by most drug users. Moore (2004) has further considered how specific harm-reduction technologies serve to "govern chaotic subjects"—namely, street-based injecting drug users who are uninvested in regimes of self-care. Overdose prevention, supervised injection facilities, and methadone maintenance have all been explored as potentially insidious mechanisms of social control, which seek to partially denude injecting drug use of both its dangerous and pleasurable facets (Moore, 2004; Fischer, Turnbull, Poland, & Hagdon, 2004; Bourgois, 2000). Harm-reduction research itself has come under attack, characterized as a confessional technology that pressures drug-using subjects into declaring their adherence to safer injection techniques (Campbell & Shaw, 2008).

While recognizing the value of poststructural analyses, other authors have in turn asked how Foucauldian theory might pragmatically contribute to the improvement of harm-reduction services. Turning his attention to Foucault's later work on ethics and the care of the self, Cameron Duff (2004) has noted the conspicuous absence of "pleasure" in harm reduction discourses and practices; in Duff's account, a monomaniacal focus upon the risks and harms of illegal drug use has served to limit the appeal and efficacy of harm-reduction messaging, while alienating the vast majority of recreational drug users. Noting the proliferation of such critiques, Kane Race (2008) has in turn asked how the idea of pleasure might be productively introduced within harm-reduction services, without contributing to the diagnosis and stigmatization of drug users as pathological in their desires. Like Race, Helen Keane (2003) keeps an eye to the practical benefits of a harm-reduction approach that declines to condemn drug users as immoral or abnormal. Though acknowledging the validity of more ambivalent appraisals, Keane concludes that potentially life-saving harm reduction services cannot be simply dismissed for their complicity with regulatory public health power. Both Race's and Keanes' call for pragmatic criticism is echoed in Tim Rhodes (2009) concept of the "risk environment." A social science approach that "enables harm reduction," the risk-environment framework also resonates with earlier Foucauldian critiques in its contention that drug harms are produced not (only) by individual behaviors, but also by larger sociopolitical structures.

This article readily concedes that the real benefits of disease prevention and health promotion offered by harm reduction strategies must not be overlooked. At the same time, I will seek to extend critical reflections on harm-reduction practice to a technology that has been relatively taken-for-granted within a country that continues to condemn such programs as insufficiently disciplinary or simply indifferent to the real suffering of drug abuse. Since Jon Stuen-Parker—former user, ACT-UP volunteer, and founder of the National AIDS Brigade—began distributing clean needles along the Eastern Atlantic seaboard in 1985, critics both obvious and unexpected have challenged the underlying logic and morality of syringe exchange (Drucker, 2009.) While Congress, led by conservative politician Jesse Helms, first passed a federal funding ban on syringe exchange in 1988, clean needle schemes also garnered lay opponents within communities heavily impacted by illegal drug addiction. In an interview with Boston Public Television, one resident of Mission Hill, a historically poor neighborhood of inner-city Boston, explained why she was protesting a local office of Stuen-Parker's AIDS Brigade: "We don't believe in allowing someone to be dependent upon clean works. They need to quit. Make a decision. Either you are or you're not" (Jones, 1991).

In the ensuing years, public health and medical voices in support of needle exchange have risen steadily, an expert chorus that was essential to the brief suspension of the federal funding ban between December 2009 and March 2012 (Fears, 2009). Yet influential detractors have continuously maintained that syringe exchange programs do not offer legitimate or lasting aid to drug-dependent individuals. Republican legislator Todd Thiara commented in 2009 that he was "very concerned that [the US] would use federal tax dollars to support the drug habits of people who desperately need help to free themselves from this deadly lifestyle" (U.S. House of Representatives Committee on Appropriations, 2011). Health care professionals have also questioned the compassion of syringe exchange programs, which defer the more desirable goal of abstinence; writing in a 1998 Op-Ed to the *New York Times*, the Harlem Hospital's Director of Psychiatry and Addiction Services argued that "Addicts need to be treated. They should not be given needles and encouraged to continue their addiction" (Curtis, 1998).

This article will counter such perceptions of needle exchange as a fundamentally "enabling" technology, at least within one of its mature incarnations in present-day New York City. The following pages will depict the "minor procedures" through which disciplinary power worked to effectively shape the behavior of participants at Bronx Harm Reduction (Foucault, 1977, p. 170). In this environment, behavior was influenced less through the levying of negative sanctions, such as arrest or dismissal, than via techniques of objectification that submitted participants to continuous examination. Representing an invisible, insidious means of compulsion, disciplinary power "coerces by means of observation," functioning through "an apparatus in which the techniques that make it possible to see induce effects of power and in which, conversely, the means of coercion make those on whom they are applied clearly visible" (Foucault, 1977, p. 171). Observation at Bronx Harm Reduction assumed multiple forms and targets, endeavoring overall to make visible the bodily practices of service users—and the work habits of staff members. Ultimately, through sustained exposure to continuous and automatic techniques of

surveillance, individuals were expected to internalize the "gaze" of their case workers, supervisors, or funders thus projected, and adjust their behavior accordingly. The next section will describe the multifarious techniques of surveillance employed at Bronx Harm Reduction, the practices of confession that sustained them, and the storage of their results in files that represented the history and progress of each risk reduction "case."

The code, the card, and the file: Making cases at Bronx Harm Reduction

Friday is rather disappointing. As usual, I set my day around attending Donald's 2:30 "Substance Use Management" group, which was covered by Pedro in the previous week. For the second week in a row, however, the group is derailed. This time, however, the group does not run at all, due to a dearth of HRR [HIV-positive] clients, who ensure that the group will be reimbursed. When I go down to the drop-in 15 minutes before the group is scheduled to start, Ronnie (who is manning the front desk) is arguing with a participant whose English is shaky. An increasingly irritated Ronnie is attempting to explain to the man that he can't sign him up for the 2:30 group until 3 HRR clients have written down their codes. As the discussion becomes more heated, Pedro intervenes, explaining the situation to the man in Spanish. I see Gavin, who has attended the Substance Use Management group 2 weeks in a row, sitting against the wall, looking tired and resigned. I rarely see him at Bronx Harm Reduction except at this time of day, and I wonder whether he attends specifically for this group; I see Flaco attempting to sign up as well, to no avail. When Leon Rogers enters the agency, Ronnie practically outs his HIV status to the entire drop-in, greeting him with "Hey Rogers, you going to the 2:30 group?" As it turns out, Mr. Rogers is not looking to attend a group, but rather, came in to see his worker. [Field notes, March 13, 2011]

Staff at Bronx Harm Reduction were quick to point out that participants need not volunteer so much as their name in exchange for a clean needle, yet this statement belied a no-less-intimate system of user tracking at the organization. Upon entering the drop-in for the first time, aspiring participants were required to complete an initial intake assessment, whose duration varied according to the type of services sought. While individuals requesting access to only syringe exchange (SEP) and other "drop-in" services were hustled into the SEP room itself to complete a two-page questionnaire, aspiring case management participants were brought to the second floor "triage room," where a more extensive interview awaited them. Yet all newly enrolled participants emerged from their intakes with three new forms of identification: a "unique identifying number," or "code," a plastic ID card, and a file—or rather two files—both paper and electronic.

Ostensibly intended to protect the privacy of service users, the assignment of codes also initiated the objectification of individuals as cases; a valid code was required for the entry of every staff-participant "encounter" into the online tracking system that monitored BHR's adherence to contract-stipulated quotas. Ranging between 9 and 12 digits, codes reflected participants' basic demographic traits—sex, age, race, and place of residence—while including some elements of their referents' names. As the primary form of identification at Bronx Harm Reduction, codes were typically memorized by participants who attended the organization on a regular basis. Asked to provide their codes in exchange for nearly every service, participants became accustomed to using their codes instead of their name in other

instances as well. Participants were observed signing handouts, artwork, or personal possessions with their code, while several interview subjects asked if they should write their code on the information sheet.

Bearing little more than each individual's code, participant ID cards highlighted the paradox of an anonymous service culture that simultaneously relied upon the collection of thick surveillance data. White or red, BHR's ID cards were mostly inscrutable to outsiders, who might be able to glean no more than their bearer's zip code, and perhaps year of birth. Internally, however, such cards immediately connoted a piece of highly personal information about their holders: namely, their HIV status. In addition to slight differences in the construction of their codes, SEP and case management users were sorted by the color of their cards, which were white and red, respectively. Presumably a matter of organizational convenience, the bicolor card system made it easier for staff members to maintain separate sign-in sheets, which were in turn submitted for separate streams of reimbursement by the state. The Administrative Director admitted the use of "red cards" and "white cards" to be a ham-fisted, if expedient, arrangement, which effectively branded HIV-positive participants with a "scarlet letter"; yet, the color of a participant's card also influenced their spatial access within the organization, with "red cards" more readily extended the privilege of entering the first floor staff offices. The shade of one's card, or enrollment within a specific case management program, also affected entrance to certain support groups, while further serving as a shorthand system of identification for individuals who might otherwise remain nameless. Employees who frequently manned the front desk often knew, and called out to, people by their program, typically represented by a short acronym: SEP, HRR, HOME, etc. Attaching service users to certain spaces and staff members, such signifiers also determined the location and thickness of their file, or chart.

Every participant's chart began with an intake survey, which was immediately supplemented by proof of HIV (or "at risk") status among those enrolling within case management programs. Such users' charts expanded quickly, in line with the extensive documentation demands of state funders. Depending upon the specific program, charts would accumulate regular blood work results, psychiatric assessments, information on entitlements, and even housing leases; also contributing to their bulk were the periodic participant "reassessments," "service plans," and "progress notes" undertaken by staff—the latter forms drafted after every interaction with one of their charges. Besides bringing Bronx Harm Reduction into compliance with its funder's data demands, charts facilitated the dissemination of participant information across time, space, and multiple staff members—much like medical records. New employees inheriting another worker's "caseload" might consult their charts before meeting their new charges, while regular "case conferences" revolved around the digestion and discussion of a different participant's chart every week. Thus situated in a "network of writing," service users were embroiled in a continuous and semi-permanent field of surveillance that proceeded even in the absence of their bodies (Foucault, 1977). Representing the accumulated professional knowledge around a participant, charts guided service users' termination, "successful" discharge, or designation as "lost to follow-up." Indeed, cases might be closed because the associated chart lacked sufficient sustenance, or documented encounters within a fixed period of time, according to the terms set by a funding contract. In this respect, charts were a site of not only participant, but also

employee, and organizational anxiety, generated by the persistent threat of external audits by the state. In general, however, paper charts were deployed toward the end of "in-house" tracking, while the electronic files submitted to the AIDS Institute Reporting System (AIRS) served external monitoring purposes. These two systems of participant surveillance operating at Bronx Harm Reduction might be seen as exemplifying Mitchell Dean's "technologies of performance," a term that implies their dual function as techniques of organizational disciplining as well.

"They just need a number": Surveillance at and of Bronx Harm Reduction

Bronx Harm Reduction is required to submit monthly reports to the AIDS Institute, via the AIDS Institute Reporting System (AIRS). AIRS requires staff from different programs to convert their participant interactions into discrete (presumably reimsbursable) categories. (Staff in the HPC program fill out daily record sheets which list the participant's name, an ID number, time spent with participant, and a list of categories which derives from the AIRS mapping. Time is not entered into AIRS, and perhaps serves the sole purpose of monitoring workers.) Today I enter forms from the Housing Provision Contract program, with Cristian. One is required to select a program (here HPC), a service category (e.g., Housing, Care Coordination, Substance Abuse), a staff member, an encounter type (e.g., Housing Placement, Pre-placement coordination, Reengagement Efforts), and a client. Re-engagement efforts is a popular category throughout. The same handful of clients seem also to appear throughout. [Field Notes, 8/25/10]

In his article "Risk, Calculable and Incalculable," Mitchell Dean describes "technologies of agency" as endeavoring toward the surveillance and control of "targeted" or "high-risk" populations, through the use of "multiple techniques of self-esteem, empowerment, consultation, and negotiation"—in short, agential techniques that exhort subjects to "transform their status" and become "active citizens capable of managing their own risk" (Dean, 1998, pp. 35–36). This term is simultaneously used to denote the contracting out of once public services (such as health promotion) to community-based organizations, as a means of handing power to authentic representatives of the populations so targeted. As a noncoercive program of risk reduction for drug users and other at-risk individuals in the community, Bronx Harm Reduction quite clearly fit the profile of an organization that both constituted and was constituted by technologies of agency. Dean notes that technologies of agency are "complemented, however, by a host of technologies concerned to monitor, compare and evaluate the performance of those whose agency is thereby activated" (Dean 1998, p. 36). Such "technologies of performance" function through the establishment of indicators and reporting mechanisms that seek to monitor, measure, and ultimately optimize individual and organizational achievement. Thus, while individuals and communities are charged with regulating their own risk, the state retains the right to supervise their progress, if only to ensure that its money is not being wasted.

At Bronx Harm Reduction, staff sought to monitor participants' risk behaviors during one-on-one encounters of varying durations and levels of formality. Here, technologies of performance took the form of an interview, or even an examination, in which information flowed from service users to staff, often in response to a standard battery of questions that

guided the interaction. In turn, such encounters would be recorded within a physical archive —the chart—that tracked participants' cumulative risk reduction over time. For individuals accessing the SEP alone, formal behavioral surveillance occurred solely at the point of exchange, and focused only upon injection practices. While participants were not asked to identify themselves by name, they were required to volunteer other highly personal information at each exchange encounter. Following a form designed in accordance with state requirements, SEP staff would record each service users' code, sex, race, and frequency of injection, as well as the number of syringes collected and distributed. Senior staff members might also inquire about a user's drug(s) of choice and preferred injection sites, sometimes offering advice on the avoidance or care of abscesses. Apart from their initial intake, SEP users were not required to sit for additional, prolonged interviews. To some degree, these encounters centered less upon the extraction of knowledge from a participant, and more upon his or her education about risk reduction. While the intake form contained a small handful of questions around drug use history, it provided an extensive "check off list of education provided to newly enrolled participants." Prompts included statements such as "Never share needles, syringe, cookers/spoons, cottons or water" and "Always use a tourniquet/tie-up when injecting." By contrast, case management users were inducted into Bronx Harm reduction via a highly structured interview that might last in excess of an hour. Following a multi-page assessment form, the intake "assessment" asked participants in-depth questions about their sexual and drug use practices, while further soliciting detailed medical information. Participants were also required to meet with workers on a regular basis for "reassessments," which were used to evaluate their achievement over time. In the words of one housing case manager, reassessments served as periodic "recertifications," which were used to confirm that participants were in fact "ready to be housed."

While New York State modeled the basic intake, (re)assessment, and progress note forms that populated clients' paper files, the AIDS Institute Reporting System (AIRS), an electronic database, provided a more continuous method of both individual and organizational surveillance from above. As a technology of performance wielded by the state, AIRS perhaps mainly targeted its contractor agencies and their employees. Every individual that received services at Bronx Harm Reduction was entered into AIRS (by either name or code), and daily interactions with staff were similarly tracked. Yet, AIRS primarily served to monitor the overall volume of participant traffic at Bronx Harm Reduction, and the agency's attainment of periodic contract quotas. Each day, case managers reported both whom they had met with, and the location and substance of each meeting, using predefined categories of activity. (In this way, AIRS data entry forms could be also used internally, by administration, to track employees' time management.) Bronx Harm Reduction's Data Coordinator went so far as to imply that the accuracy of the participant information entered was not as important as the mere act of reporting itself. Responding to my query on how missing data was dealt with, the coordinator responded, "It doesn't matter. They just need a number."

Coming/getting clean: Techniques of confession in harm reduction

About half-way through the first 'Safety Counts' session, Lisa leaves, without explanation, and Eddie begins to explain the stages of change. I notice that he has posted the steps in the

wrong sequence (Not Thinking About It/Planning to Do It/Staying With It/Taking Steps/Doing It). Nevertheless, his explanation seems to make sense to the participants. He asks everyone to attach a nametag to the board, at the proper stage they are at (for whatever behavior they are interested in changing). The first six names cluster on two stages—Staying With It, and Doing It. This is a very interesting development, given that Safety Counts is intended to target active drug users. Yolanda and Angie place themselves between two stages—Staying With It, and Taking Steps. Eddie's tag is attached to "Doing It." After the name tags are pinned up, Emilio sends the peers to get the food to heat up. In the interim, he asks everyone to introduce themselves and tell their story. I am struck by how all the participants volunteer a history of their drug use as part of their story. For example, Tori, who begins, states that she started using drugs at age 9, and that marijuana was her gateway drug, ultimately "leading" her to heroin. [Field Notes, March 15, 2011]

The valuation of the act of reporting, or confession, over the information thus divulged might also be seen with regards to service user surveillance by staff. As characterized by Foucault, techniques of confession serve not only to bring their objects into the field of visibility, but further advance the ends of individual self-discipline in the long-term. Once accustomed to the ritual of regular examination, individuals may ultimately learn to anticipate their confession, prepare its content, and perhaps adjust their behavior accordingly; over time, the incitement to confess may itself become unnecessary, as individuals internalize the expectations and judgment concealed therein (Foucault, 1977). Framing their explanation in the psychological discourse of mental stress, several staff members extolled the value of confession in itself, as a means of both unburdening the psyche of guilt, and further, divesting oneself of past transgressions. For those who viewed harm reduction as an initial step on the path to drug abstinence, confession was a vital part of the therapeutic process, while a willingness to "be honest" was a marker of change already in progress.

Aside from serving as disciplinary ends in themselves, techniques of confession were necessary to the measurement of participant risk and risk reduction—abstract concepts that derived from mostly unobservable behaviors. The medical records and laboratory results demanded of some service users at Bronx Harm Reduction made it possible to monitor changes inside their bodies (and impute their health) over time, but changes in behavior (and presumed risk) could only be brought into focus through questionnaires that relied upon user self-report. As noted, participants were regularly questioned about their bodily practices during one-on-one interviews or transactions in the SEP; they were also prodded to discuss their behaviors among a wider audience at support groups, which were subsequently written up by staff moderators. Given this frequent impetus to confess, many participants became highly accustomed to sharing private data regarding their medical or substance use history, without prompting. It was also not uncommon to hear participants exhorting one another to "come clean" during groups or even in the drop-in, perhaps sensing their ongoing surveillance by the staff surrounding them.

Spatial order and “community management” at Bronx Harm Reduction

Around 11:30, Jana asks me if I will help her prepare lunch. I accept, happy to get away from the popcorn machine. However, when Juanita returns from her cigarette break, Delia tells her that she needs me to watch the bathroom for a bit—the bathroom is typically closed, but when it is open, a staff member is required to be present to make sure that there is no “illicit activity” happening. A small older participant asks me what I am doing, and I tell him, “watching the bathroom.” He replies, “Watching the bathroom or watching the people?” [Field Notes, 10/30/10]

Participants were often informed that Bronx Harm Reduction was “their space,” and that the assembled staff “worked for them.” In the same vein, the changes to the physical space and general atmosphere of the drop-in were undertaken in the name of participant desires, while the move to impose more order was framed as a matter of individual respect. Fretting that the agency served as an “enabling” environment, the Director of Prevention noted that the participants needed more “boundaries,” in order to progress. At one level, this goal was pursued through modifications in the physical environment of the drop-in. As mentioned in the introduction, the facility received a top-to-bottom makeover at the beginning of the research period which produced a more clinical feel and appearance; walls were repainted in serene shades of light blue and violet, while old couches were replaced by adjoining office chairs. A flat-screen television that continuously streamed “community rules” and events was also installed in the main drop-in. While such renovations followed the line of participant convenience and comfort, other changes sought to restrict users’ access to certain areas of facility. The first-floor staff offices were put behind a new steel and glass door fitted with an electronic lock and buzzer, while the administrative offices saw the installation of a frosted pane of glass in the place of a once transparent window, overlooking the reception desk. Most drastically, surveillance cameras were installed both inside and outside the building, capturing every possible space—except the second-floor administration.

Of course, it is possible that many participants did not notice these particular impingements upon their physical movement, expressing more frustration with their regular exclusion from the second-floor drop-in space during important meetings, or late in the day. Most offensive was the periodic shut-down of the first-floor “participant bathroom,” which might follow the discovery of a discarded syringe or cooker in a toilet stall. A reaction to the presumed bad behavior of one individual, such lock-outs were intended to punish the participant population as a whole. The administration in fact pursued a proactive defense against on-site (typically in-bathroom) drug use, stationing a staff member or peer just outside during most hours of the day; consequently, participants lingering too long within a stall would receive a knock or shout from the on-duty monitor. Restrictions upon bathroom access were in fact an everyday source of staff-participant tension. Where some staff members reprimanded participants for using the bathroom during support groups, others locked the doors to discourage the movement of people into or out of the conference room. Decrying the constant flow of people to be disruptive, some staff members further fretted that participants who tarried in the bathroom did not deserve to receive an incentive, after missing the bulk of the group. Noting that one needed to provide a code to access nearly everything else at

Bronx Harm Reduction, one participant joked that soon enough there would be a sign-up sheet to use the toilet as well.

The intensification of spatial surveillance at Bronx Harm Reduction fueled anxiety among, and conflicts between, staff members as well. After the introduction of cameras, employees were well aware that they were also being watched. Curtailing a leisurely cigarette break one day, one community educator looked up at the side of the building nervously, noting that the camera above streamed directly to the director's computer. Yet the new cameras were only one component in the perceived escalation of staff scrutiny. In whispered tones, a veteran employee noted that he "hardly said anything any-more," hoping to avoid negative attention from his supervisors. Opposition to the new surveillance culture at Bronx Harm Reduction stemmed not only from personal interests, but also from beliefs about how a needle exchange should operate. In interviews, two employees lamented the dampened, if well-mannered, mood within the once "rowdy" drop-in, fearing that participants felt stifled in their expression. Comparing the agency's new organizational environment to that of a "high school," syringe exchange counselor Pedro mused, "If everyone is behaving OK, maybe it's a façade. But I'd rather have them very relaxed." Disputes further centered on the problem of "non-participants," or individuals from the community who were not officially enrolled within the agency. Where some staff members would allow such individuals to enter, sit, or shower without presenting a valid card or code, others noted pointedly that the organization did not receive payment for such services. Such conflicts were perhaps felt most by John, the "community manager," who was charged with signing-in participants and maintaining order in the drop-in. One of the longest-serving employees at the organization, John was a friendly, often silly, figure on the first floor, offering jokes, advice, and sometimes food to the many participants he knew by name; however, he did not hesitate to loose a sharp whistle whenever the noise began to rise above a moderate din.

Conclusion: The pleasures and perils of discipline in harm reduction

This article has sought to counter the prevalent perception of needle exchange as an unmanaged and unmanageable setting that is ideologically resistant to the imposition of discipline. While Bronx Harm Reduction's specific push to increase order was grounded in that organization's unique history and staffing, I have also tried to show how disciplinary power may be intrinsic to contemporary harm-reduction assemblages in New York and the United States at large, which are regulated by the state and identify individual behavior modification as their major aim. Where the tone of this paper may read as critical, it is not my goal to simply decry the incursion of medical or state power into harm reduction, nor lament the latter's diversion from a more revolutionary and idyllic past. Having described the operation of discipline in practice, I would here like to consider some effects upon service user experience; as with staff, the "new Bronx Harm Reduction" garnered a complicated range of responses from participants, some of whom audibly embraced the new order.

Perhaps unsurprisingly, Bronx Harm Reduction's peer workers —participants who worked part-time for a small weekly stipend—were largely quick to praise the agency's scrubbed-up environment. Indeed, nearly all such individuals maintained a sober identity as former drug

users, with many attributing their successful bid at abstinence to the help of Bronx Harm Reduction. One peer, Minnie, further credited the new administration and atmosphere with transforming her entire personality; once angry and rude, Minnie described herself as significantly calmer in the now orderly organization, for which she "would do anything." At the same time, Minnie, like many peers, betrayed a short temper with other service users who appeared unwilling or unable to achieve similar change. As quasi-employees, peer workers were sometimes charged with running support groups, supervising the drop-in, or conducting intake interviews for new participants. In doing so, many were more zealous than full-time staffers in exhorting other participants to "come clean" about their drug use practices or enroll within special interventions that encouraged behavior change. In fact, some particularly enthusiastic emissaries of discipline privately criticized their staff supervisors for coddling lazy and recalcitrant service users.

While Bronx Harm Reduction's peer workers might have associated material gain with the adoption of a disciplined identity, other service users perhaps found emotional comfort in the rituals of surveillance and confession. As I learned relatively early in my fieldwork, many clients appeared eager to "share their stories" with little if any solicitation on my part. While this phenomenon initially made me sensitive to my perception as "confessor" in the drop-in, I also began to understand my role as a mitigator of loneliness, whose mere attention passed as acceptance for some. Among individuals lacking for concerned company, it is not hard to imagine that the constant interrogation of harm reduction was also experienced as a sign of care; the resulting archives further served a practical purpose for those without a stable home or nearby family. Many participants were the major drivers of their own charts' growth, exhorting staff members to copy and store any paper of potential significance. Such individuals' stakes in their charts revealed the files to function not only as means of temporal surveillance, but also as anchors of identity among service users who feared the loss of what few credentials they possessed. It was not uncommon to encounter a participant clutching a few tattered pieces of paper with a desperate ferocity that reflected the items' practical, as well as symbolic, value. Often requiring a multi-hour, -day, or -month navigation of government bureaucracy, forms reporting social welfare eligibility obviously held enormous significance for individuals without so much as a mailing address. Yet, charts further enclosed documents of seemingly sentimental value that might otherwise be discarded in the "straight" world. In addition to notices of lapsed benefits or missed appointments, charts also contained past or present resumes, certificates of completion, or training "diplomas" from risk reduction interventions. Though often out-of-date or of questionable value, these items at least served as tangible evidence of participant accomplishment in a world that barely acknowledged their continued existence.

In providing services to nearly anyone amenable to completing an intake interview, Bronx Harm Reduction not only acknowledged the existence of its multiply-marginalized clientele —mostly poor, homeless, and/or drug-using individuals—but simultaneously validated their humanity and worth. It is here, against the agency's de facto function as a site of care and nonjudgmental sociality, that its ongoing disciplinary transformation most chafed. A vocal critic of the new administration, the agency's director of syringe exchange, Donald, specifically lamented the loss of harm reduction's "human aspect" over time—a process in which he dolefully claimed complicity. Always rushing, often exasperated, Donald

complained that his daily responsibilities in data management often kept him in his office and thus away from the participants with whom he had once spoken daily. Likewise, service users' access to Donald, and most other employees, was limited by the installation of the above-noted lock-and-buzzer system that effectively severed the first floor of Bronx Harm Reduction into two separate realms. As a consequence, informal or unplanned exchanges between participants and front-line staff inevitably declined, while individuals who tarried anxiously outside the guarded offices often became agitated by the delay. When the second-floor lounge closed for construction in the springe of 2011, the downstairs "drop-in" increasingly assumed the atmosphere of a clinical waiting room, busy and claustrophobic.

No appointment was necessary in order to do syringe exchange, provided an appropriate staffer was available, yet this interaction was also scripted by surveillance demands. Not only Donald, but also several among his SEP staff acknowledged that the often quick, impersonal interaction implied by syringe exchange required improvement. While service users were often in a hurry to get their equipment, employees were distracted by the panel of questions on the sign-in sheet. More than one peer sheepishly admitted to simply entering the same behavioral data for every user, and indeed, a quick scan of the syringe exchange log indicated that most participants injected two times per day, seven days each week. Encountering familiar service users who lost their card or forgot their code, another peer worker noted that he sometimes entered his own participant ID number into the system. Given the small incentive at stake, the collection of codes for support group enrollment was a much stricter process. Just as every exchange encounter (theoretically) began with the recording of the users' code, every support group kicked off with the public identification of each attendee with his or her number on the sign-up sheet. Bronx Harm Reduction shunned the label "client" as a referent for their service users, yet the constant request for participant codes also worked to impart the professional distance implied within this term. While warmth and familiarity characterized many employee-participant relationships, they existed within an increasingly rationalized service culture that (perhaps inadvertently) disempowered its users.

Perhaps an indignity or inconvenience in the short-run, Bronx Harm Reduction's data-driven work environment also posed a long-term disadvantage for service users who aspired to peer or even full staff positions. In the words of the Executive Director, "data became money"—a pithy testament to the growing importance of precise record-keeping in an agency that largely survived on government service contracts. Yet peers were hardly trusted to collect full information from other service users or maintain accurate case files (a suspicion perhaps validated in the previous paragraph). No peer workers were promoted to salaried positions in the course of this study, a fact that was bitterly remarked upon by the dwindling number of employees who had themselves ascended in the organizational ranks from service user to staff member. One of six former peers working full-time at Bronx Harm Reduction in the fall of 2010, community educator Shelly commented, "There used to be a big, big lot of us here…it was a very participant-led agency…Participants came here, they worked here, they developed some skills here, and eventually they would find their way into a position here."

Such sentiments were also echoed by Eddie, a veteran outreach worker who had gotten his first job at the organization in 2002, after over a decade in prison. Never hesitant to

acknowledge the agency's historical role in changing his life, Eddie often praised Bronx Harm Reduction's original administrators for "giving him a chance"—an opportunity that would not be afforded the current cohort of peers. Eddie loudly encouraged his own team of peer workers to seek jobs at other organizations where they might enjoy "room to grow" and a living salary to boot. Chatting with me shortly before his resignation in the spring of 2011, Eddie noted wistfully that he was one of two "old-timers" left, further disclosing that the agency's "numbers were down," with service users increasingly decamping to two other area exchanges. Though not betraying an overall decline in daily visitors to the organization, one SEP employee confirmed that his staff was increasingly instructed to decline the enrollment of new participants who were neither HIV-positive, nor actively injecting drugs. While utilizing space in the drop-in and support groups, such individuals were not captured in the data demanded by the agency's major funding contracts.

In placing needle exchange upon the "disciplinary spectrum," this article is not seeking to equate harm reduction approaches with the criminal justice and abstinence-adamant treatment paradigms that dominate United States drug policy; it is certainly clear that the latter models utilize far more coercive and alienating technologies of control, which further do little to reduce the real risks illicit drug use. Unlike these favored methods, harm-reduction programs attract both individuals who want to continue using drugs and those who do not, while providing all with the basic tools of survival—not least social contact and support. While the disciplining of syringe exchange may serve to keep funders happy and programs open, this article might only wonder whether such concessions arrive at the expense of the aforementioned "human aspect" that has defined harm reduction since its earliest days, and which continues to attract a diversity of vulnerable service users with few other outlets.

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