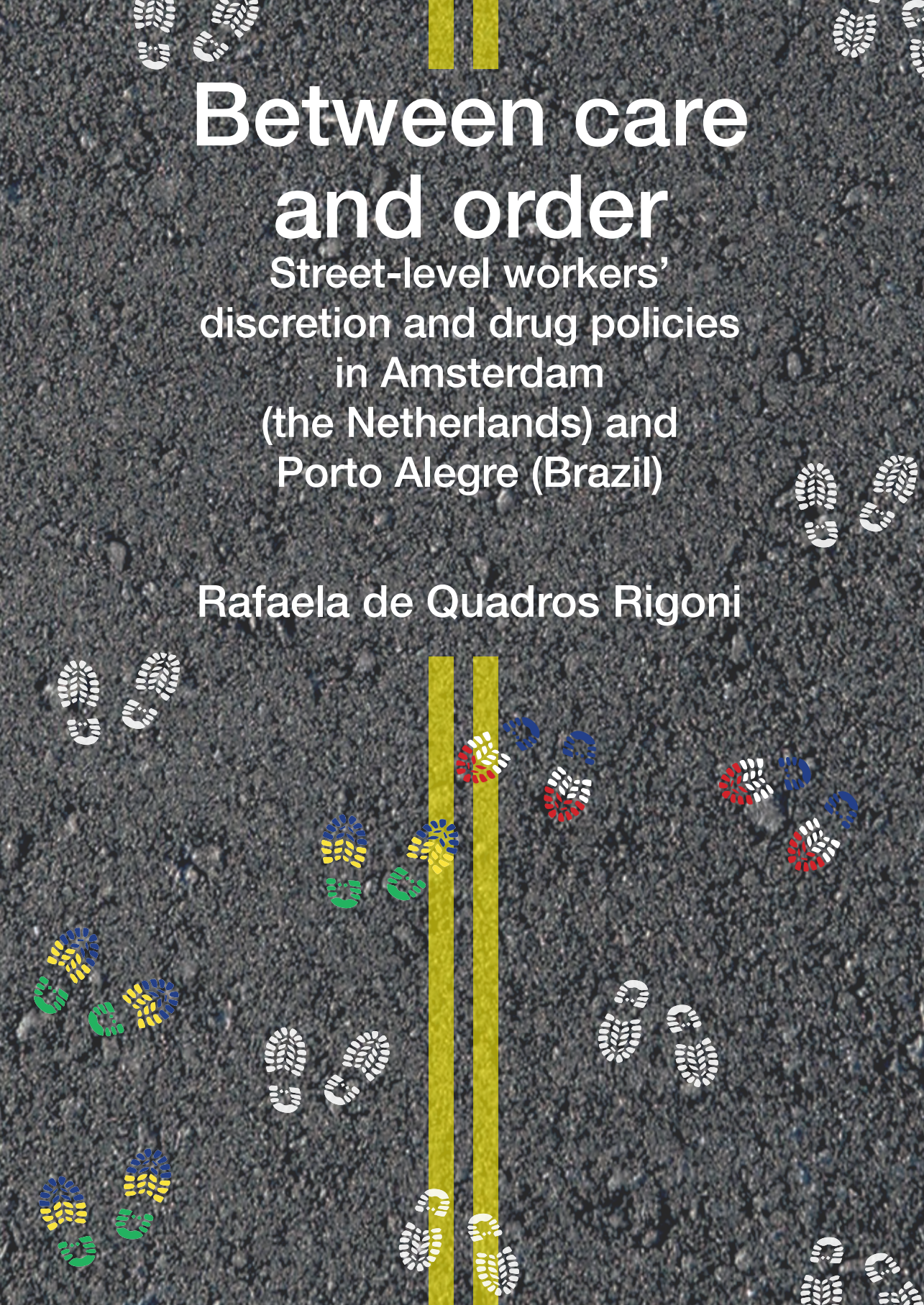
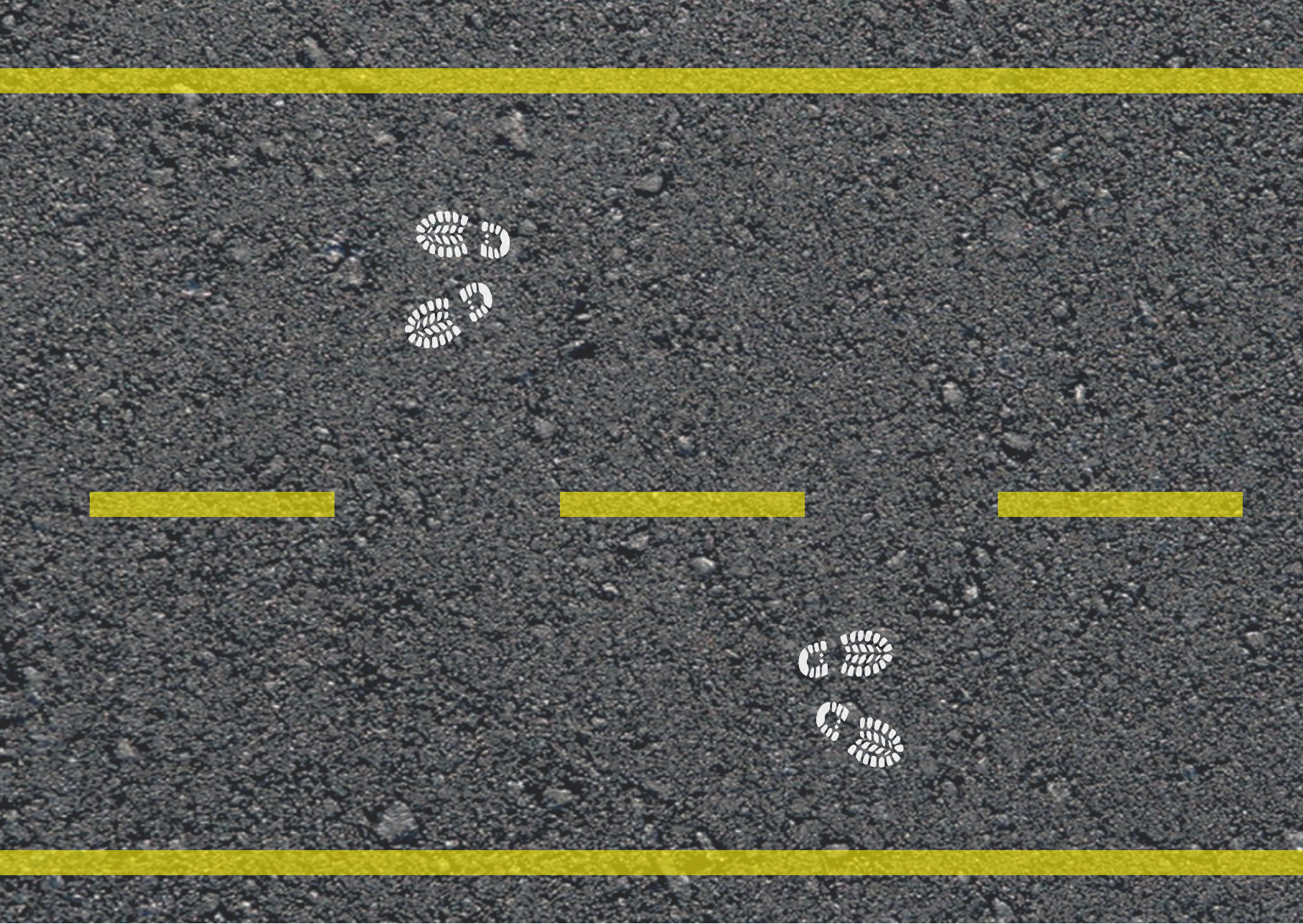
Between care and order

Street-level workers' discretion and drug policies in Amsterdam (the Netherlands) and Porto Alegre (Brazil)

Rafaela de Quadros Rigoni





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Rafaela de Quadros Rigoni

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TUSSEN ZORG EN ORDE:
BESLISSINGSRUIMTE VAN WERKERS OP STRAATNIVEAU EN DRUGSBELEID IN AMSTERDAM (NEDERLAND) EN PORTO ALEGRE (BRAZILIË)

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by

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To the street level workers who daily share experiences, dilemmas and dreams.
Specially, to those who shared them with me along this study.

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Acronyms

ADAM: Amsterdam

CCTV: Closed-circuit television

EU: European Union

HBO: University of Applied Sciences (Hoger Beroepsonderwijs)

IDUs: Injection Drug Users

ISD: Institution for Repeat Offenders (Inrichting voor Stelselmatige Daders)

MBO: Secondary Vocational Education (Middelbaar Beroepsonderwijs)

MMT: Methadone Maintenance Treatment

NGO: Non-Governmental Organization

POA: Porto Alegre

PRD: Harm Reduction Program (Programa de Redução de Danos)

PROERD: Drug Abuse Resistance Education (Programa de Resistência às Drogas)

SEPs: Syringe Exchange Programs

SUAS: Unified Social System (Sistema Único de Assistência Social)

SUS: Unified Health System (Sistema Único de Saúde)

UNAIDS: Joint United Nations Programme on HIV/AIDS

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Abstract

This comparative study analyses the implementation of policies on so-called 'problem drugs' (crack cocaine and heroin) for the cities of Amsterdam (in the Netherlands) and Porto Alegre (in Brazil). Using a variant on the street level bureaucracy approach, the study assumes that workers' discretion has a central role in understanding the processes through which official public policies come into grounded existence. Workers' discretionary choices involve the creation of strategies to cope with the gaps between the goals and expectations from official policies and the actual conditions of work at the street level. In the case of drug policies, this also includes negotiating between different approaches towards people who use drugs, which range from human rights and health care for users to law enforcement to ensure public order. Workers engage with organizational rules, goals and regulations plus other workers and users in making discretionary decisions on both problem definitions and possible solutions for drug use. All these factors are found to shape the ways in which workers' discretion is exercised.

The research focuses on State supported workers in the social, health and law enforcement fields to analyse *the dilemmas workers encounter in their daily interactions with drug users, and how they develop strategies to cope with them.* More specifically, it looks at how dilemmas and strategies vary across workers' different working territories, differing interpretive beliefs around drug use, levels of support and constraints coming from their organizations, differing patterns of collaboration within and between sectors, and experiences of relationship with drug users.

The comparison between two cities enables the research to explore the impact of different socio-economic and historical circumstances on local opportunities for discretion and approaches to the exercise of discretion. Ethnographic techniques were used to gather information through direct observation and testimonies of 80 street level workers from 40 different services in the health, social and law enforcement sectors. In depth interviews were combined with extensive observation of workers' activities in

developing grounded analytical understanding of the forms and causes of discretionary decisions.

The study approaches discretion by combining theories from the fields of the global discourse on drugs and drug policies, street level bureaucracy, and governmentality. The analysis and interpretation of the primary data benefited from these approaches, but also allowed to challenge the use of these concepts as mono-disciplinary explanations. Workers' discretionary choices in the studied cities were neither only determined by a self-centred behaviour nor only by a willingness to serve the clients, as different scholars from the street level bureaucracy field suggest. A more integrated and nuanced approach composed of different combinations was found.

The extent to which workers feel supported by their organizations have a role in discretionary decisions. Organizations perceived as more supportive, as commonly the case in Amsterdam, facilitate combinations of organizational rules and expectations with professional needs and/or the needs of users in workers' discretionary decisions. Organizations perceived as less supportive, as commonly the case in Porto Alegre, lead to an increased tendency for workers to bend organizational rules towards the needs of users and/or themselves. Professional commitments and interpretive beliefs that workers hold as to 'best practices' towards drug users are also fundamental to define discretion.

While drug policy scholars suggest disputes around public health and public order are reflected as exclusive alternatives so that workers would hold one or other position, the findings of this study point at a more nuanced picture. Street level workers produce different combinations when swaying between care and order, continuously creating different meanings and practices of civil rights, public health and public order in Amsterdam and Porto Alegre.

In Amsterdam workers from all professional sectors have a higher tendency to share meanings and professional commitments towards care and order than their peers from Porto Alegre. In Porto Alegre, these meanings and commitments present more variations, especially between social and health sectors when compared to the law enforcement sector. In addition to differences, there are also surprising similarities in the underlying processes patterning how discretion is exercised and the experiences of users caught between care and order. By clustering the various experiences of workers, the study proposes five main discretionary postures workers can take when combining care and order in their daily activities. At the extremes of the spectrum, strong rights engagement with drug users can be contrasted with

a frustrated withdrawal into alienated behaviour. In the middle of the spectrum where most workers in both cities operate, workers may combine care and order by using benefits, persuasion or enforcement of rules to promote behavioural changes among drug users.

Key–words: street level workers' discretion, drug policies, governmentality, comparative policies, crack cocaine, Netherlands, Brazil.

TUSSEN ZORG EN ORDE: BESLISSINGSRUIMTE VAN WERKERS OP STRAATNIVEAU EN DRUGSBELEID IN AMSTERDAM (NEDERLAND) EN PORTO ALEGRE (BRAZILIË)

Samenvatting

In dit vergelijkend onderzoek wordt de implementatie van beleid ten aanzien van zogenaamde 'probleemdrugs' (crack en heroïne) in de steden Amsterdam (Nederland) en Porto Alegre (Brazilië) onder de loep genomen. Het onderzoek is gebaseerd op een variant van de street-level bureaucracy-benadering en op de aanname dat de beslissingsruimte die uitvoerende werkers hebben bij het uitvoeren van beleid essentieel is om te begrijpen hoe officieel overheidsbeleid in de praktijk vorm krijgt. Dergelijke praktijkwerkers maken hun eigen afwegingen bij het creëren van strategieën om het gat te dichten tussen de doelen en verwachtingen van officieel beleid en de daadwerkelijke werkomstandigheden op straat. Bij drugsbeleid betekent dit ook dat ze moeten laveren tussen verschillende uitgangspunten bij hun benadering van drugsgebruikers, variërend van mensenrechten en gezondheidszorg voor gebruikers tot ordehandhaving om de openbare orde veilig te stellen. Uitvoerende werkers hebben niet alleen te maken met officiële regels, doelen en voorschriften, maar ook met andere functionarissen en met gebruikers bij het maken van keuzes wat betreft probleemdefinities en mogelijke oplossingen voor drugsgebruik. Al deze factoren blijken van invloed te zijn op de manier waarop praktijkwerkers hun beslissingsruimte benutten.

Het onderzoek is gericht op uitvoerende werkers in de sociale sector, gezondheidszorg en ordehandhaving (m.n. politie) en beoogt d*e dilemma's die zij tegenkomen in hun dagelijkse omgang met drugsgebruikers en de strategieën die zij ontwikkelen om daarmee om te gaan* te analyseren. Er wordt in het bijzonder gekeken naar in hoeverre dilemma's en strategieën verschillen per werkterrein, naar verschillende interpretaties van drugsgebruik, naar de mate van ondersteuning die de verschillende organisaties bieden en de beperkingen die zij

opleggen, naar verschillende samenwerkingspatronen binnen en tussen sectoren, en naar ervaringen in de relatie met drugsgebruikers.

De vergelijking tussen twee steden maakt het mogelijk om de invloed van verschillende sociaaleconomische en historische omstandigheden op de mate waarin beslissingsruimte aanwezig is en op het benutten van die beslissingsruimte te onderzoeken. Met etnografische technieken is informatie verzameld door middel van directe observatie en interviews met tachtig professionals die op straatniveau werken in veertig verschillende diensten op de terreinen gezondheidszorg, sociaal werk en politie. Met een combinatie van diepte-interviews en uitgebreide observatie van de activiteiten van de praktijkwerkers is inzichtelijk gemaakt en geanalyseerd welke vormen van eigen beleidskeuzes voorkomen en wat de oorzaken zijn.

Het onderzoek combineert theorieën uit het mondiale discours over drugs en drugsbeleid met theorieën op het gebied van street-level bureaucracy en governance bij de analyse van beslissingsruimte. Met deze benadering konden de primaire data goed geanalyseerd en geïnterpreteerd worden, maar tegelijkertijd hebben deze begrippen het nadeel dat het monodisciplinaire verklaringen zijn. De eigen beleidskeuzes van uitvoerende werkers in de onderzochte steden werden niet uitsluitend ingegeven door eigenbelang en ook niet alleen door de wil om de cliënten te bedienen, zoals verschillende wetenschappers op het gebied van street-level bureaucracy suggereren. De resultaten lieten een meer geïntegreerde en genuanceerdere aanpak zien die bestond uit verschillende combinaties.

De mate waarin medewerkers zich gesteund voelen door hun organisatie speelt een rol bij hun eigen beleidsbeslissingen. Als medewerkers zich gesteund voelen door de organisatie, zoals in Amsterdam meestal het geval is, kunnen zij officiële regels en verwachtingen gemakkelijker combineren met hun professionele behoeften en/of de behoeften van gebruikers bij het nemen van beleidsbeslissingen. Als medewerkers zich in mindere mate gesteund voelen door de organisatie, zoals in Porto Alegre meestal het geval is, zijn ze meer geneigd om losjes om te gaan met officiële regels, afhankelijk van de behoeften van gebruikers en hun eigen behoeften. Professionele commitments van medewerkers en hun opvattingen over 'best practices' ten aanzien van drugsgebruikers zijn ook essentieel voor het definiëren van de beslissingsruimte.

Wetenschappers op het gebied van drugsbeleid suggereren dat de belangen van volksgezondheid en openbare orde strijdig zijn, zodat praktijkwerkers aan een van beide de voorkeur moeten geven, maar uit de resultaten van dit onderzoek blijkt een genuanceerder beeld. Professionals op straat-

niveau combineren beide belangen op verschillende manieren en zoeken de balans tussen zorg en ordehandhaving, waarbij ze in Amsterdam en Porto Alegre voortdurend verschillende betekenissen en praktijken van burgerrechten, volksgezondheid en openbare orde creëren.

De betekenissen die praktijkwerkers uit alle drie de sectoren hechten aan zorg en ordehandhaving en hun professionele commitments komen in Amsterdam vaker overeen dan in Porto Alegre. In Porto Alegre is er meer variatie in deze betekenissen en commitments, vooral wanneer je de sociale sector en de gezondheidszorg vergelijkt met de sector ordehandhaving. Behalve verschillen zijn er ook verrassende overeenkomsten tussen de processen die ten grondslag liggen aan hoe de beslissingsruimte wordt benut en de ervaringen van gebruikers die gevangen zitten tussen zorg en ordehandhaving. Door de verschillende ervaringen van praktijkwerkers te clusteren komen vijf typen beleidskeuzes naar voren die zij kunnen maken bij het combineren van zorg en ordehandhaving in hun dagelijks werk. Aan de uiteinden van het spectrum is een tegenstelling te zien tussen een sterk engagement met de rechten van drugsgebruikers en frustratie en vervreemding. In het midden van het spectrum, waar de meeste praktijkwerkers in beide steden opereren, kunnen zij zorg en ordehandhaving combineren door met beloningen, overtuigingskracht of het handhaven van de regels gedragsverandering onder drugsgebruikers te bevorderen.

Trefwoorden: discrettionaire ruimte, beslissingsruimte van praktijkwerkers op straatniveau, drugsbeleid, governance, vergelijkend beleid, crack, Nederland, Brazilië.

Preface

I decided to do this study for two main reasons: making sense of my previous professional experience, and advancing the understanding of street level workers' practices in the drug policy field. About 12 years ago I was finishing my under-graduation in Psychology in Porto Alegre, Brazil, and started to work for a Non-Governmental Organization doing permanent education for health outreach workers. Our task was to guide them on how to approach drug users. Back then I got to know 'harm reduction': an approach which does not require from drug users to become abstinent, or to stop using drugs in order to start care. Harm reduction was understood as an alternative to the abstinence-only approach. The latter was predominant in health care practices at that time, but criticized for keeping away from welfare many users who did not want or could not stop using drugs. A national drug policy shift towards harm reduction, in 2003, led Brazilian government to invest in training health care workers on the new approach. And there I was.

In those trainings I could feel the struggle of many workers to accept and/or put harm reduction into practice. Disagreements on what to do, misunderstandings, prejudicial behaviour towards users and towards a harm reduction approach were frequent. If/when this step was overcome, more structural constraints as lack of resources and political support had an important role in hindering or enhancing the adoption of harm reduction as goal. Some years later, when I worked as a psychologist in a public clinic for drug addiction, I experienced myself having colleagues who would refrain from adopting harm reduction, even though it was part of the rules and regulations guiding our work. While I was promoting strategies for reducing harms in the groups and in individual appointments with drug users, some of my colleagues would reinforce complete abstinence in their activities. Many times, we were assisting the same users. Since each professional was pursuing and communicating to users a different type of goal, we all experienced difficulties in developing coherence in our work.

The research I carried out in my MA, on outreach workers approaching drug users, confirmed these first perceptions and brought into light new themes. Workers adopting a harm reduction approach reported difficulties in collaborating with social and health workers who were abstinence-only driven. They, also, perceived police workers' activities of displacing drug users from public areas and seizing drug use equipment –such as syringes which were given by harm reduction programs -, as hindering their tasks. At this point, one thing was clear: even though policy statements were certainly a trigger for practitioners in how to organize activities, alone these statements were not enough to change workers' practices towards harm reduction.

All these puzzling experiences came together when building a research proposal for this PhD study. How do workers in the drug field choose for different approaches on how to deal with drug users? How they decide whether and with whom to collaborate? And how come national policy statements can be, sometimes, totally ignored by street level workers?

Interestingly enough, I was granted with a PhD vacancy and a scholarship to study these questions in the Netherlands, the country where harm reduction approach was born. At that point, for harm reduction supporters, the Dutch harm reduction strategy was seen as an example to be followed, the golden pot at the end of the rainbow that all wanted to have. When compared to Dutch national policy statements, the Brazilian ones seemed to be far-behind. Which lessons could Brazilians learn from the Dutch way? How would harm reduction be brought into practice at the street level in the Netherlands? I expected to see great differences in terms of how street level workers behave, think, and decide upon what to do with drug users on a daily basis.

Along this research, however, the colours of the Dutch rainbow showed somehow different nuances, and the golden pot lost a bit of its shine. Many other questions regarding how street level workers take daily decisions arouse, and comparing ideas and experiences of street level workers across the Atlantic was definitely one of the most fun and challenging tasks I had so far in my academic career. Through the experiences of the street level workers participating in this research, I revisited the hardness and the beauty of daily negotiating of goals, meanings and decisions. What the reader will find in this thesis is an attempt to analyse these experiences and perceptions in a deeper way. I wish you a pleasant journey.

1

Framing the research

1 Framing the research

Policy usually does not happen the same way in the streets as planned on paper. From official guidelines to the ground, rules, goals and regulations of any written policy have to undergo a set of steps, enter a world of institutions and resources, different contexts and a set of workers who translate rules into practice. In these processes, it does not help much to simply describe the differences to policy's original shape as an implementation problem, blaming street level workers, local management and lack of State resources for the unintended outcomes. A more constructive approach to understand what shapes policy in practice is to analyse the factors and processes of interpretation present in the trajectory from official guidelines to practice.

This is what this qualitative-ethnographic study does. It analyses how street level workers from social, health and law enforcement sectors manage to put drug policies into practice. More specifically, it looks at how workers choose between different approaches towards drug use, ranging from care to law enforcement and public order. In order to look at policy processes from a wider perspective, the study focuses on the so-called problem drugs - crack cocaine and heroin – by comparing two cities in very different settings. One, in a developing country, historically strict, but with a recent and growing tendency towards a more open drug policy, and the other, in a developed country with a historically liberal, but recent and growing tendency towards a stricter drug policy. These places are Porto Alegre, in the south of Brazil, and Amsterdam, in the Netherlands.

By using a qualitative and grounded approach, the study aims to build a view from field workers' level, and to derive an understanding of policy in the place it happens daily: the streets. Policies as stated in official documents define the aims and the methods to be used by street level workers. In practice, however, the shortest distance between aims and

achievements is usually not a straight line. Briefly, the resources might not be enough, different meanings about the theme might have to be negotiated with colleagues and other services, and finally, the population targeted might bring specific challenges to the practice. When factors have a negative influence, they can be seen as constraints workers find in their way. In these cases, a detour has to be made by street level workers to keep on the journey. Not only constraints, however, can modify the planned path. Many times, there may be more than one route to satisfy the programme aims, and some routes might be seen as shinier or more rewarding than others by street level workers. Both rewards and constraints can raise dilemmas on how to enact policy daily. Every time workers are faced with dilemmas, or with different paths to get to one place and the need to make detours, they have to make a choice. This is the point when they use agency, or discretion.

A fundamental question to understand policy processes then is: how do workers decide on which path to take? How they define the strategies they will use to cope with the unexpected events of street policy? Would workers always choose the stress-free and most rewarding detours in order to make their work easier, or would they go for rocky and dark paths sometimes when they believe these ones would lead them to a better final destination? In other words: how much sweat is expended and risks taken by workers in order to fulfil their role and expectations? What, ultimately, determines different attitudes street level workers might have? And still, would street level workers' discretion transform policies in different ways in different environments?

These are some of the questions this research aims to answer. Based on a grounded theory method (Urquhart 2013), the study produces an understanding of street level workers' use of discretion when choosing for different approaches in drug policies. It starts from a limited number of a priori assumptions and operational concepts, and then focuses on workers' reported and observed experiences to produce analytical explanations. Relevant previous literature is referenced after a grounded explanation is reached, in a process that goes from rich data to appropriate theorization that connects critically to global debates in that literature. The comparison between the two cities – Amsterdam and Porto Alegre- is at the centre of the study.

An overview of the operational concepts used in the research is provided in the following sections. A brief explanation of the context lead-

ing to the research focus is offered and some of the main features influencing the way down from policy as stated on official guidelines to practice in the streets are revised. A new focus to understand policy processes and workers' discretion is proposed, with the main question and sub questions this study aims to answer. A general framework and the methodology used for this investigation are briefly presented, finalizing with an overview of the following chapters.

Context and contradictions on official guidelines

Policies bring preconceived ideas on how to govern people (Dean 2010). Both on official policies and in practice, definitions and meanings on what is a problem and what are the possible solutions to it, have to be negotiated among different actors participating in a given policy field. In the case of drug policies, the field has been marked by tensions between different approaches. The debate has mainly been related to whether drug use should be tackled by a repressive or a more tolerant policy.

Historically, many governments have supported a repressive policy towards the cultivation, distribution and use of the so called illicit drugs. These policies involve enforcement of prohibitionist laws, and (only) abstinence models of treatment (Inciardi and Harrison 2000) to achieve its goal of completely eradicating drugs from society (Marlatt 1998). In this approach, known as 'law enforcement' or 'public order', drug use is seen as a safety issue and treated with punishment and repression. Criticisms were and still are made regarding the lack of efficacy and unintended negative effects of these policies in terms of halting illicit drugs use (e.g. Des Jarlais 1995, Escohotado 2008, Reuter 2009, Zaluar 2004).

In the last 30 years, several policy changes have occurred in drug policies of developed and developing countries, mainly towards the inclusion of a more tolerant approach to the presence of drugs and its users in society. This has been called a 'public health' (or a 'harm reduction') approach, as it focuses on reducing harm caused by drug use and trade rather than expecting to completely ban them (Inciardi and Harrison 2000). Contrary to a law enforcement approach, harm reduction considers drug use as a public health issue, rather than a safety one, and is concerned with the health of people who use drugs.[1]

Although public order and public health approaches have often been combined, they have different aims and priorities and the combination

have led to contradictions. These contradictions are found both in (dis)agreements on the establishment of national/local policy statements (e.g. Acevedo 2007, Tammi 2005) and the way policy actually happens at the local level – or street policy. In this tension, many argue that public order dominates public health through most of the world (Eby 2006, Hunter et al. 2005, Inciardi and Harrison 2000). One main problem in integrating these approaches is how to be repressive against illicit trade and use of drugs and worried about the health of drug users at the same time. For some, contradictions are related to the debate about who should have the main role regarding drug use: the police workers or the health sector (Hunter et al. 2005). Contradictions, however, are not only related to police workers 'versus' health workers' roles, but can also be seen within sectors. Police and health workers do not represent two homogeneous and opposed ways of dealing with drugs use, the first representing a public order and repressive approach and the second a more tolerant public health one. While some health practices can be mainly directed towards keeping the public order, other law enforcement practices can aim also at users' health and wellbeing. To understand street level workers' choices and practices, a more complex account of the several nuances of meanings and activities in public health and order is needed.

When thinking about these tensions and balances at the street level regarding drug use, both Brazil and The Netherlands are interesting cases to consider. Worldwide and in the European Union (EU), The Netherlands has been seen globally as a leading country in adopting and defending this approach; more recently in the South American region, Brazil appears to be moving towards this approach. It is in the drug policies of the Netherlands that harm reduction approach has its roots (Inciardi and Harrison 2000), with the notion of drug use as a social-health problem rather than a crime (Vws 2003). In South America, Brazil is a leading country claiming to adopt public health strategies (Bastos et al. 2007, Bueno 2007), being considered an example among developing countries on harm reduction and HIV/Aids policies implementation (Mesquita 2006). Notwithstanding these apparent similarities, these countries' differences in terms of history, policies, resources and users' profile shaped their responses to harm reduction both on policy statements and in practice. The Netherlands, for instance, is considered to have achieved a good balance between 'tolerance' and 'repression', not only in terms of

official policy statements but also on the ground. An integrated approach is taken between different ministries involved in drug policy[2] (Van Der Gouwe et al. 2009); collaboration between care[3] and law enforcement professionals is seen as an absolute necessity, and has been claimed to be happening for some decades (De Kort and Cramer 1999). Despite a history of tolerance, in recent years Dutch drug policy appears to have been moving towards a more repressive approach (Uitermark 2004, Uitermark and Cohen 2005, Nabben 2010).

Brazil, on the other hand, claims to have been moving towards a more tolerant approach. The Health Ministry reformed prevention and treatment policy regarding alcohol and other drugs, and officially stated national political support for harm reduction strategies for the first time in 2003 (MS 2003). Subsequently, official financial incentives for public health approach at different levels (hospitals, specialized clinics and primary health care) of the health system (MS 2004, 2005, 2005a, 2005b) have been provided, followed by a reform of the national drug policy with decriminalization of drug use (Brazil 2006). Despite the changes, several problems are still found in putting harm reduction strategies into practice (Delbon et al. 2006,Queiroz 2007,Rigoni and Nardi 2009).

Here a question arises: do these differences regarding historical developments of drug policy shape the way public health and public order are justified and put into practice by street level workers in the Netherlands and in Brazil, and, if so, how? At this point, street level bureaucracy theories bring an important contribution for analysing drug policy practices: the concept of discretion. Discretion can be understood as the freedom in exercising one' work role (Evans 2010). Lipsky (2010), founder of street level bureaucracy approach, contends that workers have to find ways to cope with the gaps between rules and expectations and the reality they find in the streets. In doing this, they end up transforming the ways in which policy actually happens. Consequently, '…policy implementation in street-level bureaucracy must be studied at the work place rather than tracing policy through the bureaucratic and inter-organizational systems' (Lipsky 2010:188). The present research, thus, considers that analysing workers' varied histories and experiences regarding drug policies, taking into account very different socio-economic and organizational contexts, can enhance the understanding of policy implementation. This, both by unveiling the factors shaping dis-

cretion in daily practices, and by revealing the reality of claimed national policy shifts.

Interpretive beliefs and contradictions in practice

Given that policies are formed by preconceived ideas on a certain issue, and that there are different possible approaches towards drug use, analysing workers' interpretive beliefs assumes a great importance. Interpretive beliefs are understood here as formulated opinions and mental views workers hold regarding drugs and their users. These views are often imbued by feelings and a more or less subtle conviction in certain ways of dealing with drugs, being therefore a 'belief'. They, however, are not necessarily fixed commitments to certain ideas, but might be interchangeable over time and depending on the context workers are in, being therefore 'interpretive'. [4] In this sense, interpretive beliefs of workers on what to do with drug use shape their practice, or the way policy happens on the streets.

Scholars in the drug field attempted to identify and analyse workers' interpretive beliefs on drug use in different ways. Quantitative studies have produced scales to measure health workers' 'values and feelings' towards users (e.g. Brener et al. 2007, Phillips and Bourne 2008) and workers' 'beliefs' about drug treatment (e.g. Humphreys et al. 1996, Miller and Moyers 1993, Queiroz 2007). Through factor analyses, these two set of studies isolate variables and contribute to the validation and generation of scales and statistical models to predict workers' positioning regarding drugs. This positioning is attached to different 'models' proposed by the studies, each model emphasizing one of the various conceptualizations of etiology, nature, and treatment of addictions. These studies, however, look at workers' values or beliefs as fixed, universal and an expression of the individual personality of workers. Also, they solely provide a description of the ways in which workers think, but do not consider how features such as the organizational setting, workers' actual activities, profession, and territory of practice might influence these 'values and beliefs'.

Qualitative studies, in comparison to quantitative ones, have mapped health workers' interpretive beliefs in a more contextualized way (Pauly 2008, Rigoni 2006, Nowlis 1976). They also use the concept of 'models' as organized sets of beliefs in the drug addiction field, and propose simi-

lar models in comparison to the quantitative studies. Differently, however, qualitative studies look at these models in a more situated manner: they are concerned with addressing the practical dilemmas experienced by workers due to the introduction of new models of treatment, such as harm reduction, into drug policy. These studies use ethnographies and in-depth interviews for data collection, and categorization or (different types of) discourse analysis for its interpretation. They, however, tend to narrow its focus only on the health sector, and usually just one profession in the field (outreach workers or nurses). They do not provide comparisons between workers from different sectors, and also do not attempt to make cross-cultural comparisons of workers' interpretive beliefs.

Interestingly, both quantitative and qualitative studies in the field tend to use the term 'model' to refer to the different forms of thinking about or approaching drug use. This term is grounded in a biomedical set of ideas, and suggests a deterministic positivist epistemology. For this reason, we propose the use of a more epistemological inclusive term instead, which will be used from this point onwards: frame. Table 1 provides a brief summary of the main frames around drug use proposed in the literature, with some additional grounded theory features produced by the present research. Each frame represents a different perspective in drug approach or, in other words, different ways of defining problems and solutions in the drug policy field. The key-elements proposed for each frame permit a better understanding of why there might be contradictions and synergies between a public order and a public health approach.

While the first three frames (medical, coercive and moral) are linked to a more repressive approach, the fourth (psychosocial) represents a transition from a repressive to a public health approach; the fifth one (harm reduction) directly connects to a non-repressive public health approach. On the repressive side the medical frame is usually associated with the medical field in health, and relates to ideas of cure. The coercive frame is attached to the action of police workers, and the moral frame is being used by different workers in the area. The psychosocial frame connects both with actions of social and health workers, and depending on which other frame is attached to, it can assume repressive or public health nuances. The harm reduction frame, in its turn, connects with the idea of care, instead of cure, and of human rights for 'people who use

drugs'. It is associated both with social and health workers, and relatively recently also with some modes of action of law enforcers.

Table 1:
Frames of drug use

Frame	Key-elements
Medical	Drug addiction is a(n incurable) disease Drug addiction is a brain disease 'Drug users' have no control over the substance Complete abstinence is the form of treating drug use
Coercive	Drug use is a criminal issue 'Drug users' have to be punished for their behaviour Drug use leads to non-drug crime that must be punished Drugs have to be banned from society
Moral	Drug use is essentially bad 'Drug users' are morally weak and not reliable Drug treatment involves a moral reformation Drugs are a cause of evil in society Drug use causes anti-social nuisance behaviour
Psychosocial	Environment is important in determining drug use Drug use can be caused by a dysfunctional family Drug use can be caused by learned patterns (friends, family and culture) Underlying psychological problems can cause addiction
Harm reduction	Drug use is a public health and human rights issue Reducing harm is a pragmatic and effective form to deal with drug use 'People who use drugs' are citizens like any others A society without drugs (and drug use) is an utopia Weighing up rights is a part of being a worker in the drug field

Sources: This research and previous studies (Acselrad 2000, Pauly 2008, Queiroz 2007, Rigoni 2006, Humphreys et al. 1996, IHRA. 2010).

When putting drug policies into practice, street level workers assume and negotiate different interpretive beliefs coming from these frames. In these negotiations contradictions might arise, for instance, when workers' interpretive beliefs and practices are different from those indicated on policy statements, or when workers with contradictory interpretive beliefs and practices have to work together. In these cases workers might have dilemmas regarding their activities and role. In some primary health care programs from Brazil, for instance, incoherence was found between workers' values and concept of harm reduction, leading to a mischaracterization of this approach in practice. Although apparently accepting

harm reduction, workers were ignoring its ideological foundations, having stronger values associated to abstinence, dependence and drug use as disease than with statements coming from a harm reduction frame[5] (Queiroz 2007). Dilemmas can also occur in how to adapt previous interpretive beliefs and activities (related to an only abstinence frame, for instance) to fit a new harm reduction frame (Delbon et al. 2006, Pauly 2008, Queiroz 2007).

Similar challenges are faced by law enforcement workers. They have to deal with a 'double' expectation of being repressive towards drug use but also of collaborating with harm reduction programs (Beyer et al. 2002, Bull 2005, Lister et al. 2007, Lough 1998). Studies have shown that street level police workers, for instance, might not comply with new harm reduction laws that allow syringe possession and purchase; they tend to seize syringes and use its possession as legal ground for searching and arresting injection drug users (Beletsky et al. 2005, Small et al. 2006).

Different interpretive beliefs and practices regarding drug use may also make it difficult to build collaboration between workers in different services. Studies throughout the world report that different goals, expected roles and professional jargon can be fundamental difficulties in building collaboration between police and health workers (e.g. Bull 2005, Connolly 2006, Vermeulen and Walburg 1998). Examples include repression through crackdowns and intensive policing in areas where health services are offered to drug users (Beletsky et al. 2005, e.g. Rigoni 2006).These activities are understood as hindering users' access to care by driving them underground. They also induce drug use in riskier environments, and compromise the functioning of outreach work and harm reduction programs (Hammett et al. 2005, Small et al. 2006).

Despite pointing to these contradictions, studies usually consider just one side of the coin: they generally address health workers' opinion on law enforcement workers' activities, and very little is known about how social or police workers view the situation. Besides, studies that note the dilemmas experienced by workers, usually only provide a description of the dilemmas. They do not go further to analyse *how* workers deal practically with dilemmas in their daily activities or how they develop solutions for them.

Organizational context

Besides the negotiation of meanings for practices, the organizational context workers are in might influence their activities. Studies in the field of drug policies find, for instance, that work load influences the extent to which police workers collaborate with harm reduction projects by referring arrested (or approached) people to these services (Hunter et al. 2005). Lack of material to assist and places to refer drug users were seen as difficulties to develop collaboration between health services (Rigoni 2006), and also hindered collaboration between police workers and health services (Connolly 2006, Vermeulen and Walburg 1998).

Higher per capita income countries, such as The Netherlands, have considerable more resources in terms of types of services, number of workers and support of all kinds per user than a lower per capita income country, such as Brazil. Even though the Netherlands faces current economic pressures, while Brazil is experiencing economic expansion, work conditions, job security and welfare provision are still quite different. How would different resources affect street level workers possibilities to put policy in practice? Would Dutch workers have an easier life and less dilemmas than their Brazilian counterparts?

Besides resources, institutions are also permeated by work cultures and subcultures, where expectations, norms on right and wrong behaviour and an informal system of rewards and punishments are defined and developed. Sometimes these, more than the formal rules and guidelines, may influence the direction workers' practices will have. Social, health and law enforcement workers are part of very different organizations, each one with its own history, policies and work culture. What would be the effect of these differences in terms of workers' practices and interactions? Even with all the differences in the organizational context, would it be possible to find similarities not only among social, health and law enforcement workers, but also among workers from different countries? And if yes, what could possibly explain those convergences?

Strategies and decisions

Street-level bureaucrats are defined by Lipsky as '... public service workers who interact directly with citizens in the course of their jobs, and who have substantial discretion in the execution of their work' (Lipsky

2010: 3). Public service agencies with a significant number of such workers as a proportion of their work force may be conceptualised as street-level bureaucracies. Lipsky claims that street-level bureaucrats are policy makers: as they have great discretion over benefits and punishments dispensation, their practices and decisions become the policy itself for service users. When street level workers face daily dilemmas due to a gap between the rules and regulations imposed by the work (or, the work structure), and the reality they face, they make use of their discretion to create and choose strategies. The choices workers make are, in the end, what defines policy in practice. It is, therefore, fundamental for the analysis of policy processes, to know how discretion actually happens.

Recent studies in the field of street level bureaucracy (e.g. Lipsky 2010, Evans 2013) debate on whether discretion remain as important and feasible as described by Lipsky in the 1980's. Two main viewpoints have been identified in this regard: the curtailment and the continuation perspectives (Evans and Harris 2004). The first contends that managerial reforms led to the end of discretion due to increased regulation over work processes; the second affirms that discretion remains and is possibly even increased due to the escalation of managerial rules and regulations (ibid.). This second perspective is the one adopted by the present study: it accepts discretion as an existing and fundamental element to be analysed in order to understand policy processes. Rather than concentrating at questioning the existence or the extent of discretion, this study focuses on analysing *how* it happens.

This type of analysis looks at discretion as judgment: different decisions workers make and strategies they find to cope with the gaps between expectations and real possibilities in order to put policies into practice. When looking at this feature of discretion, different positions can be seen in the literature. By studying different street level bureaucracies in the United States, Lipsky (2010) contends that workers' tendency is to decrease efforts, searching for easier and more rewarding ways of doing their jobs. The author mapped three general responses that workers develop to deal with difficulties and ambiguities. One response is to ration services by limiting access and demand and trying to control clients to obtain their compliance over and above the procedures of their agencies. Secondly, workers can modify their concept of their jobs to lower or restrict their objectives in order to reduce the gap between available resources and achieving objectives. Finally, workers may modify

their concept of their clients to make more acceptable the gap between objectives and accomplishments (Lipsky 2010:83).

For Maynard-Moody and Muscheno (2000), Lipksy's explanatory framework represents what they call a 'state driven' approach. Since workers are understood as fundamentally bounded by the rules and hierarchies, and as mainly searching for self-fulfilment, the citizens they assist would be left in the background. The authors propose, on the other hand, that workers perceive their work and act more in terms of the citizens they assist, than in relation to their professional stress. For these authors, workers act first in response to individuals and circumstances, being 'citizen driven' (Maynard-Moody and Musheno 2003, 2000). The authors contend that, in order to take decisions on how to manage citizens' needs, street level workers make moral judgements about these citizens' worthiness. For that, workers use social roles and stereotypes to attribute identities to citizens, and base their decisions on benefits distribution in these judgements: worthy citizens deserve benefits, while non-worthy get denials and/or punishment (Maynard-Moody and Musheno 2003).

When looking at street level practices, however, and comparing workers in very different socio-economic and cultural environments, would it be possible that both state driven and citizen driven roles operate? And if yes, is it possible that street level workers' judgements are both moral (Maynard-Moody and Musheno 2003) and self-interest (Lipsky 2010) driven? If both approaches are mixed in practice, it may be possible to explain workers' discretion in different ways. Also, it may be possible that there are other features operating in the choices workers make when they face dilemmas. But how to investigate that?

A new focus: research questions

To examine all these questions, the present study analyses how street level workers from the social, health and law enforcement sectors manage to put drug policy into practice in the cities of Porto Alegre (Brazil) and Amsterdam (the Netherlands). More specifically, the study focus is: **What dilemmas workers encounter in their daily interactions with drug users, and what strategies do they develop to cope with them?** In order to approach this problem, six main questions are addressed:

1) How does the *territory* and *history* of drug policy influence actual support, challenges and strategies developed by workers?
2) What are these workers *interpretive beliefs* towards users, and how they affect their activities and interactions with each other?
3) What type of support and constraints do workers face in their *organizations* and how do they affect their practices and interactions with each other?
4) What are the *strategies* workers use to deal with challenges and what factors they take into account when *deciding* for a strategy over another?
5) What are the main *similarities and differences* between social, health and law enforcement workers' activities, interpretive beliefs and organizational context and to what extent do they affect these workers *collaboration* regarding drug users' assistance?
6) What *activities* do workers choose to undertake with drug users and how these are influenced by workers interpretive beliefs, organizations and collaboration with each other?
7) How do the very different political histories of Brazil and the Netherlands and the very different material resources available in Porto Alegre and Amsterdam, impinge on street level practices as a specific case studies?

Theories' framing

Researcher's standpoint

The main authors and theories used in this study lie in a social constructionist and post-structuralist epistemological approaches. A social constructionist approach argues that social phenomena are not static objective conditions, but might change on the basis of deliberations about collective definitions in different cultures and times. Consequently, assessing the processes by which the perceived phenomenon is generated and maintained is a more important task for the researcher than assessing 'truth' (Hannigan 1995).

Considering this standpoint, I am recognizing that the concept of 'problem drugs' and 'non-medical' use of drugs are both socially constructed, and that the definition of its meanings involve power relations

between different interest groups (Cohen 1990). What is understood by the word 'drugs', by the harm they can 'cause', by the legitimate (or illegitimate) forms of dealing with 'healing', and the consequent attempt to manage people who use them, vary across time and cultures, depending on the meanings attributed to them.

Another assumption here is that social, health and law enforcement workers have agency to act in their territories according to their own interpretive beliefs about illicit drug use, which can be in accordance with those indicated on policy statements or not. Agency is understood here in the direction described by Long (2001) (using Giddens): as referring to knowledgeability, capability and social embeddedness associated with acts of doing and reflecting that impact upon or shape one's own and others' actions and interpretations. Underlining agency means emphasising that social actors do not simply respond or adapt to programs or policy implementation, but have an active participation in shaping the ways in which these programs are understood and realized in practice (Long 2001). In street level bureaucracy's language, this means assuming that workers have (at least a certain extent of) freedom to decide on how to put their work in practice. And, in this sense, they have some freedom to decide for different ways of interpreting and approaching drug use. This assumption, based on previous experiences and research, was confirmed by the grounded data in this study.

Fitting the social constructivist perspective in this research, comes the use of a grounded theory approach as an epistemological and methodological choice. A grounded theory method does not seek to impose preconceived ideas on the world, but to build theory departing from fieldwork data, focusing on how individuals interact with the phenomenon under study (Urquhart 2013). The use of grounded theory, thus, allows to respect the different 'social constructions' around the positions workers might have regarding drug use, and their possible choices on how to implement drug policies on a daily basis.

Underlining agency does not mean ignoring the influence of structure, or centring the explanations too much on the agency of individuals. Although important structural changes result from outside forces, it is theoretically unsatisfactory to base one's analysis only on external structural determination or driving forces (Long 2001). Actually, from an actor centred perspective, agency and structure are not disconnected, as both include and shape each other (Long and Long 1992). In this sense, I'm

assuming human subjects cannot be understood as separated from their environment or social context (Jacques et al. 2001).

Departing from this stance, to analyse workers' interpretive beliefs about drugs does not mean to reach an 'individual' belief as if it was built apart from any historical and contextual processes. Rather, it means that the experiences workers have regarding their institutional setting, territory, and the different approaches to drug use are going to shape their interpretive beliefs and attitudes on the street. In this sense when street level workers choose to believe and/or to act within certain approaches to drug use, and when they chose one strategy above others to cope with dilemmas, the decision making involves both their own subjectivity (agency) and contextual support and constraints (or structure) from existing paradigms, institutional setting, and the territory they are in.

Finally, this research is committed to the idea that it is not possible for a researcher to be completely 'neutral', and that knowledge is embedded in power relations (Foucault and Gordon 1980). This is why it is necessary to be honest with the reader about my own assumptions, my personal and professional experience as stated in the preface, and how they frame the research I propose and the way I investigate it. During the research process, other perceptions and questions came up, brought by the myriad of experiences and types of workers found in the field, as well as by the engagement with other researchers and studies which views contrast with my own. One example is Lipsky (2010), who assumes street level workers tend to engage in primarily self-interested strategies by decreasing their efforts when using their discretion to deal with dilemmas. Another example are scholars (e.g. Blok 2008, Uitermark 2004, de Kort 1995) who suggest that a harm reduction approach face(d) more resistance in the Netherlands than what is usually assumed. Besides, also suggestions from organizational studies scholars triggered me to explore the use of different concepts, such as organizational culture (Schein 2010) [6], to analyse different meanings and patterns of behaviours of workers. All these inputs were carefully considered, and along the process were challenged by grounded data and theorization. While in some cases they remained as useful explanatory tools, in others they were confronted with other literature resources which seemed to better explain the experiences of participants. Challenges to my a priori beliefs and assumptions, thus, came both from my informants and the literature,

and this thesis is as much about exploring those challenges as confirming those a priori beliefs and assumptions.

In order to be able to use my own experience, but be apart from it at the same time, reflexivity is used as a very important tool. Reflexivity in a research is a process of critical reflection both on the kind of knowledge produced from the research and how that knowledge is generated (Guillemin and Gillam 2004: 274). In this sense, it is used to assure rigor in the approach and to reflect about possible biases in sampling, gathering and analysing data (Bourgois 2003); it is also used as a tool to pay attention to power relations in the field (Bourgois 2002). Adopting a 'reflexive research process', thus, means adopting a continuous process of critical analysis and interpretation in relation to the research methods and the data, but also in relation to the researcher, participants and the research context (Guillemin and Gillam 2004). Being reflexive during the research and honest with readers about assumptions and challenges, provides readers with more autonomy to judge the researcher's path. This honesty and reflexivity is what I have attempted to provide.

The following pages and subsequent chapters attempt to integrate reflections and experiences into a story of how street level workers use their discretion to put drug policy into practice. I hope the study produces a better comprehension of street practices related to drugs for policy makers at all levels.

Main theoretical guidelines

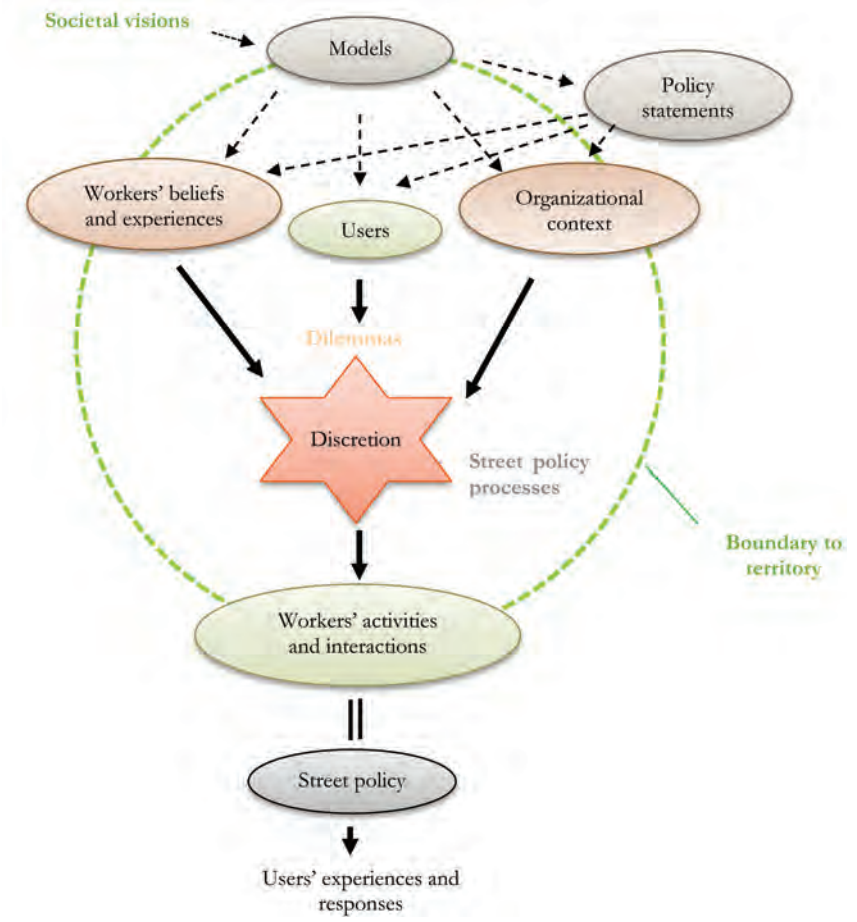
In this study drug policy is understood as processes, where different definitions and meanings about drugs and the problems their use might bring have to be negotiated among different actors (Long 2001, Long and Long 1992). Negotiation happens not only in the making of policy statements, but also at the street level, and during these processes, policy statements are transformed into street level practices (Lipsky 2010).

Seeing policy as a social construction differs from mainstream approaches: it does not understand policy as a logical succession of steps (definition of problem, identification and evaluation of options, decision, implementation and evaluation); and its main concern is not about policy outcomes, but policy processes (Colebatch 2004). In this framework, a formal policy decision is only the beginning of policy process; policy is understood not simply as proclaimed goals, but as activity, which means

that actors interact and negotiate policy in the streets, shaping, creating and modifying what is stated as formal policy decision (Lispky 2010).

Figure 1 summarizes the main concepts of this research and how they are related to each other. Dashed arrows indicate background relations while continuous arrows indicate relations focused on in the research.

Figure 1:
Analytical Framework



The main argument is that street level workers' interpretive beliefs, organizational context and territory are important factors shaping workers activities related to drug use. They bring both support and constraints

for workers on how to achieve their goals. The gap between regulations and expectations faced by street level workers produce dilemmas, which they have to deal on a daily basis. Before workers actually take an action, they use their discretion to decide on strategies to cope with the gaps and to try to solve dilemmas. Finally, workers activities are the means by which street policy functions.

In the background, workers' interpretive beliefs and experiences, as well as their organizational context (which includes rules, regulations and resources available), are being influenced by official policy statements and its developments and the frames on how to deal with drug use. In the middle, users are also influenced both by frames and official policy statements in the sense that they are based on and produce several ways of seeing drug users, and propose various forms of dealing with them. Workers, their interpretive beliefs and organizational context, as well as users, policies and frames are building the territories in which workers have to act. Social, health and law enforcement sectors are bounded by different policies, organizational contexts and frames on what to do with drugs, but the same analytical framework can be applied for each one of them, in the different cities studied.

The theories applied for these analyses are described and debated in-depth in the different chapters of this thesis. In summary, the study benefits from different scholars analysing street level bureaucracy and discretion (Lipsky 2010, Maynard-Moody and Musheno 2003, Evans 2010) to debate the dilemmas workers find daily, and the ways in which they use discretion to produce coping strategies. The analysis of workers' interpretive beliefs and experiences, profits from previous studies in the drug field (Pauly 2008, Acselrad 2000, Rigoni 2006, de Kort 1995, Zinberg 1984) and links them with an approach on governmentality (Dean 2010) to understand how workers think about drug use and how they produce different ways of governing users in their daily approaches. More specific concepts of territory (Santos et al. 2000, Lemke and Silva 2011), network (Musso 2004) and power (Foucault and Gordon 1980, Foucault 1990) are also used to problematize organizations, circulation and relationship of workers and users during street policy processes. Concepts from these authors emerged as relevant during the research process, in the spirit of grounded theorization.

Methodology

In order to understand how workers decide upon their experiences and challenges at the street level, the researcher has to live in their world. To get access to interpretive beliefs, dilemmas and decision-making processes a certain level of bond and trust between researcher and participant is needed, and this requires time and effort to be built. In line with the study of street policy processes, this research benefitted from a qualitative and ethnographic approach (Sumner and Tribe 2004). The research design complies two case studies with two embedded units of analysis each (Yin 1994). Amsterdam, in the Netherlands, and Porto Alegre, in Brazil, are similar cases in terms of being medium-sized cities with a cosmopolitan culture, having a history of hard drug use and dealing in public places, with a drug problem concentrated in certain neighbourhoods and among people at the margin of society. Both also, share process of evolution in drug policies towards harm reduction, and some frictions between a public order and a public health approach. These cities, however, contrast in their histories and types of hard drug use, histories of their national politico-bureaucratic regimes, the statements around harm reduction implementation, and the role of the law enforcement sector in drug policy. There is also a clear difference in the resources available to street level workers in the two cities and this research wished to explore whether there were underlying similarities and differences in workers' discretionary experiences, given/despite of the very different histories and resource availabilities. The comparison between these two cases is understood as enabling to explore the impact of different environments on approaches to the exercise of discretion.

The two embedded units of observation for each case comprise two districts in each city, which were chosen to cluster the observations. These are the city centre and a neighbourhood known for being one of the most problematic for drug related issues in the city –namely the Bijlmer in Amsterdam, and the North Zone in Porto Alegre. City centres are usually a place of agitation, where many different people meet to do all sorts of activities. These activities can include buying, selling and/or using drugs, or simply trying to score[7] in order to use drugs afterwards. The centre is also usually a place where public services are present in a greater scale. The second district was chosen to characterize a different context, where people who are present and walking around are more frequently living in the area, and tend to have a closer relationship with

the place and among each other. In order to be chosen, the second district had to offer street level services from all categories (social, health and law enforcement). While it is hoped that the two locations represent a range of experiences in each city, they were treated as triangulating observations revealing a range of experiences and not analysed separately.

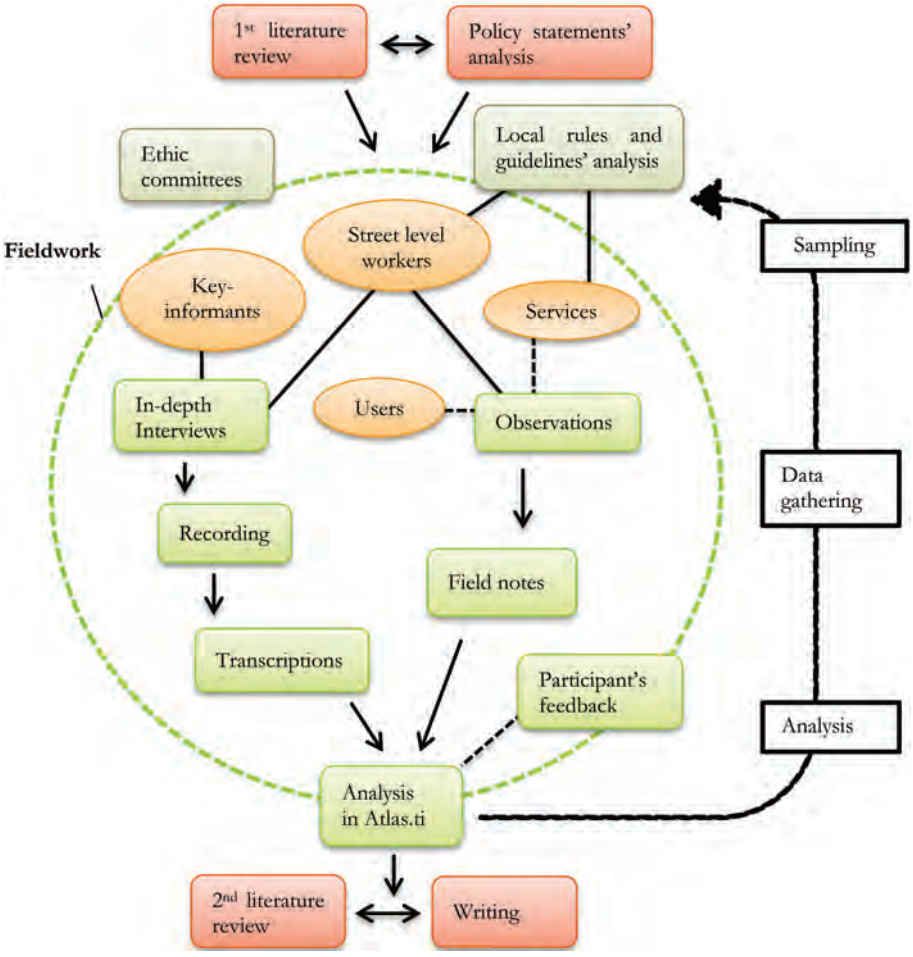
Figure two illustrates the methodology of the research design. The research was influenced by a grounded theory method (Urquhart 2013), seeking to make justice to respondents experiences and voices. A first review of the literature was carried out before fieldwork, together with analyses on official policy statements. However, previous theoretical concepts were not used to constrain workers' testimonies or to impose preconceived ideas during data analysis.

An understanding of workers experiences was acquired focused only on the data gathered, and grounded theory constructs and relationships were built to explain the perceived and reported experiences. Following grounded theory principles (Urquhart 2013), sampling, data gathering and analysis were understood as part of the same process: they occurred sequentially, with analysis guiding places and people to sample for data collection and in turn being modified by the data.

In Porto Alegre the research proposal was submitted to (and approved by) five different ethical committees, ranging from the local university supporting the research to the municipal committee of health workers and other local ethical committees from organizations participating in the study. In Amsterdam, this was not required either by the university or by workers' organizations. In one hand, participation in the committees led to interference with research design and delays. Some committees' requirements for authorization were not aligned with a qualitative research design, and information about participants was demanded before the study began, even though this could only be acquired at a later stage, due to the study methods of theoretical sampling and participant observation. On the other hand, the need for institutional approval before the study provided an opportunity to understand hierarchical relations in the workplace in terms of with whom the researcher needed to talk to in order to acquire permission to interview and observe workers. Also, the different degrees of concern with ethical issues by organizations and workers was a tool to observe more or less careful perspectives regarding the role of research and social scientists in relation to the places and people they study. In Porto Alegre, for instance, many organiza-

tions required a feedback to research participants regarding study's results. The feedback sessions were used also as a way of discussing preliminary results with research participants, challenging the researcher's views and acquiring further understanding of workers' experiences.

Figure 2:
Methodology of the Research Design



The grounded data used for this thesis comes from 800 hours of participant observation and 81 semi-structured in-depth interviews con-

ducted over 14 months of fieldwork. Fieldwork was conducted in Amsterdam from February to July 2010 and in Porto Alegre from August 2010 until March 2011[8]. I was located in the respective cities during these fieldwork periods and, moreover, lived in Porto Alegre from 1994 until 2008 and in Amsterdam since 2011. In both cities, fieldwork started in the city centre, and from there services and workers' indications led to the second district's choice. In both places fieldwork started during winter time, and therefore, the initial approach was inside institutional spaces. Not only the researcher, but also drug users, homeless or not, felt more comfortable inside warm facilities than walking in the streets.

In Amsterdam, I did voluntary work in a social institution in the city centre which has a users' room and a walk-in centre[9]. Voluntary work was chosen as a strategy to get to know drug users' care from 'inside', to build trust, and to get more acquainted with Dutch language and language spoken between workers and users. Work in this institution was done two days per week, 6 to 7 hours a day, during the first 3 months, and 1 day per week after that. This allowed systematic observations of workers and users' activities and interactions and also contacts between workers and users with other institutions. This service was the starting point to get referrals to other workers and services in the city, both by workers and users.

In Porto Alegre, because of the researcher's previous experience of work in drugs users' care in the city, voluntary work was not seen as a necessary strategy. Instead, the starting point was to search for previous contacts in order to screen the context in the area and possible participants. Meetings of social and health workers, as well as informal contacts with users served to gather further information and referrals. It was also a way to check which, from all the services and workers available in the districts, were actually reaching drug users at the time.

Given the variation of services present in each city, a sample was drawn to choose those participating in this study based on the different types of experiences emerging as categories in theoretical sampling (Morse 2007). Variation was achieved by sampling for: types of services and benefits offered; criteria to access and stay into service (threshold level); level of collaboration with other services; profile of targeted users accessed; main approach adopted regarding drug use. A balance was pursued between social, health and law enforcement services, as well as between services from different districts in the cities.

In total, 81 workers were interviewed: 58 street level workers and 23 key-informants, 40 from Amsterdam and 41 from Porto Alegre. For street level workers the criteria for participation was to have a work contract in the service and have contact with drug users as a main or important part of their daily work. For key-informants, criteria was to have vast experience in the drug policy field, mostly related to street or middle management level. All interviews were voice recorded, transcribed and then analysed with Atlas.ti, and all interviewees signed an informed consent (appendix 1) assuring their secrecy, anonymity and right to withdraw the study. In the writing process, quotes from interviewees were anonymized, and the names of services, organizations or places which could identify organizations and participants were removed. Street level workers were asked to fill in a small structured questionnaire (appendix 2) at the beginning of the interview to gather data on educational level, work load, work experience and income. After that, in-depth interviews were based on a semi-structured questionnaire (appendix 3) and lasted around 1 hour. Interviews with key-informants were based on an open-ended list of questions (appendix 4), and also lasted around 1 hour. Interviews were done in English in Amsterdam and in Brazilian Portuguese in Porto Alegre, and were translated using forward and backward translation, following the WHO guidelines for translation and adaptation of instruments (WHO 2009).[10]

Observations and interviews occurred in parallel. Around 400 hours of *observations* were made in each city, all of them typed into field notes and analysed with Atlas.ti software. Observations included the district context, services available, work conditions, workers' activities, and users presence and treatment. Street observations were done sometimes alone, sometimes together with outreach workers and other times with users. Researcher's direct observations were usually guided by workers and users' information on the 'hot spots' of drug use. Observations regarding services and workers included, in general, a minimum of 2 shifts (around 8 hours) in each of the 40 services participating in the research, but longer observations were also common. Typically, decisions on which days and which activities to observe were taken jointly by the researcher and the workers, considering both variation and importance for daily tasks. Users' opinions on what was important to be observed were also taken into account. Observations were also made of workers who did not participate in the in-depth interviews; informal conversations with workers

and users were held during the observations. To give the reader a better flavour of the streets, as well as to illustrate some of the structural differences between cities and services, some pictures of the cities, districts and services were added in the appendices. These were shot by the researcher during fieldwork. Images from services were made if/after acquiring workers' verbal consent, and avoiding identification of both workers and users. Pictures shot in the streets also tried to conceal people's identity.

Regarding the participants, theoretical sampling was applied for the selection: services and workers to be observed and interviewed were not chosen before starting the research, but during the research process. Theoretical sampling refers to 'Data gathering derived from the evolving theory and based on the concept of "making comparisons", whose purpose is to go to places, people, or events that will maximize opportunities to discover variations among concepts and to densify categories in terms of their properties and dimensions' (Strauss and Corbin 1998: 201).Once some categories were produced by the coding process from initial data, further sampling aimed at developing, intensifying and saturating these categories, taking into account their relevance and variability. Initial sampling was guided by a combination of theoretical sampling and 'snowball' method. Referrals from workers to specific services (and workers inside them) considered by them to be important for the approach of drug users were taken into account. These were combined with a deliberate choice by the researcher for participants who have had particular responses considered important in terms of variation, according to the emerging analysis of data (Morse 2007). The sample aim was to capture the range of phenomena, not the average. Thus, to enhance diversity, workers were asked, for instance, to refer both facilities and workers that were their partners and the ones they could not work with. This, in the end, also allowed mapping collaboration between different services and sectors.[11] Referrals made by drug users to services considered important by them were also taken into account, and, in general, did not differ from the ones mentioned by workers. The sampling process, thus, allowed to reach the main services being, in fact, reached by drug users (which are not always the ones specifically planned for them).

Here, the factors mentioned by previous studies as having influence on street level worker's interpretive beliefs and experiences regarding drug policy implementation were considered as starting points, but the

investigation was open to new factors coming from primary data. These factors include work load and work stability (Rigoni 2006, Petuco 2007), job category (Brener et al. 2007, Forman et al. 2001); years worked in the field and level of contact workers have with drug users (Brener et al. 2007); levels of formal education (Brener et al. 2007, Humphreys et al. 1996); and age (Humphreys et al. 1996, Miller and Moyers 1993). Therefore, according to the categories being produced by the data analysis, specific groups and types of workers and services were added to the sample. The sample size for both for interviews and observations was determined by theoretical saturation: a condition where no new relevant data seemed to emerge regarding a category; the category was well developed in terms of its properties and dimensions demonstrating variation; relationships between categories were well established and validated (Strauss and Corbin 1998: 212).

After the fieldwork and a first analysis of the data, a second review of the literature was carried out respecting the emergent findings, which turned out to change many of the previous literature searched. The writing process attempted to connect the theoretical concepts which were perceived as showing grounded relevance, to the emerging 'theory' grounded on the data. In the writing process, to help with the flow of language in the study when comparing various categories and experiences of street level workers, I have used terms such as 'most', 'many', 'some' and 'few'. By using 'most', I mean that more than 75% of the workers from a certain category are included in the statement. The term 'many' refers to around 50% of the total sample of a certain group, while 'some' describes numbers around 25 to 50% and 'few' numbers of less than 25%. I do not want to claim to representativeness, as using quantifying terms might suggest. Rather, I use them in a more discursive fashion, to give the reader a flavour of what happens in the streets, rather than a recipe.

In the comparative process of the research, some important ethical challenges were faced by the researcher. Being an outsider in Amsterdam and an insider in Porto Alegre raised the challenge of making the unknown familiar in one place and the familiar unknown on the other. Local language, street slangs, cultural norms and behavior required an extra effort of interpretation in Amsterdam, while in Porto Alegre required a reflexive distance for 'denaturalization'. Besides that, being an insider in the health field and an outsider in the social and mainly law enforcement

fields brought questions of personal identification with some participants and difficulties in empathizing with others, raising several dilemmas and concerns about possible bias in the research. The researcher found it hard, for instance, to identify with some workers and observe situations in which violence towards drug users was involved: sometimes it was difficult to understand the reasons the workers felt they had to act this way. It was unclear how far one's relativism could extend in order to avoid bias. In this type of situation, a combination of ethnographic reflexivity (Guillemin and Gillam 2004) made it possible to understand violent and aggressive workers' motivations as well as how they are viewed by health and social workers and by drug users. A continuous and critical process of examination combining reflexivity, feedback from participants, the use of memos and field notes to trace back the analytical process, was applied. This allowed balance between possible influences from the researcher's background and feelings on the sampling methods, relationships with the participants, and data interpretation in the different contexts found in each city.[12]

In summary, to map workers' territory and history of drug policy (research question 1), fieldwork observations and in-depth interviews from street level workers and key-informants were used, together with literature review and analysis of official policy statements. Workers' interpretive beliefs (question 2) were analysed from street level workers' in-depth interviews only. The types of support and constraints workers face in their organizations (question 3) were examined considering both in-depth interviews and observations with street level workers and key-informants. Local rules and guidelines were also analysed to better understand workers' reported and observed experiences. To look at workers' collaboration regarding drug users' assistance (question 5), again observations, interviews and local rules and guidelines were the primary data used. Workers activities with drug users (question 6) were examined through observed and reported experiences of workers. During the analysis of all these questions, the dilemmas faced by workers and the strategies adopted by them to decide over different possible postures (question 4) were taken into account and compared between the two cases studied (question 7).

The pathways

Following chapters provide a pathway that describes how street level workers manage to put drug policy into practice. Official policies' statements, territory, interpretive beliefs, organizational setting, collaboration among workers, and their relationship with users are features brought into light to analyse street policy in the drug field. The dilemmas coming from each one of these features and the strategies workers develop to cope with them are analysed. A special focus is given to the dilemmas and processes of deciding between different possible actions on the streets. For each chapter, the analysis compares Amsterdam and Porto Alegre.

Chapter 2 invites the reader to start the journey into the territories experienced in the research. It describes six fundamental elements to understand and compare the cities studied. These are: the official policies related to drug use; the environments of the cities and districts in which these policies actually happen; the development of a perceived drug problem in the cities; the targeted population of users assisted in each place; institutions and their services; and finally, the street level workers themselves.

Chapter 3 brings into light street level workers' interpretive beliefs about drug users. It looks at how workers of the different sectors and cities define problems regarding drug use and propose solutions to it. The analysis builds on previous studies to propose a new framework of investigation for workers' interpretive beliefs. Special attention is paid to how workers manage to mix the different approaches present in the drug policy field into more or less coherent sets of ideas to justify their choices of particular practices.

Chapter 4 analyses how street level workers relate to their organizations and services, focusing on both support and constraints these places offer them to put policy into practice. It describes the strategies workers use to negotiate dilemmas on a daily basis, with a special focus on how workers decide upon different strategies when using their discretion. Two different views are analysed and compared: Lipsky's (2010) understanding of workers as state-agents and Maynard-Moody and Musheno's (2000) view of workers as citizen-agents.

In *chapter 5,* interactions among social, health and law enforcement workers in approaching drug users is analysed. Conceptual tools of net-

work (Musso 2004) and power (Foucault and Gordon 1980) are used to investigate how and why different interpretive beliefs and objectives are negotiated by workers in their daily encounters with each other. The chapter discusses the ways in which workers use their discretion to decide on whether to build networks with other colleagues and services or not, the types of networks created, and consequences for street level workers and users.

Chapter 6 analyses the relationships street level workers establish with drug users and the influences it has in defining workers' discretion. It describes the strategies workers chose to influence users' behaviour and the dilemmas workers find on the way. The analysis questions Maynard-Moody and Musheno's (2003) proposition that street level workers' discretion is driven by a judgement on the moral worthiness of users, and offers an alternative interpretation. Studies on governmentality (Dean 2010) and power (e.g. Foucault and Gordon 1980) help to bring forward a view of discretion as judgements workers make between different forms of governing users.

Finally*, chapter 7* integrates findings from the previous chapters and concludes the thesis.

Notes

[1] The expression 'people who use drugs' has been used by social movements on harm reduction and by some associations of users instead of the most commonly used 'drug users'. The argument for this change is that this last expression carries a stigma for people who use drugs, considering their condition of 'users' as central and determinant of any other role that they have in life and society. The expression ' people who use drugs' instead, calls attention to the fact that, besides of many other things that this people do in life, and many other social roles they might have, they also use drugs. Even though I agree with this debate and the new expression, in this book I'll use the most common expression 'drug users' instead. This will be done in order to be closer to the way street level workers usually refer to this population. As the study is about how street level workers view and act policy, I aim to be open to different meanings given by workers to the population they work with, and this can be better achieved by not choosing the more specific expression.

[2] The Ministry of Health, Welfare and Sports (who coordinates drug policies), the Ministry of Justice, and the Ministry of the Interior and Kingdom Relations.

[3] Care services are defined here as social and health services.

[4] The term 'interpretive beliefs' was built from the analysis of data. A more in depth discussion about this term 'interpretive beliefs', as well as others used on this section- such as 'frames' and 'models'- is going to be done in chapter 3.

[5] This quantitative study measure conceptions about drug use, users and treatment in 120 health workers from primary health care teams of Belo Horizonte city (Minas Gerais state, Brazil), including physicians, nurses, nursing assistants and communitarian health agents. The study uses models to assess workers' conceptions, but do not assess practices (Queiroz 2007). Since 2002, following a reform on the National Policy on Alcohol and Other Drugs, primary health care teams from Brazil are supposed to include harm reduction in their daily activities.

[6] Organizational culture is defined by Schein as patterns of basic assumptions developed by a group, considered valid, and taught to new members as the correct way to perceive, think and behave (Schein 2010). The concept, however, is based on theories of small groups, therefore more suitable for in-depth studies of one or two organizations, rather than for comparisons among workers from different services. In this approach also, values within a culture are considered to be mainly individual rather than socially constructed.

[7] 'To score' is a slang used by users to refer to finding a way to get hold of drugs.

[8] The process of acquiring permission for the research delayed fieldwork in Porto Alegre for 2 months in comparison to Amsterdam. This occurred both due to delays in ethical committees and the need of acquiring permission from superiors to interview workers in almost all services.

[9] In a walk in center visitors can spend the day and do some of the following activities: have some free coffee and bread, watch television, use the computer, listen to music, play snooker, cards and other games, buy a low cost warm meal, shower, wash clothes, and be paid to do some daily activities. In this specific walk-in center there are usually 100 visitors a day, in general users of crack cocaine and/or smoked heroin, homeless or not, mostly coming from ethnic minorities' background like Suriname, Curacao, Morocco and Turkey. It is one of the biggest institutions in the center of Amsterdam assisting this population. The user room, in this case, allows the use of smoked heroin and crack cocaine.

[10] This approach aims to achieve a conceptually equivalency in each of the target countries/cultures, rather than linguistic/literal equivalence (WHO 2009). Pilot interviews were done to test comprehension of questionnaires and changes were made accordingly. In few cases, in Amsterdam, interviewees could also speak Portuguese, and opted to do the interview in this language.

[11] Social, health and law enforcement organizations as separated groups, are understood here as diverse sectors; each sector is formed by different services.

[12] Some of these ethical concerns are developed in Rigoni (2013).

2

Getting into the territories

2 Getting into the territories

Policy happens inside a territory: its elements set the scenery and the stage where street policy is performed daily. The territory provides signposts, bridges, crossroads, and a specific type of soil that enhance probabilities in terms of paths, curves, and choices workers make along the way. This study uses 'territory' as a concept, instead of context, both because it has grounded value and theoretical use. Street level workers' action is usually circumscribed within a certain territory in terms of geographical space, target population, particular goals and a set of activities that correspond to their professional function and the services within which they work. Territory, thus, carries a grounded meaning for street level workers, who usually describe their experiences by using expressions such as: 'in my area', 'in my neighbourhood', or 'in my territory'.

The concept of territory can be used to call attention not only to the geographical space, but also to the actors moving through it. This concept has been developed by the Brazilian geographer Milton Santos, for whom territory has to be considered in the way it is used and with the actors who use it (Santos et al. 2000). The 'lived' or 'experienced territory' (ibid.), encompasses actors and their attitudes, interpretive beliefs and negotiations, and is shaped by actors' cultural background, economic context, institutions, and history.

Based on the work of Santos et al. (2000) and applying it to mental health policies, Lemke and Silva (2011) propose to look at territories in two complementary ways: as ways of organization and as ways of practices. Looking at ways of organization calls attention to territories' spatial organization and regularization of access, communication, and responsibilities of workers, users and services. In this sense territories are defined by the way services are organized within cities and districts and the rules and regulations guiding services and workers' activities. As ways of practices, territories work as a principle which constitutes work pro-

cesses and care practices' processes, including the ways in which actors move, produce interventions and interact. This relates to the way workers interact with each other and with users and negotiate goals. Altogether, ways of organization and ways of practices in the territories define what street level policy is about, shaping its transformation from official policy statements to the ground. In this study, the same concepts used to analyse territories in the care sector, are broadened to include law enforcement.[1]

In this chapter I invite the reader to start the journey of getting into the territories experienced in the research. Being a starting point, the focus at this stage is on territory as ways of organization (Lemke and Silva 2011). The descriptions presented here reflect reported and observed territorial experiences of street level workers and drug users. The ways in which the researcher experienced the territories set up the basis for cross-city comparisons. The descriptions focus on the micro setting (at the street level) of the cities of Amsterdam, The Netherlands and Porto Alegre, Brazil, but the argument expands to include national and regional contexts when appropriate.

Six fundamental elements were found to define the ways in which territories are organized, being essential to understand and compare the cities studied in this research. These elements are: the official policy statements related to drug use, the environments of the cities and districts in which these policies actually happen, the development of a perceived drug problem in the cities, the population of users targeted in each place, the services, and finally, the street level workers themselves.

Drug policies on paper

The first relevant feature shaping territories is the policy approach (on official statements) towards drug use. Regarding the different strategies adopted internationally, countries can be represented as belonging to two major and opposed blocks: those with a more repressive attitude towards drug use, or the public order oriented, and those having mainly a public health attitude towards drug use, the harm reduction oriented. The first block has the United States (US) as a leading country, supported by Russia and Asian governments, while the second is represented by the EU together with Brazil and other LA countries, Australia and New Zealand (Reuter 2009, UNODC 2009). Thus, when looking at drug policies on

national policy statements, from a broad perspective, the Netherlands and Brazil are on the same side.

The public order approach considers that psychoactive drugs are inherently dangerous for society as a whole as well as for users' health. Users are understood as not capable of regulating their use in a manner that is acceptable to society and not harmful to their health (Korf and Buning 2000); as a consequence, proscriptions on drug use are necessary to protect the well-being of people using it, people around them, and society at large (Marlatt 1998). Control and (ideally) eradication of drugs and drug use is pursued mainly by repression, enforcement of prohibitionist laws, and (only) abstinence models of treatment (Inciardi and Harrison 2000).

The harm reduction approach has its roots in the drug policies of the Netherlands (Inciardi and Harrison 2000, de Kort and Cramer 1999). HIV/Aids epidemic among injection drug users, in the mid 80's, played an important role in developing this concept and establishing this approach.[2] The approach focuses on reducing harms caused by drugs use and trade rather than expecting to ban them completely from society; drug use is not seen as a crime, but as a social-health problem (Vws 2003). The aim is one of 'normalization', or depolarizing and integrating 'deviance' (instead of deter and isolate) (Boekhout van Solinge 1999), and this is done in order to prevent adverse effects of criminalizing users (van der Gouwe et al. 2009). This has been understood as a more pragmatic and feasible approach to drugs and an alternative to repression (Inciardi and Harrison 2000). From the mid-1980s on, several countries explicitly adopted harm reduction as the principle of their national drug policies (Ball 2007). In developing countries explicit harm reduction policies started from the mid 90's on, more specifically in 1994 in Brazil (Brazil 2001).

Even though both Brazil and the Netherlands are considered to be pro-harm reduction, the way the approach was introduced and the meanings it assumes depends on countries' histories, culture, resources and types of users. In other words, the way the approach happens on the ground depends on the organizations, users and workers' discretionary processes in the different territories.

In *The Netherlands*, harm reduction is not only considered a tactic to be used with certain types of drug use, but the main strategy guiding drug policy (e.g.Korf 1995, van Laar et al. 2008, VWS 2003). Although drugs are illicit, drug use is not. A market division between hard and soft

drugs[3] operates in the country since the Opium Act in 1976: trade of hard drugs is penalized, but sale of soft drugs is tolerated under certain rules (van Ooyen-Houben et al. 2013, van der Gouwe et al. 2009). The separation aims at protecting users of soft drugs from contact with hard drugs and their markets. For Dutch policy, priority is put on curbing drug trade rather than punishing users. Large-scale dealing and production of drugs is prosecuted, while possession of drugs for personal use (in general 5 grams of soft drugs and 0.5 grams for hard drugs) has low priority (van der Gouwe et al. 2009).

When harm reduction strategy was developed in response to the HIV/Aids epidemic in the 80's it encountered, thus, an already tolerant drug policy towards drug users. Even then, harm reduction strategies towards hard drugs were not easily accepted. Syringe exchange, methadone maintenance and user rooms clashed with the previously established practice of abstinence-only treatment, and a moral approach to drug use left many users without care in cities such as Amsterdam during the 70's (Blok 2008). After an initial period, harm reduction flourished and was adopted by the Dutch government as the main approach. Syringe exchange programs, methadone maintenance and user rooms spread across the country, being carried on by the public health sector of the government, instead of non-governmental and charitable organizations. Since 2009, heroin prescription has been adopted as a harm reduction strategy, making it possible for physicians to prescribe heroin to addicted users who are treated in municipal clinics. The aim and results of this treatment include both care and safety concerns: increase users' health and decrease the nuisance caused by them (Blanken et al. 2010).

This two-track approach (public order and public health) reflects the twist the Netherlands has faced since mid- 90's, with more repressive measures being adopted since that time. Most changes regarding drugs relate to cannabis use and the coffeeshops policies. A number of coffee shops were closed down (van der Donk et al. 2009) and, stricter criteria to be able to purchase cannabis were experimented in pilot cities [4] (van Ooyen-Houben et al. 2013). In the field of hard drugs, changes were made in the policy towards ecstasy[5] (Uitermark and Cohen 2005) and mushrooms, changing the latters' classification from the soft to the hard group. Harm reduction strategies for hard drugs such as crack cocaine and heroin, however, were maintained. In 2009, an advisory committee considered needle exchange, methadone substitution, heroin prescription

and consumption rooms to be working well, and recommended its continuation (van der Donk et al. 2009).

Other policies that affect heroin and crack cocaine users, however, became stricter. Since 2004, for instance, the ISD policy (*Inrichting voor Stelselmatige Daders*) allows the placement of repeated offenders above 18 years old into institutions for a maximum of two years. The measure has the twofold objective of reducing public nuisance caused by offenders, and reducing recidivism by influencing behaviour. Despite being not directed at drug addicts only, most of the offenders subject to ISD measures are addicted to drugs (van Laar et al. 2012), and the policy is a way to achieve greater control over users. In general, more repressive measures were also accompanied by investment in harm reduction measures for drug users. An example is the special shelters dedicated to hard drug users who are roofless or homeless, which are part of the national Strategy Plan for Social Relief (*Plan van Aanpak Maatschappelijke Opvang*). In Amsterdam, the plan aims at curbing homelessness, and claims to both increase users' well-being and decrease street nuisance (van Laar et al. 2012). New policies, therefore, contribute to increase both users care and control.

Brazilian drug policies have been developing in a different way, moving towards more tolerant approaches in the last 20 years. The country is seen as having a leading role in South America regarding the adoption of harm reduction strategies (Bastos et al. 2007, Bueno 2007), and was, until recently, the only country to officially and nationally endorse harm reduction programs (PRD)[6] in the region. Different from the Netherlands, however, when harm reduction started in Brazil it encountered very repressive policies towards drug use. These were inherited from the Military Dictatorship period (1964-1985) in the country, when Brazil imported the 'war on drugs' from the US (Pedrinha 2008) joining the international combat against drugs (Carvalho 2006). Brazilian 'antidrug law', from 1976, penalized dealers and users, ordering coercive treatment for users (Brazil 1976). While Dutch government provided opiate users with methadone and regulated cannabis use as harm reduction measures, in Brazil the government was sending both cocaine and cannabis users to prison or to mandatory treatment based on an abstinence-only approach.

At the end of the dictatorship period Brazil was (one of) the most unequal countries in world, which reflected also in the social health insurance system. Only formally employed workers (who were the minority)

were covered, all others depended on charity provision or expensive out-of-pocket care; the exclusionary and private model was further developed during the military dictatorship (Guanais 2010). Insatisfaction with structural equality, political authoritarism, and an elitist reactionary medical body brought about a health-sector reform movement, which was formed by academics, trade unionists, health workers from all levels, managers, policy makers, and the general population. The movement had a political and ideological viewpoint that health is not an exclusively biological issue to be resolved by medical services: it is a social and political issue to be addressed in public (Paim et al. 2011).

Following these ideas, the health reform movement campaigned for a 'collective health': an essentially Brazilian invention which criticizes and opposes a conventional public health approach (Loyola 2012). Collective health principles include: 1) the notion that health is a right of all citizens, regardless their employment status, which should be provided by the State, instead of by private or charity organizations; 2) a broader definition of health including its social, cultural, economic and psychological determinants, as opposed to a medical approach centred on medication; 3) a collective, integral and transdisciplinary approach, instead of an individualized, hierarchical model centred on physicians and the hospital; 4) the participation of users in policy and treatment planning, as opposed to top-down policies and the centrality of care workers in determining treatment plans (Carvalho et al. 2009). This movement ultimately led to a reform on the National constitution in 1988 with the creation of the Unified Health System (SUS) (MS 1990), an universal health system offering comprehensive coverage to all population.

The strong focus on participation in policy making brought groundbreaking innovations in Brazilian governance, enabling various stakeholders to take part of decision-making processes (Paim et al. 2011). National health councils and conferences were established at three levels of government (federal, state and municipal) where representatives of users (50%), health workers (25%), and health managers and service providers (25%) participate in formulating and accessing health strategies (Victora et al. 2011).[7] Specifically in the drug policy field, national, state and municipal drug-councils are part of this structure. More recently, the same principles and structure are been implemented in the social sector, with the creation of the Unified Social Assistance System (SUAS) (Mendes et al. 2009). Both the reform and the creation of SUS were part of a broad-

er movement aimed at lowering social inequality through initiatives in health, education, participatory mechanisms, cash transfers, and other sectorial actions (Victora et al. 2011).

While these principles were being introduced into Brazilian health system, in the late 80's, the country faced the rise of an HIV/Aids epidemic among injection drug users (IDU) (Barbosa Júnior et al. 2009). Inspired in EU countries, syringe exchange was adopted as a harm reduction response, and started to be gradually introduced into the country in the late 80's and early 90's (Surratt and Telles 2000). The first Brazilian PRDs were run by non-governmental organizations (NGOs) and financially supported by the government, UNAIDS and the World Bank in the form of temporary projects. The fact that collective health principles were present in a period of re-democratization when a harm reduction approach entered the country brought specific features for the approach in Brazil, that differ from those found in the EU and the Netherlands. The importance given to users' participation, the critical view on a medical model and mandatory treatments and the focus on user's life quality rather than on the public well-being (or nuisance) are the most significant differences.

In 2003, The Health Ministry reformed its drug prevention and treatment plan, officially giving national support for harm reduction strategies for the first time (MS 2003). Financial incentives to public hospitals, drug clinics and primary health care (MS 2004, MS 2005, MS 2005, MS 2004) were fundamental to enhance harm reduction sustainability. Rather than being carried out mainly by NGOs and outsourced workers, harm reduction was to be led by civil servants. Following the harm reduction tendency, in 2006 a drug policy reform decriminalized drug use: use is not a reason for arrest, even though one can be penalized with optional treatment, counselling and/or communitarian work. Both sale and trade of any illicit drugs in any quantity remains forbidden (Brazil 2006).

This increasingly tolerant approach recently started sharing space with new repressive policies and programs against drug use. Since 2010 a law (PL 7663/2010) (Terra 2010) to bring back compulsory treatment for users has been debated. National prevention campaigns – such as 'crack, no way' - preach complete abstinence as the only solution for crack use, portraying drugs as lethal. In 2011, the 'Integrated Plan to Combat Crack and Other Drugs' (Brazil 2011) was launched by the national govern-

ment, focusing on prevention, care and authority (law enforcement) integration in tackling drug use. Most incentives for drug treatment, however, relate to an abstinence-only approach (ibid).

Similar to the Netherlands, thus, Brazilian street level workers also find a territory organized by a mix of repressive and tolerant policies towards drugs. The histories of drug reforms and harm reduction development in each country gives rise to a mixed set of goals and interpretive beliefs about what to do about drug use, which will be debated on chapter 3. These, in turn, influence the ways in which workers use their discretionary power to decide on street practices.

The cities and the districts

If in national drug policy statements Amsterdam and Porto Alegre share some interesting similarities, when looking at ways of organization of cities and districts differences stand out. Size, culture, climate and socioeconomic conditions shape the ways street level workers, drug users and the general population create and use territories.

In terms of geographical area and population, Brazil (Map 1) is much bigger than The Netherlands (Map 2): Brazilian population (around 194 million) is about 12 times that of the Netherlands (around 16 million). In the studied cities the differences decrease. In 2010, Amsterdam had 767.773 inhabitants (O+S 2012), while the figure for Porto Alegre was of 1.409.351 people (IBGE. 2012): almost twice the population of its Dutch counterpart. Both cities are the main cities of their provinces, but while Amsterdam is also the capital and biggest city in the Netherlands, Porto Alegre is a medium-sized capital if compared with others, being the 10th city in population size in Brazil.

The climate is much warmer and sunnier in Brazil than in the Netherlands, even though Brazilian's southern region is located in a subtropical area. The winter in Porto Alegre has temperatures around 8° to 15° C, which is not as cold as the -1° to 6° C average from Amsterdam, but cold enough to make sick, with a cold or pneumonia, a homeless drug user sleeping on the side walk or under a viaduct. During summer, on the other hand, Amsterdam homeless users are happy to be outside with their flip-flops enjoying the 12° to 22° C, while Porto Alegre users usually hide from the sun with temperatures above 30° C in the parks under trees and in the viaducts during the day. While Amsterdam outreach

workers have to dress very well to stand the cold and the rain during winter, in Porto Alegre they need sun block and many bottles of water to cope with summer.

Map 1:
Brazil and Porto Alegre

Regarding socio-economic conditions, Amsterdam is in a high income country, while Porto Alegre is part of an economically growing but still middle income economy. The gross domestic product based on purchasing-power-parity in Brazil ($11,7 per capita a day) is about a quarter of the Netherlands ($42), which has social protection policies that prevent absolute poverty. Connected to this, the countries also have very different levels of inequality and urban violence. In 2010 Brazil had a Gini coefficient of 0,55 against the 0,31 of the Netherlands. Even though the south is one of the richest regions in the country, inequality is still a strong feature. In Porto Alegre, a quarter of the population was considered poor in 2003 (IBGE. 2012). The poor population live in areas without secure tenure, usually settled in vulnerable areas with risk of flood

and landslip (Porto Alegre 2012). The poor are, usually, a greater part of the clientele being assisted by street level workers in the public system.

Map 2:
The Netherlands and Amsterdam

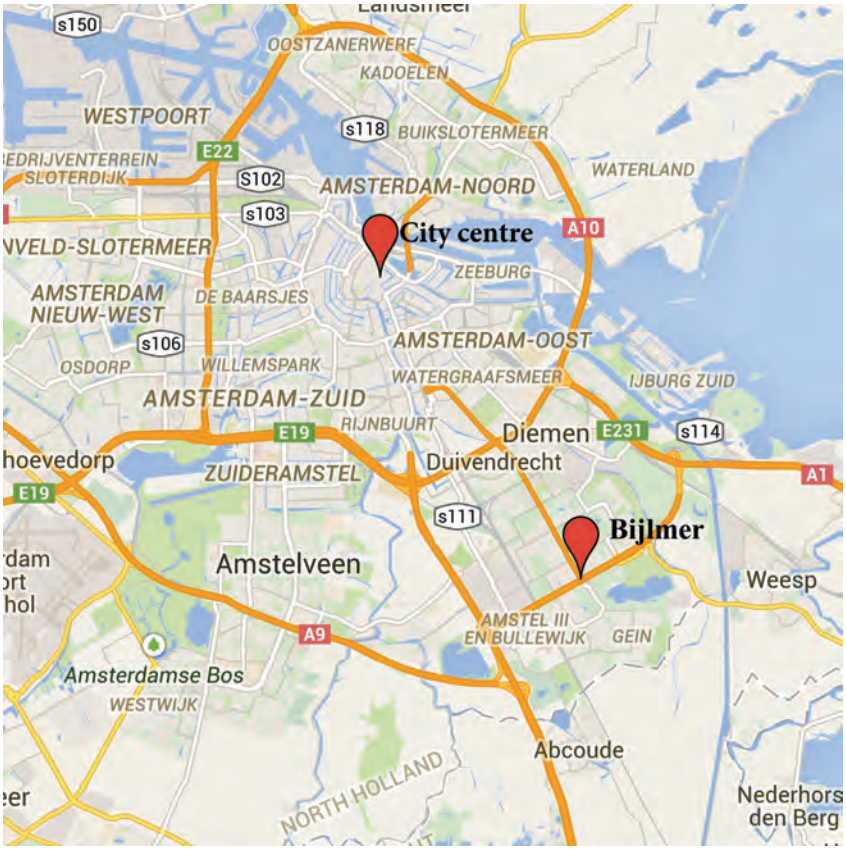
In terms of violence, Brazil is in the fourth place among the most violent when compared to other LA countries.[8] In the city of Porto Alegre, the registered homicide rate for 2010 was 36,8 for each 100 thousand inhabitants. Violence is greater among youngsters and black citizens. Rate for youngsters (between 12 and 21 years old) rises to 81 homicides per 100 thousand inhabitants and, proportionally, black youngsters die two and half times more than white youngsters (Waiselfisz 2012). Drug trafficking and police workers conflicts are thought to account for a large part of the violence, mainly in the big cities (Rodrigues 2006).

The Netherlands has a much lower violence rate than Brazil. In the year of 2010 Amsterdam police workers registered 18 homicides (Kranenburg and Vugts 2012), which represents an approximate rate of 2 per 100 thousand inhabitants.[9] The country has one of the lowest lev-

els of criminal offences for drug use in the EU (EMCDDA 2009). [10] Property crime related to drug use as well as public nuisance is said to have declined in recent years, in spite of the claimed increases in organized crime (van der Donk et al. 2009).[11]

At a more micro level, one can see how the ways of organization in the cities and districts studied shape the creation and use of territories. In the city of *Amsterdam*, the city centre and a neighbourhood called Bijlmer were investigated (Map 3).

Map 3:
Amsterdam city centre and Bijlmer



Amsterdam *city centre* is a very touristic place. Well preserved historical buildings, beautiful canals with house boats, museums, shops, restau-

rants, open markets, legal prostitution and coffeeshops establishments share space with citizens and tourists throughout the year. In comparison with the rest of the country, Amsterdam is crowded, at least in the city centre. Nevertheless, when compared to cities in LA, Amsterdam is reasonably orderly and clean. Although there are lots of people and vehicles in the city centre, horns are almost never heard. Public transportation is very good and spread all over the city, and a short trip costs around 1 to 3 euro. The bicycle is an environmentally effective and cheap alternative. Many (fast and wild) bicycles populate the streets in Amsterdam, ringing their bells at the many tourists who insist on walking in the bicycle paths in the centre.

Besides tourists, the centre of Amsterdam attracts many drug users, either the ones willing to visit one of the many coffeeshops around (mostly tourists), or those (in another socio-economic condition) willing to make money from the tourists and passers-by in general. Especially in the Red Light district, together with the open prostitution, the coffeeshops, the oldest church in town, and the tourists, there are lots of CCTV cameras and police workers watching the area day and night. Families with kids and people from all ages can be seen in the area. On warm days, both tourists and locals sit on the banks of canals to smoke a joint, eat a sandwich or chat. Even though rare, street dealers can be seen in some strategic points; drug dealing and hard drug use are virtually invisible in the streets. A main worry for police workers in the city centre is the public nuisance coming from bars and tourists, together with the few small scale dealers trying to sell hard drugs or fake drugs to tourists.

In the city centre, as in other parts of the city, it is very rare to see beggars or homeless in the streets; the few people asking for money are usually street artists playing instruments. Also, homeless population usually do not stand out, and look very similar to other citizens in terms of personal hygiene and clothes; homeless children are virtually non-existent (Pictures 1-7, appendices).[12]

Around 20 minutes by metro from the city centre is the *Bijlmer*, in the south-east of the city. Entering its territory brings a feeling of entering into a different world inside Amsterdam, or even, inside the Netherlands. This part of the south-east was built in the 70's as a living place for young starting families who worked in the centre. Most of the inhabitants in the Bijlmer are the so called *allochtonen*: people who have at least one of the parents being originally from other country than the Nether-

lands (Keij 2000). In 2010, *allochtonen* accounted for around 73% of the population in the south-east of Amsterdam, many of them with roots in Suriname and Dutch Antilles (O+S 2012). White Dutch people also live in the area, but they are few, which makes white non-habitants (such as the researcher in this study) easily recognizable on the streets. Given its population, the place has a well-known label among street level workers and Amsterdammers in general: the south east is for the dark people.

Another important feature distinguishing the Bijlmer is its reputation as one of the less safe neighbourhoods in Amsterdam. That is believed among the general population and the street level workers, as well as part of the daily news (e.g. NOS 2013, Kranenburg and Vugts 2012). Despite the reputation, a feeling of safety is usual in the streets,[13] excepting in few areas and during night time. In comparison to other neighbourhoods in the city and in the country, the Bijlmer is considered to be a poor neighbourhood; with some areas poorer than others[14]. As the rest of the city, even in the poorest areas of the Bijlmer there are sanitarian system, electricity, planned streets and leisure areas with parks, playgrounds, shops, markets, health and social services for the population.

Richer and poorer areas are distinguishable by the type of buildings and whether housing is owned or rented by inhabitants. Villas and traditional Dutch-like family houses accommodate the better off part of the population, who are mostly property owners. High-rise and renewed buildings (earlier known for their beehive shape) lodge the less social-economically favoured inhabitants, who either rent the place or receive social housing benefits. In these less favoured places, the condominium style means apartments are very close to each other, linked by a common balcony/corridor in the front facade. Structural conditions and safety are lower than in the better off areas, but even then, buildings are surrounded by a green area with trees, artificial lakes, statues and also play gardens for children and sports courts for youth and adults. All the area has public lighting, well-built sidewalks, parking places, bicycle paths and racks (which are mostly underused); public transport reaches the area though metro and buses (Pictures 8-14).

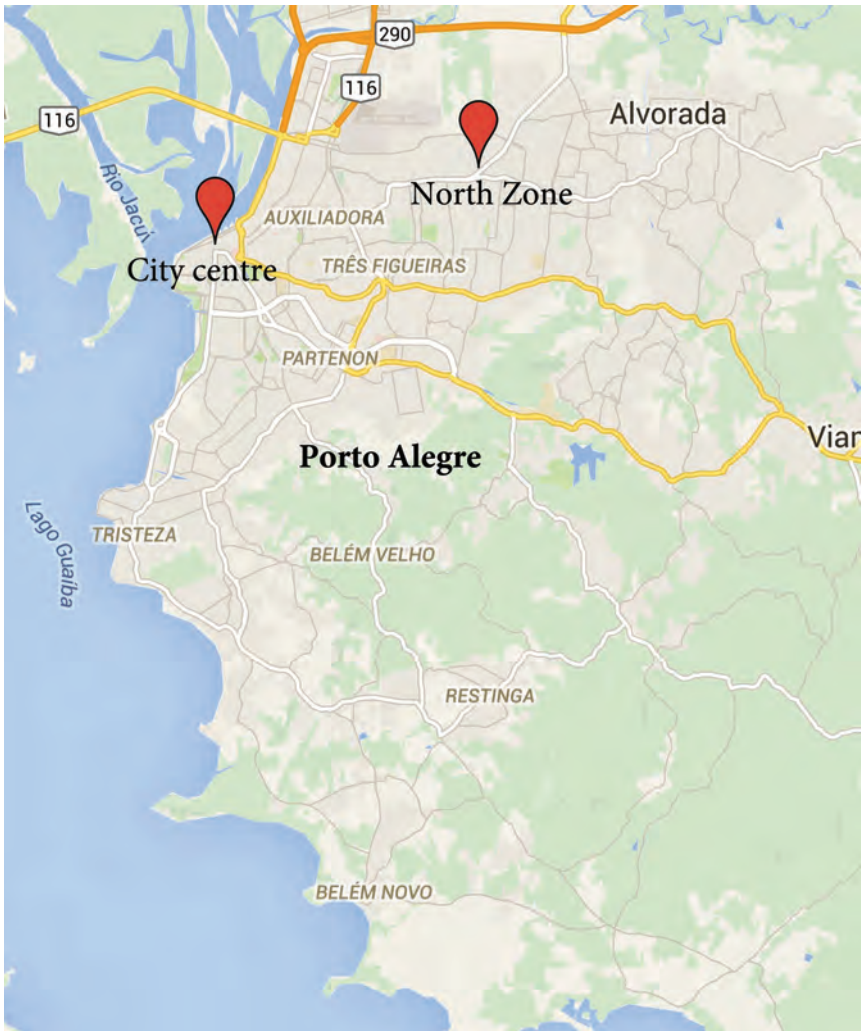
In *Porto Alegre,* the city centre and some slums from the North Zone were investigated (Map 4). Even if Porto Alegre is one of the most developed cities in Brazil, socio-economic conditions are poorer and internal inequalities higher when compared to Amsterdam. Porto Alegre is an industrial city whose name relates to its important port; it provides a cen-

tre for commerce and industries in the region as well as nationally. The city received many European migrants at the end of the 19th century, mainly coming from Germany and Italy. The majority of the population is of European descent, which gives the city and the state a very white composition in comparison to the rest of the country, and the nickname, together with two other southern states, of 'the European south of Brazil'. Porto Alegre is considered one of the top cultural, political and economic centres in the country, being one of the wealthiest cities in LA (PMPA. 2010).The city is known for its green and wooded streets, squares and parks, and also for offering excellent urban infrastructure, telecommunication, medical service and life quality (ibid.). Public transportation is good, but also relatively expensive compared to Amsterdam, given the much lower income per capita: one way ticket costs around 1,5 euro. Bicycles are not a popular mean of transportation in the city, given both long and hilly distances and lack of traffic safety for cyclists in the streets. Politically, Porto Alegre caught international attention for its 'participatory budget', a system where citizens and delegates decide in local meetings on priorities to spend public money (Fedozzi 1998). The city is known for its participatory-driven spirit, and hosted the World Social Forum for three years.

The city *centre* in Porto Alegre is very crowded. Different from the Amsterdam, passers-by in city centre are not multilingual and walking around with cameras; they are, in general, all Brazilians and use the centre to buy daily necessities, go to work, enjoy the museums, parks, shops and cafes around or wait for a bus at the station. Besides the historical and public buildings, informal merchants sell craftwork, candies, pirate CD's and DVD's, shoes, clothes, and some electronics. Street prostitution areas can be seen close to the central station, and small-scale drug trafficking happens, but is hardly visible. Similar to Amsterdam, Porto Alegre's city centre also has pickpockets and other criminals, some of them also drug users, eager to make some money out of the crowd using the place. Safety and violence assume a different meaning in Porto Alegre when compared to Amsterdam. Burglars, thefts and homicides are more common in this city, and feeling unsafe is usual in many neighbourhoods; some of them also during the day. In the city centre, people are careful with their belongings to avoid pickpockets. Darker areas, alleys and less populated streets are usually avoided by pedestrians. In

some poorer neighbourhoods and slums, one can only safely enter accompanied by a local inhabitant or worker.

Map 4:
Porto Alegre city centre and North Zone



Socio-economic differences are much more visible when compared to Amsterdam. In Porto Alegre, it is common to see, during day and night

time, many solid-waste pickers pushing pushcarts loaded with paper, cans and plastic. Many of these pickers are either homeless[15] or slum dwellers dressed in shabby clothes, and some barefoot on the warm asphalt. Homeless people and beggars are easily distinguishable from the better off population, and gather around big bus stations, parks and under viaducts, in much bigger numbers than in Amsterdam. Many of these homeless are also crack users, but open drug use is usually not seen in the centre: it happens mostly in areas of poorer housing (hereafter called 'slums'), or in parks and viaducts at night. According to outreach workers, as drug selling points are in the slums it is handier for users to stay there, both to get drugs and to make money working for the drug trade. This dislocation, however, might be driven also by government efforts (through police workers' activities) to displace homeless and 'junkies' from the better off areas.

During fieldwork and until 2011, part of the city centre comprised a slum with more than 700 inhabitants, located in an illegally settled area surrounded by governmental buildings. The settlement was known for its very precarious conditions: no public light, no sewage or running water, no pavement and very poor houses made out of pieces of wood, zinc tiles and other low cost materials. Public toilets were an achievement of the community in recent years, together with one primary health care program. Many community members used to earn their living from waste separation for recycling. In 2012, after fieldwork, the community was resettled. [16] (Pictures 15-20).

Around 40 minutes by bus from the city centre is the *North Zone*. This is one of the biggest areas in Porto Alegre: an industrial zone where more than 40 slums share space with big factories, shopping centres, cafes, and better-off neighbourhoods with gated communities. Similar to the Bijlmer in Amsterdam, the north Zone is known among street level workers, and mainly police workers, for being one of the most violent areas in Porto Alegre, and the worst in terms of drug traffic and crack use. Given the large total area size, only a few slums with their surroundings and local social, health and law enforcement services were included in the research.

In the slums of the North Zone, population is mixed in terms of race, being mostly brown skinned, but also many of white colour. It is not the race or geographical/cultural background that segregates people, but their level of poverty. In this area, as in the whole city, many slums have

undergone a process of resettlement or re-urbanization[17], but even in the re-urbanized communities, poverty is still distinguishable: there are no leisure places or parks for youth or adults (excepting bars), and in many cases schools and public services have to be reached outside the area. Even though there are clear differences in the socio-economic and cultural conditions in comparison to the Amsterdam district Bijlmer, both districts share relative poverty and (drug related) violence when compared to others in their cities. In both Bijlmer and North Zone also, the inhabitants for the poorer areas share a status of 'outsiders' from mainstream culture. (Pictures 21-24).

Development of a drug problem

The cities show different pathways in the development of perceptions of a drug problem, which includes different problem-drugs and time-frames of 'drug epidemic'. In Amsterdam, both in the city centre and in the Bijlmer (as in other areas of the city and the country in general), the situation of drug use is considered to be under control. Going back a few decades, however, the situation was very different regarding drug use and violence. The drug problem in Amsterdam started in the 70's, with the so called 'heroin epidemic'. Two open drug scenes – defined as 'situations where citizens are publicly confronted with drug use and drug dealing (Bless et al. 1995:130)- [18] were established in the city at that time: one in the centre, in a street called Zeedijk, and the other in the Bijlmer. For street level workers, as well as for researchers (eg. Blok 2008, Korf 1995), problems were connected to the introduction of heroin into the market, together with a massive entrance of Surinamese migrants after the country's independence from Dutch colonial rule in 1975.

According to workers, people becoming addicted at that time were very young, which was an extra worry. Heroin was considered a very addictive drug, and migrants considered to be easy targets for both working in the drug trade and developing an addiction due to the lack of social support they found in the country in terms of jobs, housing, money, community feeling and family bonds. According to Blok (2008), besides poor socio-economic conditions, discrimination towards Surinamese was common: they were denied entrance to bars and clubs in other popular parts of the city, were discriminated against by Dutch users and selectively approached by police workers. By the 80's, the Zeedijk and its surroundings were considered a no-go area, with heavy and increasing crim-

inality and drug use. Drug users and dealers caused a lot of public nuisance, and many users became homeless. The situation was seen as completely out of control: police workers were getting together in groups of 8 or 10 to approach the population in the area; and their maximum achievement was to temporarily displace users and dealers.

When the law enforcement sector started to clean up the city centre with repressive measures, part of the scene moved to the Bijlmer. With drug traffic moving to the south-east, drug users also started to hang around there. They found shelter in the store rooms of the beehive buildings in the neighbourhood, sometimes with permission from the owners that did not use the space, sometimes without. They lived there in rough conditions, and the area quickly developed into an unsafe environment. People who lived in the flats were scared to go to their stores, and the atmosphere was seen as intimidating. At the end of 1992 a plane crash in the area led the city hall to pull down and renew many apartments. Consequently, users who lived in store rooms were out on the streets, and drug use scene became more visible. Around 800 drug users were said to be living in the streets at that time; the Bijlmer turned out to be a place where no one would like to go or live. To tackle the situation, both in the city centre and in the Bijlmer, Amsterdam invested in redevelopment programmes to make these urban areas unattractive for drug use and drug dealing, combined with intensified police workers' interventions and drug agencies (Bless et al. 1995).

Crack cocaine also has a history in Amsterdam, with many heroin users having switched to this drug or using it concomitantly. It is interesting to note that street level workers do not mention crack use so often, and do not include this drug when talking about the development of a drug problem. Nabben and Korf (1999) state that a crack cocaine problem developed in Amsterdam during the mid-90's, when outreach workers could observe the establishment of this drug in deviant youth subcultures. By then, heroin addicts began turning increasingly into smoked cocaine, and soon ready-to-smoke crack was widely available in the street market. The authors estimated crack users had an average age of 24 years, being the majority of 'white' ethnicity (either Dutch or other ethnic European). Many of these users seemed to be homeless or roofless and used to hang around the Central Station. They had few or no contact with care services, and used to get their living from legal or semi-legal activities such as begging, selling the homeless newspaper, making street

music, offering help to tourists or entering street prostitution. Until the early 2000's, this scene developed to the more controlled situation achieved today.

Different from the feeling of control regarding the drug scene in Amsterdam, Porto Alegre suffer, nowadays, from the feeling of a 'crack epidemic'. This scene has developed in the last two decades, and has different main characteristics compared with the Dutch scene. While street level workers from Amsterdam consider both the entrance of heroin in the market and the arrival of migrants as the main characters in the development of a drug problem, workers from Porto Alegre put the drug - crack cocaine - as the main actor causing changes. Powder cocaine was already in the market since the 70's, but was mostly being used by medium/high classes inside parties or at home. The first big public worry related to the use of this drug started in the 80's, when injecting use became popular and reached also the outskirts population. Cocaine was the preferred drug for injection for almost all the user population (Caiaffa and Bastos 1998), and injecting use drastically increased the levels of HIV/Aids transmission due to syringe and other materials' sharing (Barbosa Júnior et al. 2009).[19] At this time, Porto Alegre users could be seen in the city centre and slums injecting in alleys, under viaducts, parks and under lamp posts. Not rarely, police workers would get a needle prick while doing searches at users, and used syringes were left in parks where children would play the next day. Even though injected cocaine was part of the problem, this was known as a 'HIV/Aids epidemic', not a drug one. The fact that HIV/Aids could also spread to a non-user population, together with available money from international agencies for HIV prevention, made the city government take some action. At the end of the 90's, HIV/Aids transmission among IDUs as well as injection use decreased.

Before the 90's, the drug scene in Porto Alegre shared space between the IDUs and homeless people, both adults and youth, using respectively alcohol and glue in the streets. The biggest issues at that time were the feeling of insecurity among passers-by, with eventual robberies and violence, and poor living conditions of the addicted population. A switch to a 'drug epidemics' feeling came with the introduction of crack cocaine into the market in the 90's. Crack cocaine spread particularly in socially excluded locations and populations, and by the end of the century it was already dominant among homeless youth and adults; and some former

injection users also switched to this drug (Duailibi et al. 2008). Many big cities in Brazil faced the emergence of the 'cracklands': open areas packed with crack users who would stay day and night causing nuisance for the neighbourhoods. Drug related crimes and a feeling of insecurity are common in these areas, and police workers' actions, similar to Amsterdam's heroin epidemics, can, at most, displace users from some areas to others. A feeling of despair and lack of control sweeps street level workers and the general population. In Porto Alegre, more specifically, even though a crackland never established in the city, the feeling of a crack epidemic is also alive. According to media, general community and street level workers, crack is said to have brought many users to homelessness or involvement with drug traffic and other illicit acts. It is regarded as responsible for changing the way in which people see and use the territory, influencing the way drug policy is put into practice.

Drug users

Looking at the broader picture, the Netherlands has lower *hard drugs use rates* than most EU countries (EMCDDA 2009), and Dutch drug policy has been pointed out as relatively successful (e.g Korf 1995, van der Donk et al. 2009). Since 1997 the prevalence of all illicit drugs (in the previous year) has remained rather stable in the country (van Laar et al. 2008). In 2009, lifetime prevalence of cocaine was 5,2% and last year prevalence 1,2%. For heroin, these numbers were respectively 0,5% and 0,1 %. Cannabis was the most used drug, with 25,7% life time prevalence and 7% in the last year. Most heroin users also consume crack, but some crack users do not use heroin (van Laar et al. 2012, Oteo Pérez et al. 2012).

In 2011, almost 70,000 people were seeking for addiction care in The Netherlands, a slight decrease from previous years (Wisselink et al. 2011). Majority of problems are of alcohol (47,1%), followed by opiates (16,3%); cannabis comes in 3rd place (15,3%), and cocaine (sniffed and crack) account for 10,8% of the population seeking treatment (Wisselink et al. 2011).

Brazil has lower rates for all kinds of drugs, legal and illegal, when compared to north and south-American countries[20] (Carlini et al. 2007); absolute numbers, however, are still impressive. From 2001 to 2005 rates of use increased for virtually all drugs (licit and illicit) in the country.

When compared to other regions in Brazil, the south has the biggest rate of crack use and the second highest rate of cocaine and cannabis use (Carlini et al. 2007). In 2005, 22,8% of the surveyed population had a life time use of any type of drug excepting alcohol and tobacco. Regarding hard drugs use in the south region, cocaine has the highest rate (3,1%), followed by crack (1,1%); and heroin (0,3%); inhalants use was mentioned by 5,2% of general population, but use rate escalates for homeless population (44%) (Carlini et al. 2007). Since these numbers correspond to the situation 7 years ago, when the last national survey on drug use was published, they have to be seen carefully. Nowadays, inhalants are virtually vanished from the streets, and crack incidence is visibly higher.

In 2007 134,674 drug users participated on inpatient (detox) treatment in the public system in Brazil, a slight increase from previous years. The majority of problems were due to alcohol (69%), followed by multiple drug use (23%) and cocaine (5%). The majority of users in treatment (88%) were men (Duarte et al. 2009). In outpatient services, the major demand is due to crack use (Horta et al. 2011, Duailibi et al. 2008).

Both in the Netherlands and in Brazil, crack cocaine assumed an important role in the last decades as one of the main *types of illicit drug used*. Crack started to be used in the late 80's in a purer form (homemade cooked from cocaine powder), and by the 90's it entered the market already manufactured. Many users switched to it as their preferred drug: in Amsterdam the switch was from heroin and methadone, and in Porto Alegre from alcohol, glue sniffing, and some from injected cocaine.[21] Injected use was important in Amsterdam (for heroin) during the 70's and 80's, and in Porto Alegre (for cocaine) in the 80's and 90's, decreasing significantly after that and being virtually non-existent nowadays. Besides crack cocaine (and heroin in Amsterdam), both Amsterdam and Porto Alegre users mention to use cannabis. In Amsterdam, cannabis was used by some before entering care services to keep calmer. In Porto Alegre, users refer to make use of it to control craving for crack cocaine: it helps them to relax, sleep and eat, giving a break from the intensive stimulation of crack.

The average *age of drug users* is different in the two cities, being much higher in Amsterdam. Heroin users seeking drug treatment (in-patient and outpatient) in the Netherlands are, on average, 46 years, and the majority have been treated for their addiction for around 12 years. These users are said to be getting older: only 11% are younger than 25, half of

the proportion found 10 years ago (Wisselink et al. 2011). When considering crack cocaine users only, the average age goes even higher. According to a field study in Amsterdam, Rotterdam and The Hague, the mean age of frequent crack users (including those not in treatment) was 45 years in 2009-2011(Oteo Pérez et al. 2012).

In Brazil, on the other hand, a recent (and first nationally representative) research on the profile of crack users, found an average age of 30 years (FIOCRUZ 2013). These people had used crack for eight years, on average, which contradicts common ideas among practitioners, population and the media that users would have a survival horizon of three years after starting using crack (ibid.). An important difference, probably also related to age average, relates to female crack users. More than half of the female users in Brazil reported having being pregnant once or more since they started using crack; 10% were pregnant at the time of the survey (FIOCRUZ 2013). As following chapters will show, users' age, pregnancy and history of drug dependency have a great influence on work processes, influencing workers' interpretive beliefs about drug use, as well as users' attitudes.

Reflecting socio-economic conditions of the cities and districts, *social conditions* of users being assisted by services also differ. In Amsterdam users have most of their basic needs met. The already mentioned Dutch Strategy Plan for Social Relief is responsible for taking homeless users from the streets into social relief centres which allow drug use (van Laar et al. 2012). As a consequence, most of the economically vulnerable users in Amsterdam are in shelters or have social housing, and many also get social support (*uitkering*). Since 2004 registered crimes committed by drug users in the Netherlands is claimed to be decreasing (van Laar et al. 2008). [22]

In Porto Alegre, on the other hand, many users are homeless or roofless, and can be seen sleeping in the streets, parks and under viaducts. There are not enough vacancies in shelters, and strict rules forbidding drug use inside premises and access when under drug effects prevents many crack users who are homeless from using these places. Nationally, approximately 40% of crack users are homeless or roofless, but less than 5% are in shelters (FIOCRUZ 2013). In order to get money to survive, most users engage in informal activities, such as picking waste. Working for drug dealers, stealing and begging are also possibilities; very few users have regular jobs or receive benefits.[23] In general, crack users are under

schooled and poor (Duailibi et al. 2008). A history of involvement with the law enforcement sector is also common (Horta et al. 2011).[24]

Different social conditions make homeless drug users less visually distinguishable among the population in Amsterdam. It is possible to suspect someone is homeless when they are rummaging through trash or carrying many bags with personal belongings; but to be sure, one has to know who they are. In Porto Alegre, however, even the homeless users who access care are noticeable from a distance. Their ragged clothes, sometimes bare feet, lack of good personal hygiene, and unhealthy appearance hinders the ways in which they are entitled to entry the city's spaces. In Amsterdam, homeless users are normally allowed to be inside supermarkets, shops, and libraries, but in Porto Alegre they are usually kept away from those places. Visual and olfactory conditions act as triggers to differentiate and segregate homeless users in Porto Alegre, much more than in Amsterdam.

Segregation, however, also occurs in Amsterdam, and is more likely when users are *allochtonen*. The limited knowledge of Dutch language makes *allochtoon* users more dependent on extra help from workers to communicate with services and deal with bureaucratic papers in order to get their rights assured. Clothing style and physical features can also trigger discrimination and selective enforcement/assistance. Even though pregnancy was not an issue among female drug users in Amsterdam, gender, in general, influences the way users move into the territory. Women inside drug facilities attended mostly by men sometimes feel uncomfortable and fear sexual harassment. Homeless women have harder challenges, being easier targets to be robbed or abused by men. These features are similar in both cities.

Even with clear welfare differences between users from Amsterdam and Porto Alegre, they share a marginal position in the territories. A feeling of non-adaptation, or of being an outsider to economic and cultural features of mainstream society is current for drug users, who, in general, feel the population avoids and dislikes them. In both places, users' houses and life style show a lower level of self-care, and a stronger connection to illegality and informality when compared to the overall, mainstream population.

The services

Historical developments

Social, health and law enforcement services approaching drug users in the studied cities are shaped by the development of drug policies, the perception of a drug problem, the users, as well as by the conditions in the cities and districts. These features shape not only the current organization of services, but also the ways in which they developed over the years.

Amsterdam (and the Netherlands) have not always supported a harm reduction approach towards drug use. During the heroin epidemic, in the 70's, dominating frame of work in Amsterdam drug treatment field was complete abstinence as the only acceptable and central purpose. Drug treatment clinics would not accept addicts who did not have a desire to fight the addiction. Therapeutic communities performed only-abstinence treatment, punishing relapses and aggressive behaviour with treatment expulsion. 'Lost cases' were left to be cared by the ambulatory psychiatry from the municipal health service (Blok 2008). In the early 70's, however, an outpatient clinic with methadone treatment was established by a psychiatrist from an abstinence-only institution. Due to the heroin epidemic, substitution treatment expanded, but it was far from a low-threshold service[25]: treatment access required users to avoid the drug scene, focus on abstinence, visit the clinic every day and perform urine checks (Blok 2008). Other users fell back on care from charitable religious organizations, which offered hostels, drop ins, syringe exchange and outreach work. In 1974, financially supported by the municipal government and run by a Christian organization, the first drug consumption room was opened, where users could get benefits, a meal, shower and buy drugs from a 'house dealer'. The project was extremely controversial for the wider population and among workers, some of whom felt this approach was not caring, but 'giving up' on users (Blok 2008).

Disagreements with the only-abstinence approach, however, were growing, and new organizations joined efforts towards harm reduction. During this period, the ambivalence on which approach to choose made low-threshold initiatives - such as shelters, drop ins and user rooms - be frequently opened by care organizations, and closed down by the law enforcement sector in request of the city hall; complaints about public nuisance were the main stated reasons. Since many drug users remained

under cared and made nuisance in the streets, in the 80's, the municipal health service created a broad system of methadone maintenance in Amsterdam. Accordingly, the Dutch government finally adjusted its goals to focus more on harm reduction than abstinence (Blok 2008).

Starting a decade later, Brazil saw similar developments towards a harm reduction approach of drug use. The leading motor for the change was the HIV/Aids epidemic among IDUs at the end of the 80's and beginning of 90's. Only-abstinence strategies focusing on detox and therapeutic communities were not enough to deal with HIV transmission, and the first syringe exchange programs (SEPs), based on programs developed in Europe, North America and Australia, were brought into the country and adapted to local needs. In 1989 Santos, São Paulo, made the first attempt (Brazil 2001), but despite the program being supported by local managers of STD/HIV governmental programs, a judicial decision interrupted it based on the judgement that giving syringes was an incitement to drug use and thus, a criminal act (Bueno 1998). [26] Only in 1994 the first PRD (Brazilian version of SEPs) was officially recognized in the country (the first in South America) in Salvador, Bahia. In cities such as Santos, São Paulo, Rio de Janeiro and Porto Alegre, PRDs started to work unofficially. In Porto Alegre the first PRD started in 1996 (Siqueira et al. 1998), being officially recognized by the government three years later, with the approval of a local law (Rio Grande do Sul 1999) allowing syringe exchange. Based on a different frame than the hegemonic only-abstinence one, harm reduction programs and workers faced great obstacles to put their activities and goals with users in practice. Challenges were not only due to insufficient financial and political support, but also to prejudice and misunderstanding about their work (Surratt and Telles 2000); that is similar to what happened during the 70's in Amsterdam.

The first decade of the 21st century, however, saw harm reduction programs spread across the country run by NGOs through HIV/Aids public funding (Fonseca et al. 2007). By 2006 more than 100 PRDs were operating in Brazil (Fonseca et al. 2006), working beyond syringe exchange and increasingly collaborating with other social and health services. Acceptance of harm reduction grew, but PRDs still lacked sustainability and recognition. With the decentralization of financial support (from federal government to municipalities), many programs stopped working, not able successfully to lobby in local governments for securing support for their activities (Fonseca et al. 2007). In the following years,

however, new federal legislation supporting harm reduction as a national strategy increased its sustainability by integrating it in public health services, such as hospitals, specialized clinics and primary health care. Outpatient strategies were progressively supported, with an increase in psychosocial care centres for drug addiction and a decrease of psychiatric hospital beds, following the Psychiatric Law Reform's principles of deinstutionalization and reinforcement of rights of individuals with mental health illnesses (Brazil 2001). A harm reduction strategy of user rooms, however, was never allowed in Brazil.

Participating in this study

As already mentioned in the methodology section, given the variation of services present in each city, a sample was drawn based on the different types of experiences emerging as categories in theoretical sampling (Morse 2007). Tables 2 and 3 show the distribution of services participating in the research, respectively, in Amsterdam and in Porto Alegre. In the tables, services are organized by sector, type, spatial area of coverage in the cities, and population targeted.

In a broader sense, the *type of services* offered and being accessed by drug users in the cities have similarities. Fundamental differences, however, relate to the much bigger presence of low-threshold and harm reduction based facilities in Amsterdam as compared to Porto Alegre. Number of services and vacancies available, as well as general resources, also vary across the ocean. In the *social sector*, both Amsterdam and Porto Alegre provide walk in centres, outreach work teams, shelters and social assistance. Only in Amsterdam, user rooms are also present. In a walk in center visitors can spend the day having free coffee and bread, watching television, listening to music, showering, washing clothes and playing some games. In Amsterdam, users can also buy a low cost warm meal, use the computer, and be paid to do some daily activities (*dagbesteding*), such as cleaning the place or picking up garbage in the streets. Only in Porto Alegre, walk in centres offer communitarian therapy, art therapy and other groups aiming at improving users' autonomy and participation. A group orientation is common for many health and social services in the city (and the country), and is based on collective health principles of participation and equity.

In both cities, outreach work teams do active searches focusing on the hardest-to-reach population, who do not approach care by them-

selves; only in Amsterdam, shelters allow drug use inside their premises. Centres for social assistance dispense social benefits in both cities, but in Amsterdam, they also provide employment opportunities, social housing, and financial benefits to drug users. User rooms were created to provide a safe drug use place for homeless and roofless users. Only-registered users are allowed to bring and use their own drugs inside; rooms to use injection drugs are usually separated from the ones to smoke crack and heroin. In Amsterdam, all social services participating in this research focus exclusively in adults; in Porto Alegre youth services were also included, since drug use in this population is considered a social problem. (Pictures 25-32).

In the *health sector*, services being accessed by users are those providing in-patient and outpatient drug treatment, outreach work, and in the case of Porto Alegre also primary health care. The main approach used by these services, and the type of services mostly accessed by users, however, differs across the cities. In Amsterdam, most users under drug treatment access out-patient services: clinics that provide methadone treatment, smoked and injected heroin prescription, syringe exchange, and doctor's appointment. Even though the rooms for smoking heroin are collective, treatment is individualized. Out-patient clinics have a very clear focus on harm reduction, and some are specialized in targeting women.

In Porto Alegre, on the other hand, many out-patient clinics focus on abstinence, but some harm reduction strategies can be mixed by pursuing abstinence for the most harmful drug, while tolerating the use of others. Drug use inside the facilities is strictly forbidden, and being under drug influence can be enough reason for not being allowed to enter. Rather than gender specialized, clinics assist both male and female adults who use all types of drugs: alcohol, cannabis, cocaine and crack cocaine. For youth, in Porto Alegre, no outpatient clinic was available at the time of research, creating limitations for workers on how to treat minors.[27] Group activities are very intense, going from therapy, to medication management, occupational/art therapy, basic health, spirituality and others.

Table 2:
Services participating in the research - Amsterdam

Sector	Service type	Coverage	Population	Total
Social	Walk in	2 centre	Drug users	2
	Outreach wok	1 centre 1 Bijlmer	Drug users	2
	Shelter	2 Bijlmer	Drug users	2
	Social assistance	1 entire city	All (guidelines for drug users)	1
	User room	2 centre	Drug users	2
Health	In-patient treatment	1 entire city	Drug users	1
	Outpatient treatment	1 centre 1 Bijlmer 1 city	2 drug users 1 female drug users	3
	Outreach work	2 entire city	1 drug users (homeless or in social housing) 1 all (mental health care)	2
Law enforcement	Police workers station	2 centre 1 Bijlmer	All	3
	Probation	1 entire city	All	1
Total				19

Table 3:
Services participating in the research - Porto Alegre

Sector	Service type	Coverage	Population	Total
Social	Walk in	1 entire city	Homeless adults	1
	Outreach work	1 North 1 centre	1 all (adults) 1 all (youth)	2
	Shelter	2 entire city	1 all (adults) 1 all (youth)	2
	Social assistance	1 centre 1 North	All (youth and adults)	2
Health	In-patient treatment	3 entire city	1 drug users 2 drug users (youth)	3
	Outpatient treatment	2 North	Drug users (adults)	2
	Outreach work	1 entire city 1 North	1 drug users (adults) 1 all (adults and youth)	2
	Primary health care (+ outreach)	1 entire city 1 centre	1 all (youth and adults) 1 homeless (adults)	2
Law enforcement	Police workers station	1 centre 1 North 1 entire city	All	3
	Tutelary councils	1 centre	All (youth)	1
	School prevention	1 centre	All (youth)	1
Total				**21**

Amsterdam had far less referrals to in-patient drug treatment clinics than Porto Alegre for the population under research. All in-patient clinics aim at drug abstinence in both cities, but the ones in Amsterdam allowed users to be outside for some times a day, as long as they keep abstinent (controlled by urine checks). In-patient treatment is regarded as a crisis management service in Amsterdam: users stay around seven days for detox, while the team works to connect them to other care services for follow up. In Porto Alegre, in-patient services also work as emergency services based on detox, but users stay around 20 days. Together with Therapeutic Communities, detox is the only drug treatment available for youth in Porto Alegre.

In both cities outreach work teams have a bridging role between harder to reach users and different care services. Amsterdam teams are specialized: one in adult homeless drug users or adult users who have social housing; another in people with mental health problems approached by police workers (which includes drug users having criminal and nuisance issues). While the first tries to connect users to welfare services, the second is a special 24 hour team supporting police workers in their daily approaches when needed. In Porto Alegre outreach focuses on the homeless population, specializing either in youth or adults. Primary health care centres also undertake outreach work. These places are expected to assist the whole population which resides in a certain neighbourhood, adults and children, users and non-users. They provide basic health care and are the main entrance door to more specialized services in health.

In Amsterdam, as well as in Porto Alegre, both social and health care services are organized according to the level of care provided and requirements they have towards drug users. Amsterdam adopts the 'stepped care': a more intrusive or intensive form of care or treatment is offered only when a less intensive form has been insufficient (Schippers et al. 2002). Low-threshold services such as walk in centres, user rooms and outreach teams offer basic needs and do not ask users to follow many rules, focusing on getting harder to reach users into the system. Drug use is in general allowed, even when further steps towards drug treatment are taken. A harm reduction approach is the general trend. Also in Porto Alegre care system is organized in different levels of complexity, starting from basic care (in primary health care, walk ins or outreach teams) and growing to specialized (drug treatment, shelters) or

complex care (detox in hospitals) when needed (MS 1990). In the case of drug users, however, the threshold is high towards drug use (which is always forbidden), even in basic care. This way of organization, ultimately, affects users access and permanence in the system. (Pictures 33-39).

Law enforcement services includes police workers stations responsible for specific districts in both cities. While in Amsterdam there is a well-established community policing style, in Porto Alegre militarism is very much present, but with increasing efforts towards community policing. In community policing, police workers are allocated to particular areas so that they become familiar with the local residents and their main problems and develop a closer relationship with them. The strategy also intends to promote partnerships between police workers and other governmental organizations (including social and care sector), private business, community members/groups and non-governmental agencies in the area. Community police officers, thus, are responsible both for curbing crime and connecting with community and care services from their area. A military police force, on the other hand, is solely responsible for maintaining public order and acting as a deterrent against the commission of crime. The military troops in Brazil, are categorized as reserve troops and auxiliary forces of the Brazilian Army, to be called in time of war or other emergencies. As such, this type of police workers receives military training. Since the early 90's, a few military police workers participate also in a drug prevention program: the PROERD (Programa de Resistência às Drogas). This program is based on the American program D.A.R.E. (Drug Abuse Resistance Education). It is developed in public primary schools, where trained police workers offer lectures to children based on the idea of drug use prevention and abstinence. Lectures are based in materials translated from the American version and presentations made by police officers themselves. This is, in general, a voluntary work not officially included in police workers job's description.

In Amsterdam, police workers getting more frequently in touch with drug users are the community police workers officers (*buurtregisseurs*) and the patrolling police workers. This latter is not responsible for contacting community and community services, and is more focused on curbing crime. Different from Brazilian military police workers, patrolling police workers in Amsterdam do not receive any military duties or training, but are commonly recognized among users, community and care workers, as stricter than the community police officers. In Porto Alegre, besides

military police workers, also civil police workers gets frequently in touch with drug users. While military police workers curbs crimes on the streets, civil police workers are responsible for crime investigation, and gets in touch with users as soon as they become involved in crime prosecution (which involves drug dealing, drug possession, and drug use in doubtful cases where dealing might be involved).

In Amsterdam, probation officers follow drug users who have committed crimes into reintegration programs, while in Porto Alegre guardianship counsellors take care of youth and child protection in case of violence, drug use or other issues that can compromise child/youth care. All these law enforcement services are directed towards the whole population, excepting the probation services in Amsterdam which are specific for drug users (Pictures 40-45).

In terms of *coverage*, all street level services are organized to cover a specific district in the city, unless they are considered a reference service for the city as a whole. In both cities the centre provides comparatively more services than the districts, but the types of services available to the population are, in general, similar in both areas. In the case of Porto Alegre, however, some specialized services are overloaded with users from outside the local area because neighbouring regions had no equivalent service. Services' location could also vary between centre and districts. In the case of Amsterdam, services are more concentrated in one place in the Bijlmer, while in the centre they were spread around the area. In Porto Alegre, services were decentralized in both regions.

Regarding the *population* assisted, services from Amsterdam are more specialized than the ones in Porto Alegre. Excepting from in and out patient drug treatment services, all others are directed to the general population in Porto Alegre, while in Amsterdam they are focused on (hard) drug users only. In both cities, many of the services being accessed by drug users are focusing on homeless and roofless population. An important difference brought by the level of specialization, is that in Porto Alegre drug users have to compete for services with other citizens who have less economically favoured conditions. They also have to follow the same rules of behaviour inside facilities, which ends up bringing them disadvantages, and negatively impacting their access to care. A more informal type of distribution in social services such as shelters, user rooms and walk-ins in Amsterdam is related to users' ethnicity: while some facilities are mostly used by *allochtonen* from Suriname and Antilles,

others are crowded with eastern-European, or still others with white Dutch users.

Street level workers

Workers participating in the research are divided into street level workers (58 participants) and key-informants (23). The former are the main focus of this research, as they are in direct contact with users on a daily basis. Key-informants, however, provided valuable background information due to their experience and key-positions in the field, being mostly medium level managers or users' representatives. They offered a broader and historical perspective on drug policies in their countries, regions or cities.

Table 4 compares some features of street level workers in both cities. Street level workers sample was balanced for sex, age, and experience working with drug users - both within cities and sectors of work. The literature contends that these factors impact workers interpretive beliefs and activities (e.g. Brener et al. 2007, Forman et al. 2001, Humphreys et al. 1996, Miller and Moyers 1993), which was found to be the case also during grounded analysis. Emerging categories for theoretical sampling (Morse 2007) were also added to form the sample: type of service; type of work contract; level of collaboration with other workers; main approach adopted regarding drug use; being considered liberal or strict by colleagues and drug users; type of relationship with colleagues and users; being office-based or outreach worker.

Participants are almost equally divided into male and female, and have an average age of 39 years in both cities. While ages are more equally distributed in Amsterdam, in Porto Alegre 75% of the workers are between their 30's and 40's. Amsterdam workers have, on average, more years of experience working with drug users than the ones in Porto Alegre. This difference possibly reflects services specialization on drug users and lower turnover (due to better work conditions and stability) in Amsterdam. Despite having less experience with drug users, street level workers from Porto Alegre have, on average, more years of formal education than in Amsterdam, with a third of them holding a post- graduate degree. Higher education reflects the labour market in Brazil: higher unemployment rates[28] push workers into services that would require less education than they had achieved. Interestingly, in both cities health workers have, on

average, higher formal education than social and law enforcement workers. Also, office based workers from all sectors are higher educated than outreach workers. As chapter five will show, these differences on assumed knowledge influence workers ways of practices, enhancing power relations (Foucault and Gordon 1980) among actors during their daily interactions and giving some workers more room for manoeuvre in negotiating strategies than others.

Table 4:
Profile of street level workers participating in the research

	Amsterdam	Porto Alegre
Sex	Female 44% (12) Male 56% (15)	Female 52% (16) Male 48% (15)
Age	Av: 39 (25-56) 20's = 26% (7) 30's = 19% (5) 40's = 33% (9) 50's = 22% (6)	Av: 39 (21-56) 20's =16% (5) 30's = 29% (9) 40's = 45% (14) 50's = 10% (3)
Years of work with users	Av: 11,25 (1,5 -31) 1 to 5 y = 33% (9) > 5 ≤10 y = 26% (7) > 10 ≤20 y = 22% (6) > 20 y = 19% (5)	Av: 8,73 (0,5- 34) 1 to 5 y = 42% (13) > 5 ≤10 y = 19% (6) > 10 ≤ 20 y = 33% (10) > 20 y = 6% (2)
Formal education	Basic/fundamental – 4% (1) Secondary – 30% (8) Tertiary – 66% (18) Post- graduation – none	Basic/fundamental – 3% (1) Secondary – 29% (9) Tertiary – 33% (10) Post- graduation –35% (11)
N. of jobs	One- 100% (27)	One – 65% (20) Two or more - 35% (11)
Type of contract*	Civil servant – 33% (9) Permanent contract – 52% (14) Temporary contract – 15% (4)	Civil servant – 42% (13) Temporary contract- 35% (11) Outsourced - 23% (7)
Monthly income*	< €1200 – none €1200 - €1599 – 15% (4) €1600 - €1999 – 26% (7) €2000 - €2399 – 44% (12) €2400 - €2799 – 11% (3) €2800 - €3200 – 4% (1) > €3200 - none	< R$** 510,00 - none R$ 510 - R$ 1019 – 13% (4) R$ 1020 - R$ 1529 - 33% (10) R$ 1530- R$ 2549 – 19% (6) R$ 2550- R$ 5099 - 19% (6) R$ 5100- R$ 10200 – 16% (5) > R$10200 - none
Working days/week*	Av: 4,37 (3-5)	Av: 5,12 (3-7)
Working hours/week	Av: 34,4 (27-40)	Av: main job 36,6 (20-44) all jobs 40,45 (20-60)
Total	27	31

* In the main job **Brazilian reais (1€≈R$3)

Other prominent differences in terms of work conditions are related to number of jobs, hours of work, income and work contract. While in Amsterdam all participants have only one job, 35% of the workers in Porto Alegre have at least two. Multiple sources of income are related both to low salaries and the instability of job contracts in Porto Alegre. While in Amsterdam 85% of the workers have stable contracts, only 42% have the same in Porto Alegre. Being a civil servant is a guarantee of stability in both cities, but being hired under formal work conditions can be quite different. In the Netherlands, by law, after a maximum of three years of temporary contract in an organization, workers should get a 'permanent contract', with similar conditions to a civil servant position in terms of stability. Brazilian work laws, on the other hand, do not assure stability for workers after a given period; not being a civil servant, thus, puts workers in a permanent unstable position.

Besides that, the practice of outsourcing increased in Porto Alegre during the last years. The increase in hiring civil society organizations to provide services for the government corresponds to a direct decrease in vacancies for new civil servants.[29] It is common for outsourced workers not to have health insurance, paid holidays, health licence, or the thirteenth salary. [30] Lack of stability leads to a high turnover, producing discontinuity, lack of standardized practices, and consequent fragmentation of public policies.

Workers from Amsterdam tend to work less hours a week than workers in Porto Alegre. Dutch work contracts are usually around 36 hours/week, while in Brazil it is common to have contracts of 40 to 44 hours/week. Counting with the second or third job, that many workers from Porto Alegre have, working hours can go up to 60 h/week. Salaries, however, are lower in Porto Alegre. Income ranges in Table 4 were calculated based on national surveys to determine social and economic conditions of the population. The lowest range represents the minimum wage in each country at the time of fieldwork: €1200 (euro) per month in the Netherlands and R$510 (reais) in Brazil (around €170). Minimum wages represent very different purchasing power in each country, and thus, different living conditions for workers in the same range in Amsterdam and in Porto Alegre. Besides that, inequality of income is much higher in Porto Alegre: while in Amsterdam workers' wages were clustered around middle ranges, in Porto Alegre they were more widely distributed. Workers' functions within sector (generally related to required

educational level) accounted for most of the differences. Civil police workers and physicians have the highest wages in Porto Alegre, while workers with functions that do not require an university degree, namely outreach workers from the social and health field and military police workers, are in the lowest ones. In between, are the care workers whose work requires an university degree – psychologists, nurses, social assistants, physical educators. Income inequalities can be quite drastic within services: a physician, for instance, can easily earn ten times more than his/her outreach worker colleague. Together with educational differences, income inequalities have consequences for workers' wellbeing and for power relations in terms of room for manoeuvre in negotiations among workers.

What defines the territories: main features

This chapter explored six fundamental elements defining the ways of organization (Lemke and Silva 2011) in the studied territories: the official policy statements related to drug use, the environments of the cities and districts in which these policies actually happen, the development of a drug problem, the population of drug users assisted in each place, the services available and its history of development, and finally, the street level workers.

Both Amsterdam and Porto Alegre (and respective countries) share the fact that public health and public order coexist in drug policies. In both places harm reduction developed with HIV/Aids epidemics in IDUs, but while in Amsterdam the approach encountered already relatively liberal policies towards drugs, in Porto Alegre it faced repressive policies inherited from the dictatorship period. Differences in police workers' culture and behaviour, as well as in movements in the health sector in Brazil, account for important differences in the ways of organization of drug policies in the territories. These histories of drug reforms and harm reduction developments gave rise to a mixed set of goals and interpretive beliefs about what to do with drug use which, in turn, will influence work processes in the territories.

Cities and districts show clear differences in the socio-economic and cultural conditions, even though Porto Alegre is one of the most developed cities in economically growing Brazil. Levels of violence –much higher in Porto Alegre- and official tolerance towards drug use – much

higher in Amsterdam- are main differences. Porto Alegre shows a much higher level of inequality, although the wellbeing of the better off population may be considered similar in both cities. Differences in inequalities are clearly visible in the housing, sanitary, feeding and overall health conditions of the less economically favoured population in both cities. In this study, this population is represented by the citizens living in the Bijlmer and the North Zone, and by the homeless hanging around in the city centres. Notwithstanding the differences, in a relative manner one can see similarities among the cities: in both, the outer districts share a relative level of poverty and (drug related) violence when compared to others. In both also, their inhabitants share a status of 'outsiders' from mainstream culture.

Regarding the development of a drug problem, the cities show different pathways, with different problem-drugs and time-frames of a 'drug epidemics'. While in Amsterdam the heroin epidemic occurred in the 70's and crack established in the market in the late 80's, the crack epidemic spread in the early 2000's in Porto Alegre. Similarly, however, is that in both cities the idea of having a drug problem developed when an open drug scene was established. When drug use hit people from the outskirts, and mixes with poverty and lack of opportunities, it creates a 'drug problem'. A first governmental reaction, in both places, was to invest in public order by displacing drug users to less public areas.

Although is difficult to compare data across the countries, it is possible to say that, overall, life time and last year prevalence rates of hard drug' use are not so different in the studied places; despite differences in absolute numbers. Relative to the number of users, a much lower percentage seek drug treatment in Porto Alegre, but in both places most of the new clients are crack cocaine users. Users average age is around 15 years higher in Amsterdam than in Porto Alegre, and people have more years of drug use in the former city. Probably due to younger age, many female crack users face pregnancy in Porto Alegre. Age and gender related features have a great influence on work processes, influencing users' attitudes, the relationship between workers and users, and workers' interpretive beliefs about what to do with drug use.

The social conditions of users being assisted by services also differ in Amsterdam and Porto Alegre, reflecting socio-economic conditions of the cities and districts. While in Amsterdam users have most of their basic needs attended, in Porto Alegre they struggle to get food and shel-

ter. In both cities, however, users share a feeling of marginalization with respect to mainstream society. Segregation is enhanced by disfavoured social conditions in Porto Alegre and by being an *allochtoon* in Amsterdam.

Social, health and law enforcement services approaching drug users in the studied cities developed in different ways along the years, but in both cases harm reduction strategies were introduced with difficulties due to previous hegemonic abstinence-only approach. The approach started being developed as temporary programs run by NGOs and supported by local governments, and with time developed to be included in the public health system and carried out by civil servants. In Amsterdam, this process happened two decades earlier than in Porto Alegre. Nowadays, Amsterdam public care has a much bigger presence of harm reduction and low-threshold services than Porto Alegre. Amsterdam services are more specialized towards drug using population, and more focused on individual approaches; in Porto Alegre group approaches are more frequent. While in Amsterdam community policing is well developed, a military frame is still the main mode of police workers practice in Porto Alegre.

Finally, street level workers face some differences in the territories, mainly regarding work conditions in each city. More than one job, longer working hours, lower stability of contracts, and lower salaries are usual conditions for workers in Porto Alegre when compared to their counterparts from Amsterdam. Following chapters go deeper into the territories to analyse the ways of practices occurring in them (Lemke and Silva 2011).[31] As they will show, the differences in the way the territories are organized have consequences for the work processes established on the ground: they ultimately shape workers' choices on strategies to cope with gaps from official p guidelines to practice, defining ways in which they use their discretion.

Notes

[1] As care, law enforcement workers also have their spatial organization and communications organized within a circumscribed area (spatial organization). This organization provides boundaries which define their movements and the way their practices are built (work processes and law enforcement workers practices and processes). The two meanings of territory, therefore, can be applied both for care and law enforcement sectors.

[2] A new "target population" was created for prevention programs: the 'IDU', or 'injection drug user'. HR strategy was syringe exchange, for preventing syringe sharing and spread of HIV/Aids and other blood-borne diseases. Even before HIV/Aids epidemic in IDUs, some harm reduction strategies such as Methadone Maintenance Treatment (MMT) had been already introduced. During the 60's MMT was both in the EU (Sweden, Netherlands, UK and Denmark) (Hedrich et al. 2008) and in the US. These were, however, two decades of slow developments in harm reduction strategies until the HIV/Aids epidemic among IDU's took place in the 80's (Hedrich et al. 2008). In the case of the Netherlands, although the Dutch concept of 'normalization' contains elements of what became known as 'harm reduction', this last concept just emerged in an explicit way with the introduction and spread of HIV/Aids among people who use injection drugs in the mid 80's (Korf et al. 1999). In developing countries, harm reduction started mainly as a response to HIV/Aids epidemic among IDU's.

[3] Cannabis and hashish are considered soft drugs (Schedule II), while heroin, amphetamines and LSD are hard drugs (Schedule I). Since 1988 ecstasy is on schedule I; since 2008 fresh magic mushrooms are on schedule I together with dried magic mushrooms (van der Donk et al. 2009). Soft drugs have a tolerated sale in the coffee shops as long as they follow the AHOJ-G criteria.

[4] The idea was that being a Dutch resident and a registered coffeeshops member would be a criteria to purchase cannabis. The new repressive measures were curbing tourists inside coffeeshops, but were not able to decrease drug-related nuisance in the streets, having increased a black market for cannabis also for Dutch residents, who resisted the registration process. The contradictory effects of these changes led the government to back off the decision (van Ooyen-Houben et al. 2013).

[5] Repression is supposed to be directed towards drug trade (and not use), but some effects can be seen also for users and health services. People could have their ecstasy pills tested inside parties together with information about safe consumption, for instance, given by health workers. Nowadays, partiers are checked at the entrance by police workers and have their pills seized.

[6] PRDs (Programas de Redução de Danos) are the Brazilian equivalents to the internationally known SEPs (Syringe Exchange Programs). They bring, however, important local differences, since they do not work only with syringe exchange, but also with pipe exchange (for people using crack), kit sniff (for cocaine snorters) and other prevention and counseling activities. Therefore, the Brazilian name and abbreviation is kept.

[7] Health councils are permanent bodies in charge of formulating health strategies, controlling implementation of policies and analysing health plans and management reports submitted by their respective level of government. Conferences are

held each 4 years at the three levels, with the mandate of accessing the health situation and proposing directives for health policies (Victora et al. 2011).

[8] Rates of violence are measured by homicide rates. Comparing homicide rates in LA countries, Brazil came just after Colombia, Honduras and Jamaica (Rodrigues, 2006). In 2010, there were 25,8 homicides per 100 thousand inhabitants in Brazil. From this total, 28,5% were towards white, while 71,1 towards black citizens, which shows a selective and unequal level of violence among the population (Waiselfisz 2012). Conventionally, a situation of violence is considered epidemic when it reaches a rate above 10 homicides per 100 thousand inhabitants (ibid.).

[9] Official statistics from Bureau Onderzoek & Statistiek Amsterdam (O+S 2012) bring a rate of 48 per 100 thousand inhabitants, but this rate includes both 'successful' homicides (murder and manslaughter) and attempted homicides. The statistics provided by Het Parool count only the successful cases, similar to statistics from Porto Alegre.

[10] Recent research has shown that the nuisance problems that most bothered citizens are fast driving, dog dirt, and nuisance from traffic. Few people reported being bothered by drug-related nuisance (4,8%) and even less reported this as the most important problem (2,9%) (CBS. 2012).

[11] The number of registered cases of violations of the Opium Act has been decreasing in the country and the share of offences under this Act related to hard drugs is decreasing, while proportion of convictions for soft drugs is increasing; different from previous years, soft drugs related violations are now the majority of the cases (van Laar et al. 2012). In the case of hard drugs, virtually half of the offenses are related to drug possession, while the other half is related to trafficking or production. Offenses against the Opium Act consist of trafficking, production and cultivation, dealing and possession of drugs; small amounts for personal use are usually not prosecuted(ibid.).

[12] All pictures are in the appendices. In the North Zone' slums pictures were not taken, respecting citizens and workers' willingness. An illustrative picture (pic. 24) was downloaded from the internet to show the overall condition of the houses in the slums visited. (http://pt.wikipedia.org/wiki/Porto_Alegre).

[13] At least for the researcher and in comparison to drug-problem districts in Porto Alegre. Some Dutch citizens who do not live in the Bijlmer might have other feelings when walking in the area.

[14] The commercial center, Bijlmer Arena, is the richest one, being a very lively and mixed place. During working hours, Dutch and non-Dutch citizens can be seen walking around the shops and sitting in the wooden benches in the area to peacefully eat their sandwiches during lunch break. Women with children, mostly black, are also walking around the shopping area during day time. The place as-

sumes other aura in the evening, with mostly black men hanging around or sitting in the few bars and pubs Other two areas in the neighborhood part of the 'old Bijlmer', Gaazenhoef and Kraaienest, are less busy and less mixed: most of the population hanging around are local citizens. Both areas have a smaller commercial center, an open market and a metro station. In all three areas many shops sell African products or specific food and hair products for black people.

[15] In Porto Alegre the expressions 'homeless' or 'roofless' are being changed by the expression 'people in street situation'. This is to detach the person's identity from being someone from the streets and also to call attention to the situational character of this condition. There are 2 types of street situation: 'street surviving' is when the person has a place to sleep but just works or begs at the street, and 'street living' is when the person stays only in the street. According to the workers, nowadays there are lots of adults in street living situation, while children are more in street surviving. This would reflect an improvement in the situation as compared to some years ago, when many children were living in the streets. Even being aware of the term implications, this study keeps the expression 'homeless'. It does that due to its more common use, reflecting the way most workers (both police workers from Porto Alegre and workers from all sectors in Amsterdam) refer to this population.

[16] In May 2012 slum inhabitants were resettled in the North-East of the city. Most of the community was unsatisfied with the moving, mainly due to the distance from the city center and its consequences in terms of their daily work. Life conditions in terms of housing, lighting and sewage, however, were clearly improved. No pictures were made from this and other slums, respecting both workers and citizen's willingness.

[17] Not, however, without controversies around the removal of population from their original places. The distance of resettlement areas from the centre makes difficult for solid waste-pickers and other workers to dislocate; also the style of housing and rules in new places are said to constraint previous habits of people.

[18] By comparing the meanings of open drug scenes for 9 European cities, Bless et. al. (1995) define three key elements for its definition: visibility, size and site. Considering variations, the authors propose a typology with concentrated open scenes, dispersed open scenes (where Amsterdam was identified by the time of the study) and hidden open scenes.

[19] In the early 90's, the incidence rates for Aids were 200 times higher for IDUs than to non-drug users (when considering heterosexuals males). Share of males who use drugs in Aids cases increased rapidly during the late 80's until the mid-90's: from 16,5% (1.380 people) during 1980-88 to 32,6% (12.520 people) during 1989-1992 and 28,5% (20.983 people) during 1993-1996. During 1997-2000 cases slowly decreased to 19,2% (19.061 people) to fall in 2001-2004 to 9,5% (9.366

people). One of the possible factors of the decrease are the HR strategies such as syringe exchange adopted in the country (Barbosa Júnior et al. 2009).

[20] Comparisons are drawn between Chile and the US, countries were the survey methodology is similar, and data is comparable. Brazil still has a shortage of information and statistics about drug use, drug treatment and crimes related to drugs when compared to developed countries. The second national survey about drug use was done in 2005, and only considered the population living in the cities with more than 200 thousand inhabitants (which corresponds to approximately 40% of the total population). First survey was done in 2001, with the same methodology (Carlini et al. 2007).

[21] According to a recent research, more than 80% of crack users use, concomitantly, alcohol and tobacco; only 9,2% of them were previous IDUs (FIOCRUZ 2013).

[22] In 2010 crimes committed were mainly property crimes without violence (52%), followed by violence against persons (28%); vandalism and disturbance of public order (20%); and Opium Act offence (16%); traffic offense (11%) and property crime with violence (7%). From the drug users arrested by the police workers 93% were male and 96% over 24 years old. Many of these users are prolific offenders: 80% was arrested more than ten times before and 24% more than 50 times (van Laar et al. 2012).

[23] This reflects the national situation of crack users, who mostly work in informal activities and jobs (64,9%), which can also be combined with begging (12,8%) and being helped by family and friends (11,3%). Illegal activities such as stealing or selling pirated goods (9%), together with working for drug dealers (6,4%), or prostitution (7,5%) are also possibilities. Just a small portion of crack users mentioned to have a regular job (8,2%) or receive benefit (5,4%) (FIOCRUZ 2013).

[24] A national research showed that almost half of crack users were arrested at least once. Main reasons for detention were drug possession (13,9%), robbery/assault (9,2%), thefts/home invasion/fraud (8,5%), and drug traffic or production (5,5%) (FIOCRUZ 2013).

[25] Low threshold services work from a harm reduction perspective, not asking users to follow many rules to be able to access the service. They are considered an 'entrance door' into the care system, and focus mainly on the harder to reach users.

[26] Art. 12 of law 6.368/76 classified 'instigating, inducing, and/or assisting' the use of drugs as criminal acts, carrying 3 to 15 years imprisonment. Therefore, the act of giving syringes to drug users could be classified as a crime. This classification happened, repeatedly to many harm reduction programs across the country; the way to solve this was usually by creating a local law allowing syringe exchange.

In Brazil it was/is not forbid to purchase syringes; however, accessibility is a problem due to opening time of pharmacies and prejudicial attitude of pharmacy staff towards people that 'look like' someone who inject drugs (Surratt and Telles 2000).

[27] One outpatient youth clinic was being established in the North Zone at the time of the research. There were no sufficient or in some districts no care services at all available for youth using drugs in Porto Alegre. Lack of out-patient care for youth is one main problem, since services specialize in adults with drug addiction, and usually deny assisting users under 18 years old. Services for youth's mental health, on its turn, deny assisting drug using youngsters. For youth, only detox (in-patient) clinics were available in Porto Alegre at the time of the research.

[28] Nowadays, countries unemployment rates don't present a huge difference (5.9 in Brazil and 4.4 in The Netherlands), but absolute numbers of unemployed and work conditions of those employed are pretty distinct (IMF. 2012). For the period between 2010 and 2012, Amsterdam had an unemployment rate of 6.7% (O+S. 2012). Data available for the metropolitan region of Porto Alegre shows the area follows the country's tendency, with rates going down; in 2011 unemployment rate estimation was of 7.6% (FEE 2012).

[29] There is a disputed vision that regulations to hire civil servants are too rigid: open competitive processes are long and expensive, and dismissing underperformers is not easy. In this vision, special contracts would allow easier hiring-dismissal processes and more competitive salaries according to different categories and geographical areas (Victora et al. 2011).

[30] The 13th month's salary [13° *salário*] is a legal bonus paid for workers in Brazil. It is proportional the number of months worked on a year, and it usually corresponds to one month's salary.

[31] How workers negotiate their beliefs (chapter 3) and the organizational resources and goals they have (chapter 4), and how they interact with each other (chapter 5) and with drug users they assist (chapter 6).

3

Interpretive beliefs and ways of governing users

3 Interpretive beliefs and ways of governing users

Preconceived ideas on desirable citizens and attitudes, and preferred methods to achieve these aims are at the core of policy making. For Colebatch (2004) policy is a central concept in both the analysis and the practice of the way we are governed; policy is used to shape, explain and validate the process of governing:

> 'Policy' is a way of labelling thoughts about the way the world is and the way it might be, and of justifying practices and organizational arrangements (Colebatch 2004:8).

The ways in which we think about governing certain behaviours, such as drug use, are based on certain sets of ideas which are (re)produced by various organizations, individuals, and society at large. In the drug policy field, the different ways of framing problems and solutions influence street level workers in building their own set of ideas and interpretations on how to deal with drug users daily. These discretionary choices workers make and meanings they build around drugs and their users are what I call here 'interpretive beliefs'.

On the ground, street level workers' interpretive beliefs shape the way in which practices and strategies are selected, justified or avoided by workers when in contact with drug users. Interpretive beliefs and the frames they are based on have a central role in understanding mentalities of governance (Dean 2010) and are key factors guiding street level decisions and actions (Maynard-Moody and Musheno 2000).

But how to assess street level workers interpretive beliefs? The present chapter reviews previous studies and proposes a new framework of analysis based on data coming from fieldwork. Special attention is paid to how workers manage to mix the different approaches present in the drug policy field into various sets of interpretive beliefs to justify their choices of certain practices. First, a review on the importance of inter-

pretive beliefs for the making of drug policies is provided; then, the different ways proposed in the literature to assess street level workers' interpretive beliefs and their limitations are debated. A new approach is proposed and applied to analyse social, health and law enforcement street level workers' interpretive beliefs in the cities of Amsterdam and Porto Alegre. Conclusions are drawn by comparing interpretive beliefs across the cities and debating the advantages of the new framework.

Interpretive beliefs in the making of drug policies

In the field of drug policies there are different ways of interpreting drugs and governing their uses. In the literature, this diversity is understood as a source of difficulties both to negotiate the making of formal policies (e.g. Acevedo 2007, Tammi 2005) and implementing them in practice (e.g. Hammett et al. 2005, Pauly 2008, Small et al. 2006). Contradictions are pointed within the UN drug control system[1] (Bewley-Taylor 2005) as well as in different regions and countries (e.g. Chatwin 2007, Fonseca et al. 2007, Tammi 2005, Limbu 2008). In a general perspective, variations in drug policy are represented in two approaches with different aims and priorities, which are usually combined: the 'law enforcement' (or public order) and the 'public health' approach. Law enforcement has been related to the aim of a drug free world, considering use a safety issue to be dealt by the use of repression and punishment. Public health, on the other hand, has been related to a harm reduction approach with the aim of increasing drug users and society's quality of life without the need of completely banning use. Drug use can be dealt by treatment, prevention, and welfare policies.

The literature has reported that countries which adopt a harm reduction approach face difficulties in its introduction and development, both in agreements for officialising policy statements and on how to put the strategy into practice. The orientation of a country's drug policy is one important factor related to possibilities for harm reduction support. According to Heidrich et al (2008), several countries in Europe (such as Germany, Greece, Spain and France) had drug policies oriented towards the abstinence paradigm during the 1970's and 80's, and did not support harm reduction strategies at the beginning. In the Netherlands and the UK, on the contrary, harm reduction principles were already part of the country's policy when harm reduction approach started, leading to a different response (Hedrich et al. 2008). In South America most countries,

including Brazil, had a low tolerance or 'drug free' approach. Experiences with military dictatorship (and its prohibitionist drug policies) and structural violence, need to be considered as important contextual factors in this region (Bastos et al. 2007, Rodrigues 2006, Zaluar 2004) shaping countries responses to the drugs phenomenon.

Acceptance of street level workers towards a new approach is also an important factor shaping practices at a local level. Diverse policy choices demand different roles and practices from workers (more tolerant or repressive, for instance), but workers in their territories can be partisan towards different forms on how to deal with drug use. In this situation constraints might be created, for instance, when workers' interpretive beliefs are different from those indicated by official policy statements, or when workers with different interpretive beliefs have to work together. In these cases, workers might choose to follow their own views regardless of policy statements and its implied interpretations; also workers might have dilemmas regarding their activities and role.

Several studies in the drug policy field have shown that interpretive beliefs about drugs impact workers' behaviour when enacting policy, and consequently, their practices and attitudes towards users. This is observed for different professions in health (e.g. Brener et al. 2007, Cameron et al. 2006, Forman et al. 2001, Humphreys et al. 1996, Malet et al. 2006, Pauly 2008, Phillips and Bourne 2008) as well as in the law enforcement field (e.g. Beletsky et al. 2005, Hammett et al. 2005, Small et al. 2006). In Brazil, for instance, health care workers' values and conceptions were found to be inconsistent with their acceptance of a recently implemented harm reduction approach. These workers' values of abstinence, dependence and disease were stronger than the values associated with harm reduction. The study concludes that workers disagree with harm reduction's ideological foundations, and that this may lead to a ignoring the approach in practice (Queiroz 2007). Other studies (e.g. Delbon et al. 2006, Pauly 2008) report dilemmas of street level workers from health care on how to adapt their previous ideas and activities (related to a only abstinence frame, for instance) to 'fit' the new harm reduction frame. For law enforcement workers, dilemmas relate to a 'double' expectation of being repressive towards drug use but also of collaborating with harm reduction programs (Beyer et al. 2002, Bull 2005, Lister et al. 2007, Lough 1998). This might lead also to contradictory practices, which include police workers seizing syringes given to injection drug us-

ers by outreach programs, and arresting users who possessed them, even when (reformed) law allows syringe possession and purchase (Beletsky et al. 2005, Small et al. 2006).

When workers with different interpretive beliefs and practices have to work together, this might hinder collaboration regarding giving assistance to users. Problems related to different goals, expected roles and professional jargons are said to be fundamental difficulties in building collaboration between care and law enforcement actors all over the world (e.g. Bull 2005, Connolly 2006, Hunter et al. 2005, Rigoni 2006, Vermeulen and Walburg 1998).

In this 'tug of war', scholars have argued until recently that public order has been predominating over public health throughout most of the world (Inciardi and Harrison 2000, Eby 2006). An increase in public health approaches, thus, is seen as the solution. Many countries, notably in the EU and in LA, have developed their drug policies towards a public health approach regarding drug use. Yet, rather than lowering policy contradictions, these developments stimulated new difficulties to integrate public order and public health into the drug use field. The challenges are being transformed. Specially in the countries which have increasingly adopted a public health approach, the debate is not who should have the main role - the law enforcement or the care sector as some scholars say (Hunter et al. 2005). The challenge now is how to integrate these diverse actors and goals into a coherent policy. How to be repressive against illicit trade and use of drugs and worried about health and wellbeing of drugs users at the same time?

'Structural' issues as financial and legal support for harm reduction approach might also be influenced by these different understandings on how drugs use should be tackled, guiding government investment on certain programs, actors and strategies. Besides, social, health and law enforcement workers have inherent differences in their professional background, work environment and expected roles in society, which might elicit different interpretive beliefs and responses to drugs' policy. Looking at how these actors negotiate meanings in their daily tasks will allow a better understanding of the tensions between care and order in the field. Would care workers be always be in favour of public health and law enforcers of public order? And if not, how would a care worker justify the need for punishment and a law enforcement worker for drug treatment and social help for users? Besides that, would the differences

in workers' territories across the ocean produce a different variety of interpretive beliefs for street level workers in Porto Alegre and in Amsterdam? Even, maybe, regardless their professional commitments?

In order to answer these and other questions, it is necessary first to assess and analyse workers' interpretive beliefs on how to deal with drug use. The next section presents a framework for this analysis.

A framework to analyse workers' interpretive beliefs

Studies in the drug field analysed workers' interpretive beliefs in different ways. Some quantitative studies have used psychological scales to measure health workers' values and feelings towards drug users (e.g. Brener et al. 2007, Phillips and Bourne 2008). These studies use (adaptations of) Schwartz' theoretical model of basic human values - see (Schwartz 2012)- to measure, for instance, how open or closed to change workers are. Other quantitative studies, measure workers' beliefs about drug treatment (e.g. Humphreys et al. 1996, Miller and Moyers 1993, Queiroz 2007) by producing statistical models, which emphasize the various conceptualizations of etiology, nature, and treatment of addictions. Through scales, individual workers' beliefs are measured as connected to one main 'model' – for instance, understanding drug addiction as a disease ('disease model') or as function of a poor environment ('psychosocial model'). [2] These studies contribute to the validation and generation of scales to predict workers' positioning regarding drugs. However, they theoretically and epistemologically assume that 'values' or 'beliefs' are universal characteristics, and are expressions of the individual personality of workers. Besides, their statistical models provide a description of worker's interpretive beliefs, but not a situated understanding on how these would interact with other relevant features - such as organizational setting, territories of practice or workers' profession- in drug policy implementation.

Qualitative studies, in comparison to quantitative ones, have mapped health workers' interpretive beliefs in a more contextualized way (e.g. Pauly 2008, Acevedo 2007, Nowlis 1976). They also use the concept of 'models' to emphasize the various ways of thinking about how drug use should be tackled. Each model is seen as an organized and coherent set of beliefs in the drug field, which includes conceptualizations of etiology, nature, and treatment for drug use, similar to their quantitative counterparts. Qualitative studies, however, use these models to analyse national

policies' statements (Acevedo 2007, Acselrad 2000, Nowlis 1976), and workers' interpretive beliefs at the street level (Pauly 2008, Rigoni 2006). They use ethnographies, in-depth interviews, categorization, and/or (different types of) discourse analysis as methods to assess the different ways in which workers interpret problems and solutions for drug use. Therefore, and in comparison to quantitative studies, they provide more sensitive tools to understand how workers' interpretive beliefs interact with daily experiences of putting drug policies into practice. In these studies, beliefs are understood as broader than individual features, being influenced by and influencing the making of different frames around drugs and their users. However, qualitative studies tend to narrow its focus only on the health sector, and usually just one profession in the field (outreach workers or nurses).

Interestingly enough, even though these quantitative and qualitative studies depart from different epistemological stances to understand interpretive beliefs, both tend to work within the framework of ideal-typical internally consistent 'models' through which workers' beliefs would be assessed. In other words, neither address the existence of contradictory 'models' or frames in workers' interpretive beliefs. How would they explain, for instance, workers supporting harm reduction but requiring abstinence to participate in a drug treatment? Considering the coherent patterns of statements which built each frame –in this case harm reduction and medical -, holding interpretive beliefs which combine both frames do not 'fit' the ideal models. The few studies which mention these contradictions, label them simply as an 'eclectic' orientation (Humphreys et al. 1996), or as problems of implementation (e.g. Kroeff et al. 2010, Pauly 2008), meaning either lack of training or lack of understanding from the workers on what a certain approach really means. This explanation might not be the best one; or at least, it is certainly not the only possibility. There is a lack of attention to the processes through which policy statements becomes policy in practice, and the fundamental role of street level workers and their interpretive beliefs in these processes.

In organizational research, far from drug policy studies, street level bureaucracy scholars call attention to the importance of workers' interpretive beliefs in shaping their choices (or discretion) when assisting clients. Lipsky (2010: 108) contends that workers might have preferences for some clients over others, being influenced by 'the diffuse moral assumptions of dominant social orientations' that permeate society. This

'worker bias' would be active, for instance, when street level workers have to decide upon access and eligibility. Maynard-Moody and Musheno (2000), on their turn, show that, when explaining their decision-making processes, street level workers are strongly oriented towards the needs of the people they assist, and towards their own set of 'value systems' (Maynard-Moody and Musheno 2003). For the authors, workers would use these value systems to assess clients by judging their moral worth and then deciding on whether to bend organizational rules and regulations in favour of users' needs or not. [3] Similar to Lipsky, Maynard-Moody and Musheno, do not provide a framework to access street level workers interpretive beliefs, and broadly relate workers' value systems to 'mainstream beliefs about good and bad character' (ibid.:7). These ways of assessing interpretive beliefs carries an underlying assumption that workers would passively accept and adopt main stereotypes in their practices, using their discretion only to selective apply these ready-to-go values in different situations for different people they assist. The same approach, also, misses the connection of workers' interpretive beliefs with different professional status and the production of knowledge which build different frames on how to deal with a certain issue, such as drug use. Without considering these boundaries, with possibilities and limits they establish, workers' interpretive beliefs and their influence on discretion cannot be understood in a grounded manner.

A different way of looking at forms of dealing with drug use, which is widely known in the drug field, is offered by Zinberg (1984) with the concepts of drug, set and setting. The concept of *drug* refers to the chemical substance being used and its properties; *set* corresponds to the user and his/her physical features and personality (including how past history transformed their personality); and *setting* to the environment surrounding drug use (where drug use occurs and with whom). Originally, Zinberg used these concepts to develop an explanatory theory on how drug use is manifested, and how some users acquire a controlled use of drugs. In this theory, the effect caused by a drug in one person is determined by these three factors, with setting being the most important one to define drug control – it can modify rituals of use and social sanctions, bringing use under control. The concepts of drug, set and setting were used by de Kort (1995) in a different direction: to classify and interpret shifts on drug policy statements. The author investigated the shift between a repressive and a socio-medical approach in The Netherlands between 1919

and 1976, analysing their underlying assumptions. In this study, a social medical approach was related to a setting oriented policy, chosen when setting was perceived as the most important factor explaining drug problems and addiction. A repressive approach, on the other hand, was related to a focus on drug and 'set' as explaining factors.

As the author points out, the concepts of drug, set and setting, were useful but not enough to explain why policy in practice was not always in accordance with dominant policy statements: governmental interests and street level workers' interpretive beliefs and attitudes play an important role in the way policy happens in the streets (de Kort 1995). On the ground, a repressive approach might be as well connected to a setting oriented policy, while a social-medical approach might be connected to a policy oriented to drugs and 'set'. Workers interpretive beliefs, thus, transcend the boundaries imposed by 'models' and concepts. How, then, to assess street level workers interpretive beliefs?

When describing their views on drug users and what to do in respect to drug use, workers participating in this study followed an interesting path. Although participants were not asked to talk about why they think people use drugs or become dependent on them, they usually provide an answer for that. It seemed workers needed to build up an explanation for the use in order to localize what would be the problem, to then build up solutions for it. In this way, they expected to be able to change users' lives for the situations perceived as problematic. In workers' descriptions and proposals, it was possible to perceive the influence of the different frames on how to deal with drug use, but not in a deterministic manner: there was a lot of room for the creative negotiation of meanings, and combination of different frames was very common. This grounded data led to the formulation of a new framework to analyse workers' interpretive beliefs, by combining different theories.

Willing to move away from reductive notions, the present study proposes to look at beliefs as both individually and socially constructed, based on inter-changeable choices workers make from the different ways of framing problems and solutions for drug use. From a social constructive perspective, the various approaches towards drug use are constantly being re-built and re-interpreted according to changes in time, culture, or knowledge systems. To account for this flexibility, the term 'frame' is used in this study instead of 'models'. The latter suggests a deterministic positivist epistemology, grounded in a biomedical perspective, and do

not leave much space for flexibility and re-invention. Frame, on the other hand, calls attention to the interpretive factor: it can be understood as an organized set of key-elements or principles that allow a particular interpretation of drug use and what to do with it. In other terms, frames are 'underlying structures of belief, perception and appreciation' (Schön and Rein 1994:23). As already exposed, the main frames proposed in the literature are: the medical, the criminal, the psychosocial, the moral, and the harm reduction frames [4] (see Table 1, chapter 1). Influenced - but not determined - by these frames, workers build what we call here 'interpretive beliefs'. Interpretive beliefs are understood as formulated opinions and mental views workers hold regarding drugs and their users. More specifically, views on what the problem regarding drug use is, how would be the best way to solve it, and who would be responsible to define/apply the solution. These views are often imbued by feelings and a more or less strong commitment to certain ways of dealing with drugs, being therefore a 'belief'. They, however, are not necessarily strong or fixed commitments, but might be inter-changeable over time and place, depending on the context workers are in, having therefore, a strong 'interpretive' element.

The term 'interpretive beliefs' derives inspiration from Potter et al. (1990:212) term of 'interpretive repertoires': 'broadly discernible clusters of terms, descriptions, common-places and figures of speech often clustered around metaphors or vivid images, and often using distinct grammatical constructions and styles'. Departing from a social constructionist perspective and, and in opposition to a mainstream positivist-cognitive psychology (Potter 1996), this approach to discourse analysis affirms that minds do not have fixed essences, but are built from symbolic resources that are available in a particular cultural setting. This calls attention to the variations and situatedness of people's construction of meanings, as well as the agency present in these constructions (Potter et al. 1990). Instead of adopting and adapting to a particular abstract/hermetic 'repertoire', actors would often draw on a number of different sources to build sense of a particular issue. Meanings, therefore, are situated in specific contexts (ibid.), and built through a process of active participation. Within this framework, it is possible to explain how actors might hold beliefs which bring together opposed ideologies (Wetherell et al. 1987), through a process of active interpretation and selection from existing frames.

This emphasis on the practice of mixing elements from various ideal-typical internally consistent frames is what brings the present study close to this approach. However, its closer attention to the structure of discourse in the form of grammatical coherence, metaphors, and tropes to access interpretive repertoires (Potter 1996) is what differs the approach from the analysis proposed here. Rather than focusing on linguistic resources to analyse meaning-making, this study focus on broader systems of beliefs and perceptions on what to do with drug use. It chooses, therefore, the term 'beliefs' instead of 'repertoires'.

Still, based on grounded data on how street level workers describe their interpretive beliefs regarding drug use – first defining a problem to then propose solutions -, the idea of policy as a way of governing seems a useful tool for analysis. Dean (2010) proposes to use a Foucauldian analysis of the attempt to govern the self, to investigate different mentalities of government. This analysis involve four aspects: what we seek to act upon; how we govern; who we are when we are governed in such a way; and why we are governed to achieve which aims. For this chapter, adapting to grounded data, I translate these aspects into four questions which define for drug use: 1) what is the problem; 2) how to deal with it (meaning also which knowledge, practices and institutions are seen as legitimate to do it); 3) who is the subject being governed; and 4) what should be aimed at when governing. To capture nuances and contradictions from street level workers' interpretive beliefs, Dean's approach is combined with the use of frames on how to deal with drug use and with Zinberg's concepts of drug set and setting. While a governmentality approach allows to analyse workers' interpretive beliefs from a policy grounded perspective, the use of frames captures the paradigms embedded in cultural and professional ideas and practices that inform workers' interpretive beliefs. Zinberg's concepts, in their turn, bring a new way of analysing workers' interpretations, offering a common framework to cluster and link problem definitions and solutions proposed.

For this proposed framework, Zinberg's concepts are broadened. Workers' interpretive beliefs focused on the *drug*, emphasise the substance and its chemical properties with its (supposed) dangerous qualities regarding drug related problems. Interpretive beliefs focused on *set* correspond to the physical and emotional features of users, their perceived personality and attitude while being assisted or using the substance, the amount of self-care s/he is able to have and the perceived amount of

control users have over drug use. Finally, *setting* driven interpretive beliefs go beyond the use 'scene' to comprise the importance of cultural and socio-economic environment surrounding drug users and drug use: community resources, leisure and work activities, family and friends.

Table 5 shows how the four questions on mentalities of government can be applied to the frames on drug use (Table 1) and Zinberg concepts. Two subsequent sections apply the proposed framework to explore how street level workers define users and the problems regarding drug use, and the solution and aims they propose to achieve.

Table 5:
A framework to access workers' interpretive beliefs

Frame	Problem	Ideas of user	What to do	Aim
Coercive	Users commit crimes and public nuisance SETTING	Criminal	Punish SET	No problems for society ('others')
Moral	Users have bad behaviour and/or no will SET	Deviant	Personality reformation SET	Morally correct behaviour
Medical	Users are ill and powerless over drugs DRUG	Patient	Drug treatment Guide patient on what to do DRUG/SET	Drug abstinence
Psychosocial	Users have/had unsupportive environments SETTING	Victim	Change environment Psych. treatment (to heal past environment) SETTING/SET	Supportive environment + healthy personality
Harm reduction	Users need care even when using drugs Damage to self and society SET	Health citizen	Enhance users' self-knowledge regarding drug use Modify setting to decrease harm SETTING/SET	Decrease personal and social harms
Human rights	Users are marginalized , their voices are not heard SETTING	Political citizen	Enhance participation SET	Politicization (collective rights)

In this table, frames are still seen in their 'ideal' state, which do not reflect the mixed ways in which workers use them on practice. The ideal frames, however, set the basis for comparison and comprehension of the implications of mixing frames in policy practices. An additional frame to the five ones brought by the literature - the human rights' frame- it is brought in Table 5. It is based on the interviews and observations done with workers. The ways in which workers apply these frames to justify their interpretive beliefs is the focus of the rest of this chapter.

Defining the problem and the people to be governed

A crucial point in an analytic of governance is to identify and examine the particular situations in which governance is considered to be needed (Dean 2010). During in-depth interviews street-level workers defined what they see as problematic situations regarding drug use, when they think their intervention should be called into question. These definitions also carry interpretations about the subject needing the intervention, or, the drug user.

When facing the question to describe a drug user, many street level workers from Amsterdam and Porto Alegre mention diversity. They consider users can be so different from each other as there are people in the world, being hard, or even impossible, to describe 'a' user. During the interviews, however, a number of distinctive features appear in workers' discourses. Features describing drug users were similar for those workers who easily described a common profile for drug users after the question to do so, and for the ones that refused a unique profile in the first place. Interestingly, despite the various territorial differences across Amsterdam and Porto Alegre (especially regarding users' age and socio-economic conditions), there are many similarities in the way workers describe drug users. In Zinberg's (1984) terms, street level workers from both cities put an equal emphasis on set and setting to describe users; the drug occupies an important role in the description only in Porto Alegre. Set and setting features, however, are usually seen in relation to drug use: as a consequence or a cause of it. When one looks ta the ways in which these features are interpreted and combined with the different frames on how to deal with drugs, it is possible to find interesting differences across the ocean. The three main patterns in workers' interpretive

beliefs regarding the problem and the subject under governance are now described.

Unsupportive setting leads to drug use (and crimes)

The cultural and socio-economic environment surrounding drug users and drug use, have a strong weight in the features workers believe to be leading to problematic drug use. In the interviews, workers referred to see users as most likely to be homeless, lack a job or a productive activity, have connection with crimes and other illegal acts, and have family problems. Setting features are specially considered when workers try to define a reason for why people use drugs and/or acquire problems with it. When using the idea of an unsupportive setting leading to drug problems (psychosocial frame), workers interpret the subject to be governed (the user) as a victim of his/her environment.

Many times the same feature is seen both as a problem leading to drug use, and as a consequence of use itself, leading to a vicious cycle from which is hard to escape: the more failures and losses the user has, the more drug use increases as a way of coping with or avoiding problems; the more use becomes an addiction, the more likely problems are going to repeat or increase.

> NL02:[5] Most of them have problems in their families, and they use drugs as an escape from real life… or just had wrong friends and tried some drugs, and then tried some more… and got hooked up. Then they get problems with the family because they need money; so they start asking for money or stealing… Then the family won't support them anymore… and then they are on their own, their relationships crashes; they have to move out or they are in debt with the housing firm; they lose their home and they get homeless. They go to the streets, it is cold, then they use more drugs to get rid of…and then it's adding, adding, adding. (Amsterdam, social worker)

The probability of having an unsupportive setting and developing a problematic relation with drugs, is considered higher for certain populations in each city. Especially vulnerable population are considered to be migrants (or *allochtonen*) in Amsterdam, and slum inhabitants and homeless people in Porto Alegre. Workers from Amsterdam tend to think that drug users from an ethnic minority background got addicted because of the poor social conditions they faced when coming to the country: low

education, lack of employment, non-adaptation to Dutch culture and distance from family. A similar pattern is applied for slum inhabitants and homeless in Porto Alegre: a harsh environment with lack of job opportunities, poor education, lack of a leisure places, and marginalization from mainstream society would have led them to problems.

> BR24: Because I see in my walks in [slum] a lot of 3 or 4 years old children without any activity, watching everything that happens there the whole day, and that's all they know about life. So, what are they going to reproduce tomorrow or after? Probably the same things they are seeing there. And what they are seeing is drug dealing, drug use and… violence, also a lot of family violence sometimes (Porto Alegre, social worker).

> NL06: … in the 70´s it comes the heroin […] and at that time, we had very much people from Suriname and the Dutch Antilles in Amsterdam that were from a lower social class: they were unemployed, no money, bad houses, no social community like they were having in their own country. So, they got into the heroin. […] [Then], you got all typical criminality which is connected with the world of the drugs: burglaries in houses, in cars, robberies, pick pocking... (Amsterdam, law enforcement worker).

Workers who emphasise setting describe problems in a similar way in both cities, however, the intensity the features assume varies. Being homeless in Amsterdam can mean staying out of the shelter for a couple of nights or weeks, using drugs non-stop, for instance. In Porto Alegre, however, homelessness means sleeping in the streets for months, having no place for personal hygiene (and thus being smelly with ragged clothes), and usually having to beg or steal to eat. Despite the territorial differences, what is similar both in Amsterdam and in Porto Alegre is that the status of an outsider (from mainstream society) is seen as bringing along a greater risk of becoming a problematic user and, perhaps, also a criminal. The unsupportive setting is believed to influence users' personality (set) in a way that can leads them to use drugs and, in a worst case scenario, to commit crimes.

For some workers in Amsterdam, also the culture in which ethnic minorities were raised, favoured them to get into drug addiction and criminality. A culture of being in the streets would lead *allochtonen* to have easier contact with drugs and criminality; being more easily boiling-over emotionally, would mean they are more prone to violence; finally, coming from mother-lands which were not so free as the Netherlands re-

garding drugs, would mean they lack knowledge on how to handle drugs use.[6]

The same idea of a setting which negatively influences users personalities (set) and makes them more vulnerable to drug use and criminality is found in the concept of 'destructured families'.[7] For workers in Porto Alegre, more than for those in Amsterdam, lack of a supportive family, or having a 'destructured family' is seen as a fundamental setting feature leading to problematic use (psychosocial frame perspective), and potentially also to crime (coercive frame perspective). Workers believe that these families couldn't give enough love, limits and good examples to follow; absent fathers, non-caring mothers, domestic abuse and violence, family members' involvement with drug use and criminal activities are common features defining such families.

> BR05: A lot of them have families that the mother rejects them. [...] The fathers, they get the woman pregnant and go away…(Porto Alegre, social worker)

The fact that blaming 'destructured families' for drug use and (in worst case scenarios) crimes is mentioned more often in Porto Alegre, may be due to the fact that users are, on average, younger in Porto Alegre than in Amsterdam: family influence tends to be perceived as stronger on youth behaviour than on adults in their mid-40's. The strong influence of psychoanalytical theories during university training of care workers[8] and a closer family culture in Brazil might also contribute to the differences. In any case, both in the cases of *allochtonen's* culture and people from 'destructured families', setting is seen as both shaping users' personality in the past, and providing (or not) support for them in the present.

When workers see setting as leading also to crimes, besides a problematic drug use, the user can be defined as a criminal in need of coercion. The reasons to commit a criminal act, though, are not considered to be due to one's personality (or set), but the setting, making the person who commits a crime also a victim of society.

Uncontrolled drug use brings problems for users and society

Perceived personal features of drug users (or set) are also considered an important source of drug-related problems for workers. The control users manage to have over the substance, and their physical and emotional

characteristics, are the main 'set' features mentioned by workers in Amsterdam and Porto Alegre.

In both cities, a controlled use means that the drug is not the centre of the person's life. How a user in control is described and the extent to which controlled use of drugs is perceived as possible vary across territories. While in Amsterdam most workers mention the existence of controlled users, in comparison with uncontrolled ones, in Porto Alegre few social and health workers do it. Control over drug use is usually described in terms of consequences it has in users' setting; however, since it is defined in terms of personal control over drug use, it is considered a 'set' feature. Controlled users are seen as integrated, productive and not causing trouble to others. Their drug use happens during leisure time; they have productive activities such as a job (formal or informal), have family and/or friends and contact with them, and are able to pay for their own drugs without getting into illegal activities. A controlled use, thus, brings no (or very little) problems for users and society. Uncontrolled users, on the other hand, are described as likely to be homeless or roofless, lost or have problematic contact with family, have debts, have no productive activity (lost job, or is not able to follow school), and to be causing problems to society (such as using drugs in the streets, begging or committing crimes). The problems are both for users and society around them. When workers assume controlled drug use as possible, they are operating in a harm reduction frame.

The difference between cities in terms of interpretive beliefs on the existence of controlled use might be related to the higher availability of harm reduction services and welfare benefits in Amsterdam. In the low-threshold facilities described in chapter 2, Amsterdam users are able to have a place to sleep, to have basic nutrition, clothing, hygiene, have a productive activity, and get some money from small tasks or benefits (thus not needing to commit crimes to survive) even while using drugs. Many drug users, therefore, can achieve a certain integration into what is considered a 'normal life pattern'. This, ultimately, may lead workers to believe in controlled use as a possibility, in a 'seeing is believing' attitude. Since in Porto Alegre being inside care services is generally not allowed when users are under drug effects, less of them are into care. As threshold is higher, most users are perceived as not being able to (and actually cannot) comply with rules or control themselves, leading to a disbelief in this possibility.

Another personal feature considered important to differentiate users and their relation with drug use and self-care is gender. In general terms, women are perceived to have a better level of self-care than men, which would lead them to develop less problems with drugs in comparison to men. Care workers from Amsterdam and Porto Alegre focused on explaining women's behaviour, and diverged on their interpretations about female users' approach to care:

> NL02: Women are usually socially stronger, so they can stand on their own feet a longer period of time than men. […] So I think women … meet people and men on the streets and then they [say] 'oh, come with me, I'll help you'. And of course they have to do something in return but… yeah…There are these men who get off at women who are in problems; they take them in their home, they provide them with a bed and meals and clothes and stuff like that, and in return they ask for sexual favours. (Amsterdam, social worker)

> BR09: The women, they usually get out with their children. As the head of the family, they go search for social assistance, for an appointment to stay in a protected space, running away from a situation of drug dealing and domestic violence. And then they can structure themselves in a shelter or a place to live with their children. (Porto Alegre, social worker)

While in Amsterdam many workers believe women would search for private solutions being helped by men, most Porto Alegre workers think women search for governmental help, running away from damaging situations which may be caused by men. Interesting to note that women's supposed behaviour of exchanging basic needs for sexual favours in Amsterdam is not considered a problem per se. Woman are seen as able to decide whether this is a good or bad exchange, not victims from whom men would take advantage. Here sexual morality does not play a role when defining the subject to be governed. This way of thinking in Amsterdam may be explained by greater gender equality in the country and the official recognition of prostitution as a profession.

In Porto Alegre, differently, workers focus on women's responsibility in taking care of their children. Here 'women' turn to be 'mothers', and maternity is seen as a protective factor pushing women to search for assistance for both her and her children. Female users might be considered able to decide if they want to use drug or not, as long as they can care for their offspring. For most workers, when 'crack mothers' are perceived as

not able to care of their (born or unborn) children due to their drug use, this is a case for State intervention.

While care workers focused on the women to describe gender difference regarding relation with drugs and self-care, law enforcers focused on their perceived nature of men. For these workers, men have more behavioural and criminal problems than women: men are perceived as more aggressive or less conforming than women, and this attitude would make them more exposed to drugs. Men using drugs, thus, tend to be more easily classified as potential criminals in comparison to women.

Emotional characteristics of users (set) are also considered to have an important role in making drug use problematic. Restlessness, aggressiveness, instability, untruthfulness, and a manipulative character are mentioned as a problem both by workers from Amsterdam and Porto Alegre.

> NL27: […] they are very creative in the manipulation…and they use all sorts of ways, from being as sweet as possible to be as angry and violent as possible to get what they want. (Amsterdam, health worker)

These features contribute to the reputation of users as difficult to deal with, and are often considered a reason why users cannot stay in care. Particularly in Amsterdam, many office-based care workers (especially workers from shelters, user rooms and walk in centres) mentioned immaturity as an emotional feature. Users were referred to be like children, being disobedient, not following rules and testing limits. Immaturity was considered to have particular implications for the willingness users have to follow rules, and in the amount of responsibility workers believe users could assume. This interpretation triggers views of users as patients who have to be told what to do, and monitored closely to follow it. At a certain point, however, if emotional problems lead users to commit crimes, they may be seen as criminals. Immaturity as a standing feature in Amsterdam may be linked to the higher average age of users in this city: a 40 years old behaving in a 'rebellious' way may be less accepted than when a young adult does it.

Drug properties cause crimes and low self-care

Last, with less frequency, the drug and its differential chemical properties is considered the main problem for some street level workers. More frequently in Porto Alegre, workers consider crack cocaine's addiction potential as the reason leading users to a problematic use, lack of physical

self-care and, potentially committing crimes. Law enforcement workers from Porto Alegre tend to emphasise crack properties in comparison to social and health workers in the city; they also emphasize the potential of committing crimes because of the drug. The perceived low-level of physical care caused by the drug is mentioned by both sectors, and specially by outreach workers.

Crack users are frequently described as very thin, dirty, smelly, bare feet, and having ragged clothes; they are seen as not careful with their body, nutrition, hygiene and clothing. These visual features are used by outreach workers both to recognize a crack user in the streets and to classify the seriousness of drug use in a first glance:

> BR03: ... those who use the drug intensively, the crack, have this profile. Sometimes we find a user that is just starting, in some dark alley where they are all messy and stinking. Then we find a user who is there but is tidy. […] when we ask him the first thing he say is 'yes, I´m a user'. 'For how long have you been using?' '6 months'. Then we get another one who is messy, dirty and so … We ask them for how long they have been using and it is 2 or 3 years. So we see that the one who is just arriving, he starts to lose his self-care little by little until he gets to the same point that this other one who was there. (Porto Alegre, law enforcement worker).

The loss of ability for self-care and self-organization due to drug use is perceived as a downward trail that will not stop unless someone intervenes. Even if both care and law enforcement workers agree in perceiving low physical-care as a problem, they diverge in their main interpretation of it: while care workers tend to worry with users and their ability to be in care, law enforcers tend to worry with society at large and see users as causing crimes or other ways of public nuisance.

For most law enforcement workers in Porto Alegre, once someone uses crack, s/he would become dependent within a short period, being dragged to a worst case scenario of no self-care, homelessness and crimes. The craving for crack, by itself, is understood as having the power to lead users to become violent and commit crimes.

> BR03: … It is like a survival instinct. If you get a lion and let him hungry, you put any animal in front of him, he is going to kill to eat. The crack addicted, he needs to feel this pleasure, his body is asking for it, his brain doesn't produce [the substance he needs]. So they commit a lot of thefts,

> stealing, burglaries... Anything they can steal to sell, they steal and sell. (Porto Alegre, law enforcement worker).

Since the perceived extremely strong properties of the drug are seen as responsible for driving users to criminality; people seem to have little room for autonomy in resisting drug effects and craving. This opens room for a negotiated mix between seeing users as criminals and also as patients. Users might commit crimes not because they are essentially bad in their nature (moral frame), but because they are sick (medical frame). Many law enforcement workers mentioned to have changed their view from seeing users as immoral criminal, to see them as sick, which reflects the start of an integration between public health and public order in Porto Alegre. Physically uncared users can be also perceived as public nuisance, carrying views that 'normal citizens' do not like to see smelly people with ragged clothes around. Solutions directed to take them out of public sight can be proposed, usually, to be carried out by police workers.

The social and health workers from Porto Alegre who also tended to be concerned about the drug properties in characterizing problems believe that because of the strongly addictive properties of crack, users would be harder to approach than users of other drugs. Crack users are seen as more restless, and harder to keep in care once they are contacted.

> BR06: … the crack is a more serious situation, because people generally make a much repetitive use and it causes more harms. So they really don't access, don't seek, and can't stay in protected spaces, in services[…] I think that's because of the drug effect into the organism, because they need to use more, and more, and more. And they have to score to get resources for that […] In the times of loló[9] or cannabis, they used to access us and other services more often. Now, crack users […] don't allow being approached and receiving guidance (Porto Alegre, social worker)

For these workers, as well as for the law enforcement workers previously mentioned, crack is such a strong drug that it would be nearly impossible for users to control its use. This reinforces the idea of these users as patients.

The fact that drug users are not described by their physical aspects in Amsterdam connects with city differences regarding poverty and homelessness. As it was described in chapter 2, homeless users in Porto Alegre are much more visible or distinguishable from the rest of the population,

since they do not have enough social support to keep them clean and with a good aspect as in Amsterdam. It seems, thus, that street level workers define problems based on what they see in their daily practices.

The emphasis on the drug and its properties in Porto Alegre also reflects the perception of a crack 'epidemic' in Brazil. The drug is considered the evil of society, provoking all sorts of problems and crimes. An important influential factor in this regard might be a massive campaign against crack cocaine happening in Porto Alegre's media in the last years. Horrible images of supposed crack users with a very sick appearance and with dirty and ragged clothes are shown in the TV and posters throughout the city (Picture 46). The campaign affirms crack is an evil drug, making a person addicted very quickly (even after a first trial) and destroying lives.[10] The same feeling of an 'epidemic' surrounded Amsterdam in the 70's, when heroin played an important role in explaining problems and criminality that were arising. When talking about the past, many workers from Amsterdam mentioned heroin as a terrible drug, causing problems of public nuisance, criminality, homelessness and extreme low self-care.

Table 6 applies the framework proposed to summarize workers' interpretive beliefs regarding the main problems related to drug use, and how the users are seen. Comparisons between categories of workers are shown. As it can be seen, the ways in which workers interpret what is a problem in drug use have both similarities and differences across the sectors and the cities studied. For instance, while in Porto Alegre being from the care or the law enforcement sector influences on workers' perception of users as potential criminals, that is not the case in Amsterdam, where both care and law enforcement workers adopt the coercive frame as soon as a criminal act takes place. Not only workers' professional background, but also the multidisciplinary work between care and law enforcement sectors might have a role in explaining these differences. Similarly, territorial features such as a users' age and socio-economic situation, and the presence of low-threshold services offering treatment and financial support for drug users, influence the interpretive beliefs of workers in Porto Alegre and in Amsterdam: including possibilities or not of controlled drug use, use of drugs during pregnancy, and the perception of low physical care. Whether low physical care or uncontrolled use are perceived as a problem for the user only, or also for the society around him/her, is influenced by workers' professional attachment to

care or law enforcement sectors. In sum, both the attachment to different professional sectors and the structural conditions from the different cities, have an important role in how street level workers frame 'the problem' regarding drug use. Also, in many cases, workers interpretive beliefs on problems are built by the combination of two or more frames on how to deal with drug use.

Table 6:
Perceived problems and people to be governed

Problem	Outcome	Ideas of users	Frame	Workers
Unsupportive *setting*	Uncontrolled drug use	Victims	Psychosocial	Most Adam Most care POA
Unsupportive *setting*	Uncontrolled drug use + crimes	Victims	Psychosocial	Most care POA
		Criminal-victims	Psychosocial+ coercion	Most police workers POA Most Adam
Controlled drug use (*set*) (No problem)	-	Health citizen	Harm red.	Most Amsterdam
		Political citizen	Harm red. + Hum. rights	Few care POA
Uncontrolled drug use (*set*)	Bad setting *	Health citizen	Harm red.	Many Amsterdam Some care POA
	Bad setting +crimes	Health citizen - criminal	Harm red.+ coercion	Many Amsterdam
Uncontrolled drug use of women (*set*)	Sex for of drugs	Health citizen	Harm red.	Some care Adam
	Not enough child care	Immoral - Patients	Moral + medical	Most POA
		Health citizen	Harm red.	Few care POA
Bad emotional features (*set*)	Not follow rules, not stay in care	Patients (children in Amsterdam)	Psychosocial + Medical	Most office-based care
	Not follow rules, not stay in care + crimes	Patients +criminals + (health citizens)	Psychosocial + coercive+ harm red.	Most office-based care Adam
Crack cocaine (*drug*)	Low physical care, drug dependency	Patients	Medical	Most outreaches POA
	Low physical care, drug dependency + crimes/nuisance	Criminals +patients	Coercive + medical	Most police workers POA
Crack cocaine (*drug*)	Difficulties to enter/stay in care	Patient	Medical	Many care POA

*Homelessness, joblessness, isolation, debts.

The next section analyses how workers frame the perceived solution for drug use and the aims they believe should be achieved.

Proposing solutions and aims

When first trying to address what to do about drug use, most workers mention there can be diverse solutions, depending on the type of user. [11] When further questioned, workers do offer main solutions they believe in, or in some cases, define situations where no action would be needed.

Not always workers interpretive beliefs about problems definitions and proposed solutions regarding drug use follow a straight logical line. A similar perception on what is the problem regarding drug use can lead to different proposed solutions by workers, and connect, in the same rationale, different practices on what to do about drug use. Most of the solutions proposed are somewhere in the middle of a continuum between a public health and a public order approach. Different approaches and frames are, actually, very often combined in workers interpretive beliefs on how to handle drug use; even the ones at different extremes.

While defining the important features leading to a problematic use of drugs, most workers focus on setting and set, with the drug being prominent only in Porto Alegre. When offering solutions to tackle the problem, however, most workers from both cities focus on the drug. Actions on setting come just after, and are usually proposed in combination with actions on drugs. Solutions focusing on set come in third place, mostly mentioned by social and health workers. Again, here, apart from the similarities, the meanings drug, 'set' and setting solutions assume, and the ways in which they combine different frames around drug use, showed different nuances across the two cases studied, as well as the three professional sectors.

To understand workers' rationality on how to deal with drug use, it is necessary to analyse, separately, the solutions they propose and the aims they want to achieve. Many times workers propose an action on one factor (the drug, for instance), aiming at changes in another (the setting). This helps to explain why workers' reasoning appear to be sinuous, and how they combine frames to justify their actions on the ground. The five main patterns of solutions proposed by workers are now described. Alongside the text, Tables 7, 8 and 9 will, respectively, summarize solutions focused on drug, setting and 'set'.

No action: drug use is a personal right

The differentiation between controlled and problematic use reported by workers when describing users and problems, offers the first boundary to the perceived need of intervention. When a drug user is perceived by workers as having control over the use, no action is seen as necessary by street level workers:

> NL03: … normally you have people that are using heroin for many years every weekend; they have a job but only in the weekend they are using it. So, is this an addiction? Yes. Is it problematic? No. It is not a problem. Do we need to treat this person? Well, if he has no wish to be treated, no! Ok, but he is a hard drug user, but socially embedded, hé? Not a problem; for this person not and for society neither. If the person is using a lot and getting debts or getting problems with the police or he is not able to maintain his relation or he is losing his house; that is a different problem. We have a complete different situation. Then yes, hard drug can influence your life violently in a way that most people don't want; and well, we can treat you perhaps. (Amsterdam, health worker)

Since most workers in Amsterdam perceive controlled use as possible, a belief of 'no action' in these cases is more often mentioned there. If drug use is not perceived as causing very harmful consequences for the society and the person, there is no justifiable governmental intervention. Drug use, then, is seen as a personal choice which shall be respected, and users, as citizens with personal rights. The few care workers from Porto Alegre who mentioned to believe that a controlled use of drugs (especially crack) is possible, also share this perspective.

No drugs in a closed place

Proposed solutions focusing on the drug, in general, refer to drug treatment. The type of treatment proposed varies across the cities and within sectors, as well as the combination it can have with actions on setting or 'set'. One of the proposed combinations is to remove the drug and to change users' setting by putting them into a closed place. This is a solution given by many social and health workers in Porto Alegre, aiming at solving different perceived problems.

Following the ideas of crack as an extremely addictive and harmful drug, and of an unsupportive setting leading to a problematic use, many workers consider confinement to be necessary. A closed place from

where users cannot run away, where they are not under influence of an unsupportive setting which leads them to drug use, and where their craving for crack is controlled by the prescription of legal drugs (medical frame) is seen as the best solution. For these workers, detoxification clinics and therapeutic communities (both in-patient treatment based on drug abstinence) are understood as means to achieve drug abstinence (medical frame), while taking users out of their setting - streets, slum, involvement or debts with drug dealers (psychosocial frame).

In certain situations considered life-threatening, such as extreme low physical care and lack of child care for crack using mothers, a mandatory treatment in a closed place can be considered a good solution by care workers from Porto Alegre. In the case of low physical self-care, mandatory treatment is seen as a temporary solution to give a break in drug use in crisis situations (harm reduction + medical frame). In these cases, abstinence might be a long term aim, but emergency care is the immediate concern. For crack mothers, compulsory treatment is thought of as a solution for women to achieve both drug abstinence and behavioural (set) change in terms of increased self-care and child care. Interesting to note here, that the same solution is not offered for 'crack fathers' – only women behaviour is a target for this action. Moral and coercive frames inform these interpretive beliefs: crack using mothers are judged as deviant, and the loss of parental rights can be added as a protective measure for the children (and punishment for the mother): child rights to safety trumps parental rights to bring up the child.

Also in Amsterdam mandatory drug treatment is offered as a solution, but the situation considered to be extreme and requiring enforcement is for repeating offenders who are drug users. The ISD policy (explained in chapter 2) allows to imprison these users for two years, and oblige them to have drug treatment in jail. Here also, the proposed solution involves a combination of action on the drug and the setting: aims at drug abstinence (medical frame), but also at stopping crimes (coercive frame) committed by users. Behavioral changes on the user by enforcing abstinence, aim at increasing safety for society at large.

A variation of this pattern can be seen in a solution proposed by police workers in Porto Alegre: to curb drug traffic as a way for users to be abstinent. Here the combination of acting on the drug and the setting is present, but the absence of drugs is supposed to be achieved by completely banning drugs from society. With no drugs available, no users

would remain, and no drug related crime would occur. The coercive frame guiding these interpretive beliefs is evident and is visibly connected to police workers' role of curbing drug traffic. As using drugs is understood as depending on market availability, users' agency is practically not taken into account. Table 7 summarizes the different drug-focused solutions proposed by workers: no action, no drugs in a closed place and drug treatment in an open place.

Table 7:
Drug-focused solutions

Problems	Aims	Solution	Frames	Partisans
Controlled use (no problem)	-	**No action**	Harm red. + human rights	Most Adam Few care POA
Crack cocaine	Abstinence	**No drugs in a closed place**	Medical	Many care POA Few police workers POA (PROERD)
Unsupportive setting (+crimes)	Protective setting		Psychosocial + medical	Many care POA
Extreme low physical care	Give a break on drug use		Harm red.+ medical (+coercive)	Many care POA
Uncontrolled drug use of women	Enhance self/ child care		Moral + medical (+coercive)	Many care POA
Uncontrolled drug use +crimes	Abstinence, no crimes		Medical+ coercive	Most Adam
Crack cocaine	Abstinence, no crimes	**No drugs (no drug traffic)**	Coercive	Some police workers POA
Uncontrolled drug use	Users in care, harm reduction, less nuisance	**Drug treatment in an open place**	Harm red. + medical+ public order	Most Adam
	Harm reduction, enhance users' agency		Harm red. + medical	Few care POA
Crack cocaine	Crack abstinence, harm reduction, critical thinking		Harm red. + human rights	Some care POA

Drug treatment in an open place

Both in Amsterdam and in Porto Alegre, many street level workers mention drug treatment in an open service as a good solution for tackling

drug use. But the characteristics these services and drug treatment assumes, vary between the cities. While in Amsterdam out-patient drug treatment means controlled drug use by drug prescription or substitution, in Porto Alegre it usually means abstinence of the drug considered most harmful (crack cocaine) combined with a controlled use of other legal and/or illegal drugs in outpatient clinics. In very few cases in Porto Alegre, it could mean having a controlled use of crack cocaine while being assisted by harm reduction programs (PRDs) in users' own environment (outreach work). The types of services available, together with workers' interpretive beliefs, explain the differences.

In Amsterdam, most workers perceive drug prescription and substitution in the form of heroin prescription and methadone substitution treatment as good strategies. A shared belief among these workers is that many of people they work with will never quit drugs. Even when workers would prefer users to stop with drugs, they believe this is very difficult to achieve, as relapses are much more frequent then recoveries. The best solution, thus, is to reduce the harms from use (harm reduction frame) by providing the drug in a controlled way, or substituting it for a less harmful drug (combination with medical frame). Here, the focus of the action is on the drug, which is administered or controlled in a medical setting perceived as safer.

> NL39: When you put them into detox to get them clean, two days after they will be using hard drugs. They tried many, many times, so that's over, they don't want that anymore. We use the methadone so the pressure of scoring to get drugs isn't there anymore […] but you must not, you cannot make obligatory, say 'you have to be clean'. Then they won't accept it, then they will go away. (Amsterdam, social worker)

An important perceived effect of harm reduction strategies is to attract and keep users in the care system. The combination of a harm reduction and a medical frame, with the drug being administered as a medicine, is used as a decoy to attract users and influence their behaviour, or, to change set.

> NL29: And … because of the fact that methadone itself is an attractive product that people come for it and get in touch with services… it works like a sort of glue, hé? It glues health services to patients. And the recipe is simply exploiting this established contact by improving the situation and treating the addiction but also all the mental health and social problems

> […] if you have a tolerance to opiates and you stop use you come in withdraw, and methadone takes away the withdrawal symptoms! [So] they have a physical motivation to come and to stay. It has nothing to do with motivation for abstinence! What you can do, hé, is to exploit, to use this existing contact and try to influence behavior, by what we would call today behavior therapy. (Amsterdam, health worker).

Dependency here is seen as a disease, and the possibility to control it is in the hands of the workers who prescribe drugs and monitor users' behaviour. These are, more specifically, workers from the health sector.

What is interesting here is the 'twist' occurred by the combination of a medical and a harm reduction frame: abstinence is not necessary, as long as (hard) drug use is controlled by the use of medically prescribed drugs. Besides the medical frame, another important factor contributing to the wide acceptance of controlled drug use as a solution in Amsterdam comes from the coercive frame: the perceived effects heroin prescription and methadone substitution have on public nuisance. Most workers in Amsterdam believe that by having users controlling their addiction through treating the drug as a medicine, the aim of having less crime and nuisance in the streets can be achieved:

> NL06: Because when they are getting their heroin like a medicine, there is not a reason to get burglaries, to have robberies, to steal... they got other life. The main thing is the addiction. So, it is very important what to do with it. (Amsterdam, law enforcer)

An action on the drug together with a modified setting in which the use is made, allows society to have a cleaner and safer environment, free from drug use scenes. This combination of the medical, the coercive and the harm reduction frames ultimately justifies Amsterdam workers' support for harm reduction practices: the strategy it is not only about being flexible with drug users and allowing them to keep using drugs while in care, but also about bringing safety for community in general, given that changing users' behaviour leads to decreasing crimes and nuisance in the streets.

In Porto Alegre, on the other hand, drug treatment in an open place does not entail prescription of illegal drugs or drug substitution. When outpatient treatment is offered as a solution, the aim pursued is usually to remove the most harmful drug (crack) (medical frame), while keeping the use of others (alcohol and maybe cannabis, for instance) under con-

trol (harm reduction frame). The action here is in the drug, but since drug use is not allowed inside services, the setting on which drugs are consumed is not modified. Rather, changes are directly aimed at users' behavior and personality (set). Group discussions and therapy, as well as individual therapy and guidance, are done expecting users can improve self-care and awareness of use, being more critically conscious about their choices in life. The belief in cracks' strong potential for addiction restrains Porto Alegre workers from believing that harm reduction could be a good strategy for this drug: controlling crack use is considered impossible or very hard to achieve. The same reasoning, however, do not apply to Amsterdam workers regarding heroin, as the solutions offered for craving involve harm reduction strategies. Even in the times of the heroin epidemic, as other solutions failed, harm reduction was seen as a way out. Why did not Porto Alegre workers get to a similar solution?

One reason may be the type of hard drug used when harm reduction was established. Both heroin and crack are considered very addictive substances, provoking hard withdrawal symptoms. For heroin, medicine found a substitute in methadone to stabilize addiction; for crack, no effective substitute or 'cocadone' has been found. Crack users have developed their own strategy to control the craving by the use of cannabis. Considering cannabis a medicine and prescribing it to curb crack craving is, at least, very controversial in the medical discourse and practice. Therefore, harm reduction for crack keeps being a question mark in terms of drug solutions. PRDs in Brazil have developed a harm reduction strategy of distributing or exchanging pipes (to smoke crack), usually carried out by outreach workers. Having a private pipe (not sharing it) instead of using a soda or beer can (usually out of the garbage bin) to smoke the drug, potentially reduces transmissible diseases (leptospirosis, tuberculosis, hepatitis) and lips-burning. The strategy, however, is not always supported by the government, and cannot be found in out-patient clinics. In Amsterdam, no specific harm reduction strategies can be found for crack based on the drug, but crack users benefit from the low threshold services allowing drug use in protected spaces (setting).

Few care workers from Porto Alegre mentioned to prefer harm reduction solutions (not combined with medical solutions) for crack cocaine use. These were, more often outreach workers. These outreaches provide crack users with counseling about pipes or about the use of cannabis to fight craving. These are, also, the ones who have more dilemmas

regarding offering mandatory treatment as a solution when dealing with low self-care or crack mothers. The problem, for them, is to define a limit: when it is not possible anymore to give the woman a chance to try to cope with the situation, since users' agency and rights are taken very seriously. Workers try to respect mothers' feelings that the mother-child bond can have a potential curative power: enhancing the contact and woman's responsibility over the child care could trigger her own self-care and use control or abstinence. Also, workers worry about who will take care of the children while the mother is in confinement for drug treatment or after children are legally taken away from her. Without a good carer, the child can be in the same or even in a worst situation than with the addicted mother. Workers who believe in harm reduction strategies for crack in Porto Alegre believe in users' agency to control drug use without medical intervention. This differs from how harm reduction for heroin or crack is understood in Amsterdam. The fact that harm reduction are very rarely offered as a solution for drug use in Porto Alegre, might also reflect services availability: very few outreach programs officially working in this direction.

Supportive setting for users

Acting on setting is a popular solution among most social workers from both cities, which reflects their professional attachments, but also health workers and law enforcers mention it. Investments in setting are usually described in terms of social benefits: housing, nutrition, daily activities such as sports, leisure and/or jobs, and help with basic documents (such as ID, health card or insurance, benefits). Financial support and the possibility of a safe place to use drugs – in user rooms and shelters allowing drug use- are mentioned in Amsterdam, reflecting the availability of these benefits in this city.

Especially for social and health workers, one of the aims to be achieved when acting on setting is meeting users' basic needs, which is perceived as facilitating them to enter and stay in drug treatment. For these workers, having food, shower, clothes, shelter, transportation to get to the health center, plus work and education opportunities (setting), can increase users' willingness for self-care and their ability (set) to follow a drug treatment, which, at the end, influence their choice and frequency of drug use (drug).

> NL08: Because you imagine that someone has an addiction, but has no income, and he is homeless.. It is always a priority to have a kind of basic and then, maybe then, people will talk about get treatment for their addiction. (Amsterdam, health worker).

In Amsterdam workers believe that investment on setting has to be prior to an investment on drug. A drug treatment is not seen as possible to happen without having basic needs assisted. In Porto Alegre, differently, acting on setting is seen as increasing the chances of contact with service providers and permanence in care, but not as an absolute criteria for starting or maintaining a drug treatment. These differences are related to actual social and welfare conditions in each city: in Amsterdam, welfare can assure the basic needs for drug users; in Porto Alegre, not. Therefore, even if Porto Alegre workers believe in the need for investing in setting, they lack resources to effectively do it, and thus, see this investment more as a 'better option' than a strictly necessary one.

Some workers from Porto Alegre, both from care and law enforcement sectors, mention another type of investment in setting, which is acting on users' family. Following their belief that families can be responsible for users' problems with drugs, workers believe that families should be treated together with users.

> BR13: [We] would have to work with the family, to start with the family to get to them [users]. I think that's the main task, otherwise you cannot get [to them]. Because, then, what's the point? He goes to detox, spend 20 days and goes back to the family that keeps using drugs and behaving the same way. He is going to relapse! (Porto Alegre, social worker)

The family is perceived as having a fundamental importance not only as being possibly causal in problematic drug use, but also as an important source of support for users' treatment. Workers believed that in the process of addiction, or even before that, the family would have dysfunctional aspects and develop patterns that lead their member to use drugs in a problematic way. The psychosocial frame where the environment and its patterns influence users' behavior influence this belief. Acting on the family is also seen as able to prevent a dysfunctional personality, and by these means, future (problematic) drug use. Focusing on family only in Porto Alegre relates both to the younger age of users in this city and the already mentioned concept of 'destructured families' influencing workers' education and societal norms.

Another proposed solution for drug use focused on setting is to keep users busy with daily activities. This solution was proposed by many workers in Amsterdam and some workers in Porto Alegre, both from all sectors. Activities are supposed to help users to manage their time and energy in more healthy ways, taking the focus away from the drug, socializing, and getting more structure in life.

> BR08: … to stimulate other possibilities of leisure, sport, education places, acquaintance places, I think this could do a certain dislocation, where the drug use could be at least questioned. 'If I'm not doing this, what am I going to do', right? Well, maybe there are other things, other pleasures, other possible satisfactions, because you don't stay with an only object [the drug]. (Porto Alegre, social worker)

> NL03: [they need] these work activities or day activities, so people have something to be proud of, to be busy, something to look forward during the weekend. When you are not working all the days are the same, so the moment you walk in the town you see 'Oh, the shops are closed, it must be Sunday!', so that happens to many of them. And often yes, the work is important, you meet a lot of people, and it gives some meaning to your life. (Amsterdam, health worker).

The type of activities mentioned vary in the two cities. While in Amsterdam activities relate to the possibility of making some money, that is not always the case in Porto Alegre. Amsterdam workers mentioned small tasks (such as cleaning the facility, picking up garbage in the streets, washing clothes, cooking) offered by some services where users can make pocket money, or part time work people have to do in order to receive their full social benefit. In Porto Alegre, workers mostly mentioned sports and leisure; school (for youngsters) and work were mentioned in a lesser extent.

These differences, again, reflect the different social and welfare conditions on each city. In Porto Alegre, users in general do not receive any financial benefit, and mostly work as garbage pickers or have other informal jobs (legal or illegal) to make their living. Income generation projects are very rarely frequented by people with problematic drug use, also because of the high threshold in terms of behaviour requirements for these programs. Slums and poor neighbourhoods from where many users come, usually have no leisure spaces, and, as it was already seen, this lack of structure and better options for fun, is seen by workers as one of

the reasons why people end up choosing drugs. Activities for seeking other pleasures than the drug, thus, assume a great importance in Porto Alegre. This way of thinking mixes, thus, psychosocial frame by acting on the unsupportive environment, with a harm reduction frame (not necessarily aiming at drug abstinence, but decreasing harms). This also includes the effect on set of learning to have a more structured life (Amsterdam), or finding other sources of pleasure rather than the drug (Porto Alegre). Since most users in Porto Alegre have to work in informal tasks to be able to survive, this is not seen as missing for them.

Specially in Amsterdam the workers proposing to invest in setting for users, have another aim than increasing users' health and control over drug use. By providing users with basic needs, workers from all sectors perceive they also decrease public nuisance and crimes in the streets.

As expected, law enforcers see fighting public nuisance caused by users as part of their main role, as an aspect of fighting crime and keeping public order. Surprisingly, also care workers from Amsterdam see fighting nuisance as part of their role, or, as a positive consequence of their job. For these workers, taking users off the streets means improving their life quality.

> NL15: What you see now is that the number of homeless people dropped tremendously; there are still some in Amsterdam. In a lot of shelters people are not asked to stop using drugs, they are allowed to use inside, they have their own consumption rooms, it reduces the visibility of drug use in the streets and people get jobs or something to do; they don't stop their use of drugs, but they are being taken care off. This helped a lot in drug policy, in terms of nuisance and health problems (Amsterdam, health worker).

Housing, financial support and user' rooms for users are understood to increase safety and to promote a clean environment for society in general. This interpretive belief, again, reflects actual services available in Amsterdam: and increased offer of shelters and other facilities allowing drug use, means many users out of the streets. These measures, similarly to user rooms, are believed to be responsible for users staying inside services. Users inside services and receiving money from social benefit means no need for crimes and no (or less) drug related nuisance for society.

This way of thinking about how to deal with drug use mixes different frames: the unsupportive setting is modified by providing users with basic needs (psychosocial frame) and drug use is made possible inside services (harm reduction) to keep users inside care. This is believed to affect users' self-care (set) and may affect their relationship with the drug; ultimately, not needing to get money for daily activities and not needing to use drugs in the open air will decrease nuisance and crimes in the streets (coercive or public order frame). This perceived effects of user rooms, drug shelters and financial benefit makes possible for law enforcement workers to justify their support for these benefits. In other words, this justifies the combination of public health and public order in Amsterdam.

Table 8:
Setting-focused solutions

Problems	Aims	Solution	Frames	Partisans
Lack of basic care	Provide basic needs, users in care	**Supportive setting**	Psychosocial	Many social POA Some health POA
Lack of basic care (+nuisance)	Provide basic needs and safe space to use drugs, users in care, less nuisance		Psychosocial + harm red.+ public order	Most social Adam Many health Adam
Unstructured families	Treat family, prevent (problematic) use		Psychosocial	Some POA
Lack of daily activities	Leisure, less drug focus, other pleasures		Psychosocial +harm red.	Care POA
Lack of daily activities (+nuisance/ crimes)	Activities for money and structure; less crimes, drug focus and nuisance		Psychosocial +public order + harm red.	Many Adam
	Mandatory work; less crimes and nuisance, more structure	**Supportive/ coercive setting**	Psychosocial + public order	Few police workers POA

Changes on users' setting with the objective of promoting public order were also a solution offered by few workers from Porto Alegre, all of them from the police force. In this, enforced labour is offered as an activity to solve drug problem when users are committing crimes. Workers perceive this would give structure to drug users and offer them a chance

to pay their debts to society. Enforced labour assumes the feature of a punishment (coercive frame), changing the setting (psychosocial frame) to promote a moral reform on users' personality (moral frame) and achieve drug abstinence (medical frame). In this case, the coercive frame assumes more clearly the feature of punishment than of public order only, and changes on setting can be said to be less 'supportive' than the solution offered in Amsterdam.

The power of users' will

Finally, actions primarily focused on 'set', or users' personality, are the least mentioned, and solutions of this type were proposed only in Porto Alegre. Focusing on set connects to develop or enhance users' will, but law enforcement and care workers mentioned different ways to get there, departing from a different perception of drug users.

Many police workers from Porto Alegre, understand users' will as their willingness to stop drug use, and consider this to be the only efficient way to get abstinent.

> BR03: Look ... [sigh], honestly... The recovery comes from the person, I think. From the moment the person wants to recover, he doesn't need a clinic, doesn't need anything. He can do it. [...] because I believe there is no point in treating a person... is like preparing him not to go to a war and then putting him in the middle of a war. He is not prepared to be there, because he is going to die back there, it is the person' weakness, there is no way. You treat and then you throw him back there where he had fallen...he is going to fall again. I honestly don't believe in recovery clinics (Porto Alegre, law enforcement worker).

Police workers' interpretive beliefs in investment in set, aiming at drug abstinence, comes from their perceived failure of drug treatment and welfare support. Workers mention repeatedly seeing users going into treatment and then getting back to the streets and drug use in a short period. Based on their experience, they believe the solution is the person to be strong to resist to the drugs and its properties, and drug friends and setting in general. Despite users here are seen potentially as victims, they are understood as able to assume responsibilities in order to control their lives. To be responsible, for these workers, means opting for abstinence (medical frame). The emphasis police workers give to the need of promoting users' will can also reflect the changing view of users as crim-

inals in need of punishment to a view were users' agency has to be taken into account for a successful intervention. This type of agency denies the view of users as patients, and puts the responsibility of changes on the user alone.

A different view of enhancing users' will as a solution to deal with drug use was offered by few care workers from Porto Alegre. This related to the idea of users as political citizens who are entitled to have an opinion and to be heard. More than only aiming at reducing the harms of drug use, the aim is to enhance participation and citizenship of users. Workers believed that they should help users in developing a critical view on life choices (which includes the choice for using drugs), increasing their autonomy to decide upon their lives, and to organize collectively in a search for rights. Group interventions, therapy and guidance were the means chosen to develop this (collective) reflexivity. Autonomy assumes an important role, even if users are being helped by street level workers. Users should grow independent from drugs, care services and workers, and be allowed to live according to his/her choices. The basic idea is to break the notion of a patient who has to be told what to do by social or health worker, and is able to make his/her own choices. Here, thus, harm reduction frame is connected to a human rights frame, where rights are not only seen as the private right to use drugs, but also the collective right of being heard and not marginalized by one's way of life. An action on set, enhancing users' reflexivity, is supposed have an effect on their life choices and drug use, which is not necessarily mediated by changes in setting or the specific drug they are using. These interpretive beliefs were usually informed by collective health ideas.

It is interesting to note that most social and health workers in Porto Alegre agreed with the idea of developing people' autonomy and political participation as a necessary feature of care. Excepting for the few workers described above, however, these interpretive beliefs were held only for actions not related to drug use. Once the question was what to do with drug use, many workers turned to stricter approaches: abstinence, either by will or enforced. Workers holding these interpretive beliefs were usually the ones who put a greater emphasis on the drug when describing users. For them, autonomy was not possible when using crack cocaine, as the drug would be too strong to allow critical thoughts and control.

It is curious, still, that enhancing users' will was not offered as a solution in Amsterdam. Given that this city, and the Netherlands in general, are widely recognized as liberal towards drug use, this was not to be expected. One of the reasons for this absence, might be that the idea of respecting users' rights of choice is already part of the system. In most low-threshold facilities, users can be attached when they want, and there is no need of engaging in any specific type of activity of treatment to benefit from the service, besides accepting some rules. Workers are there for when users decide to take a further step. As long as users do not disturb society at large with public nuisance, debts or crimes, they have their will respected. Few users and users' representatives from Amsterdam did mention political participation as important, mainly regarding users' participation in services councils and in drug policy planning. Criticisms were directed towards the extent to which users really had a voice to make decisions. Workers in Amsterdam did not mention enhancing this level of citizenship as a possible activity for them to be involved with.

Table 9 summarizes the set focused solutions debated here.

Table 9:
Set-focused solutions

Problems	Aims	Solution	Frames	Partisans
Crack cocaine	Abstinence	**Users' will**	Moral	Many police workers POA
Lack of choice and participation	Enhance users' participation and critical thinking; groups		Human rights	Some care POA

The last section contains some concluding remarks. It emphasises how street level workers discretionary choices and combinations around drug frames create different meanings for harm reduction and law enforcement in the different territories, and for different professional sectors.

Pulling pieces together: interpretive beliefs and frames' combinations

The literature on drug policies (e.g. Humphreys et al. 1996, Pauly 2008, Queiroz 2007) proposes different frames to explain the diverse interpretive beliefs of workers in the field. As this chapter shows, however, street level workers' discretionary choices cannot be understood in terms of a main or exclusive adoption of the coercive, moral, medical, psychosocial or harm reduction frames. Workers' discretionary choices also, go beyond simply adopting or being influenced by 'mainstream beliefs about good and bad character' as some scholars (Maynard-Moody and Musheno 2003) in the street level bureaucracy field affirm. When using their discretion to deal with the diversity of perceptions and possible actions in the drug use field, workers create, mix, and transform policy and the assumptions (frames) policies are based on. In these processes, workers create different meanings for policy approaches. Instead of ignoring or understanding mixes as 'implementation problems' due to workers' poor comprehension of approaches, or to take an 'eclectic attitude', as previous studies did, the present research proposes to see mixes as a fundamental part of the policy processes, and as strategic choices workers make to justify their practices.

The framework proposed to analyse workers' interpretive beliefs, grounded on workers' descriptions and complemented by the theoretical approaches of frames, Zinberg's (1984) drug, 'set' and setting, and Dean's (2010) approach to governmentality, allows a broader understanding of workers' discretionary choices for different ways of interpreting problems and solutions for drug use. By analysing interpretive beliefs of workers from three different sectors (health, social and law enforcement) on 40 different service delivery locations distributed across Amsterdam and Porto Alegre, a more dynamic comprehension of discretion was reached. Overall, most of the workers in both cities hold their interpretive beliefs somewhere in the middle of the so-called public health and public order approaches, using both strategies in mixed ways depending on the situations they find. The ways in which workers negotiate between the different frames, and the type of interpretive beliefs they build, have tight connections both with the territories workers' find in each city, and their attachment to a certain professional sector. In other words, discretionary choices in terms of interpretive beliefs happen dif-

ferently in the different territories and sectors, although similarities can also be seen.

In Zinberg (1984) terms, street level workers from Amsterdam and Porto Alegre put a similar emphasis on 'set' and setting to define what would be problematic about drug use, with the drug itself occupying an important role only in Porto Alegre. When offering solutions to tackle the problem, however, workers mostly propose actions focused on the drug in both cities, usually in combinations with actions on setting. The ways and intensities in which drug, set or setting are evoked and defined, and the frames combined to form the different problems and solutions proposed around these features, however, may vary.

The fact that in Amsterdam organizations have more resources available, for instance, make workers from this city slightly more prone to propose providing a supportive setting for drug users as a solution for tackling drug use than in Porto Alegre. Both when defining unsupportive setting as a problem leading to drug use, and when offering setting-focused solutions, workers from the different cities hold different interpretations for this feature. What is considered to be the minimum acceptable to define setting as supportive –or what basic needs are-, is defined in different ways in the cases studied, being adapted to their actual socio-economic conditions. While housing in Amsterdam means having your own house, or your own and stable bedroom in a shelter, for instance, in Porto Alegre means sharing a room with 10 to 20 people in a night shelter.

Differences in drug users' socio-economic conditions and the type of services available in the different cities also influence interpretive beliefs' construction around setting problems and solutions. While in Amsterdam workers aim at providing users with paid activities, for example, as a solution for lack of daily activities, in Porto Alegre the aim for the same problem relates to leisure and sports. The types of frames combined are also different in this regard. Setting focused solutions involve, in both cities, the use of a psychosocial frame in combination with harm reduction and/or public order frame. In Amsterdam, lack of daily activities as a problem is seen as possibly combined with crimes and nuisance by workers from all sectors, with paid activities as a solution (in a mix of psychosocial, public order and harm reduction frames). In Porto Alegre, only law enforcement workers combine psychosocial and public order frames, but with the different aim of supporting enforced work. Care

workers, on the other hand, do not consider crimes in their interpretive beliefs, and choose to combine a psychosocial and a harm reduction frame to propose leisure activities as a possibility for decreasing the focus on the drug while substituting it for other pleasures.

Regarding drug focused solutions, they usually include either/or harm reduction and medical frames, combined with coercive, psychosocial, moral, and/or human rights. Only in the case of police workers from Porto Alegre neither medical nor harm reduction frames appear, but the coercive one takes the lead, with the solution of curbing drug traffic proposed. The differences in terms of law enforcement workers' interpretive beliefs across cities, regardless their attachment to the same professional sector, can be understood by the variations in their policing style and consequent job descriptions. While in Porto Alegre police's main task is to curb crime and, indeed, drug traffic, in Amsterdam community police workers are the ones mainly responsible for approaching drug users; these community police workers have as part of their tasks, the contact with care services aiming at decreasing nuisance while pushing users into care.

Interesting also is to notice how the different frame combinations workers' make in Amsterdam and Porto Alegre end up producing different meanings for care and order. In Amsterdam drug solutions mostly aim at developing controlled drug use by offering drug treatment in an open place (usually methadone maintenance or heroin prescription). Both care and law enforcement workers have a common reasoning that these actions not only help to increase users' well-being and keep them in care, but also help to decrease nuisance for other citizens. Harm reduction, medical and coercive frames are put together to justify workers' interpretive beliefs. In Porto Alegre, harm reduction and medical frames are also combined, but with a different meaning: drug focused solutions usually aim at abstinence (medical frame), at least of the drug considered most harmful (usually crack cocaine – harm reduction). No drugs in a closed place is the main solution offered by care workers, who believe a controlled use of crack cannot be achieved without a closed setting. For this, workers believe in referring users to detox programs in hospitals, detox clinics for youth or longer period treatments in Therapeutic Communities. Depending on the intended aims, different frames are combined in workers' interpretive beliefs: abstinence (medical only), giving drug use a break (medical +harm reduction /+coercive when en-

forced), enhancing self-care of crack mothers (moral +medical/ +coercive when enforced) or providing a protective setting for users (medical + psychosocial). Similar frame combinations, thus, can carry different interpretive beliefs, connected to the type of resources available in each city.

Despite an arguably general stricter approach towards drug use in Porto Alegre, as a main pattern, health and social workers' solutions focused on drug in this city do not aim at decreasing nuisance for others, as in Amsterdam. Rather, they are focused on improving users' well-being and changing behaviour. The different positions of street level workers across the cities regarding the use of a human rights frame relates to these differences. In Amsterdam the human rights frame is used by workers, in combination with harm reduction, in the cases where no intervention is perceived as necessary (when drug use is perceived to be under control). In Porto Alegre, even though less workers mention the possibility of no intervention, human rights frame is used (in combination with harm reduction or alone) to offer a focus on collective reflexivity and political participation of users as solutions for drug use. The same does not happen in so-called 'laissez faire' Amsterdam.

Workers' interpretive beliefs also show variation regarding to cases when crime is committed by a drug user. In Porto Alegre, workers' interpretive beliefs clearly change across sectors. Care workers tend to interpret users who commit crimes still as victims or patients only (psychosocial and/or medical frame), and propose solutions based on the need for social and/or health services. Law enforcement workers in this city, however, tend to emphasize users' role as criminals (coercive frame) and propose punishment. In Amsterdam, once a user commits a crime, s/he is interpreted as a criminal by workers from all sectors, but usually combined with a victim or a patient role. The explanation for the differences rely not only on professional sectors isolated from each other, but also on the higher level of integration between care and law enforcement, and higher level of welfare state support in Amsterdam. For social and health workers in Porto Alegre, approaches towards public nuisance are usually seen as unjustifiable, since are not understood as bringing benefits to users. These differences relate also with how workers perceived problems: despite the fact that in Porto Alegre crimes and violence are much higher than in Amsterdam, drug users are much more often perceived as potential criminals (and nuisance makers) in this city. When crimes become a

problem related to drug use, the focus of action may shift from increasing life quality for users, to worrying about society's safety as a priority.

Finally, in a general view, the cases studied present different main patterns of interpretive beliefs. While in Amsterdam workers tend to share similar interpretive beliefs across sectors, in Porto Alegre social and health workers tend to share similar interpretive beliefs, while law enforcers have a different position. Also, while in Amsterdam interpretive beliefs tend to be clustered, in Porto Alegre more variations and extreme patterns seem to occur.

Notes

[1] Contradictions have been pointed between the UN drug control system and UN core values. Areas under discussion are those related to: sovereignty and jurisdiction of countries in choosing their own path to deal with drug policies; mixed messages about harm reduction interventions and support of approaches that are considered to harm human rights of drug users; the support of prohibitive drug policies for the maintenance of international peace and security, that ends up on increasing terrorism and transnational organized crime; and solutions to health, social and economic problems related to drug use that appear to be contrary to the UN's Millennium Development Goal related to the spread of HIV/Aids (Bewley-Taylor 2005).

[2] Humphreys et al scale, for instance, contained 3 sub-scales, based on different models. The 7-item 'disease model' subscale, assessed the beliefs that substance abuse is a disorder that can only be arrested (not cured) trough abstinence; the 5-item 'psychosocial model' subscale assessed beliefs that substance abuse is a learned behaviour; and the 7-item 'eclectic orientation model' subscale reflects the belief that people who use drugs are diverse and therefore need diverse treatments (Humphreys et al. 1996).

[3] Maynard-Moody and Musheno (2003) developed their theory based on street level workers' stories about decisions on fairness and unfairness in schools, police workers departments and vocational rehabilitation agencies in the US.

[4] Besides these, other frames include the 'eclectic frame', specifically for the treatment field (Humphreys et al. 1996, Miller and Moyers 1993); and the 'socio cultural' for the prevention field (Nowlis 1975). In more recent publications, however, these frames are not used.

[5] In order to respect workers' rights to secrecy, all the interviewees received codes in place of their real names. Interviewees from Amsterdam received the code NL (Netherlands) followed by the number referent to the chronological order of interview (NL01 to NL41). Interviewees from Porto Alegre received the code BR

(Brazil) also followed by the number referent to the chronological order of interview (BR01 to BR41).

[6] In all these beliefs about problematic drug use and *allochtonen* seem to be implied the idea of outsiders that come to bring problems. This seems to be recurrent in criminology and in the drug scene. In conversations held during fieldwork observations in Amsterdam with people who use drugs and who were from ethnic minorities, there was also a perception from their side of a clash and non-adaptation with Dutch culture. They usually perceived themselves as non-welcomed in the country, and target of prejudices and differential treatment by general Dutch citizens, and some street level workers from the police workers. It is good to remember that in the Netherlands there was also a political change towards a more right-wing composition, and the context is becoming stricter and less receptive towards ethnic minorities' migrants in the last years. This might reflect as well more strict and prejudicial beliefs towards this population.

[7] The concept of destructured families is defined in opposition to the traditional middle class family model: provider father, caring mother and well educated children. The concept is based on a psychoanalytical perspective that defines the traditional family as the base for a healthy emotional development of the human being. Families considered to be dysfunctional are mono parental, usually with father's absence, or with grandmothers, aunts or neighbours taking care of the children. All those correspond to very common family configuration in the less economically favoured classes. With the concept of destructured families, however, these features acquired an explanatory power for drug use, domestic violence and criminal involvement. The concept brings an artificial separation between individuals and the context they live in society (Rauter 2011), by imposing a model of good emotional development that is not compatible with certain economic conditions or life styles.

[8] In The Netherlands, differently, cognitive-behavioural theories are more popular. While psychoanalysis focus more on personal reflexivity about how past history influence present situations (considering the unconscious level), cognitive-behavioural psychology focus on training behaviour and cognition in a more conscious level.

[9] Loló is the name given to an inhalant drug that was very popular among homeless and poor youth before crack. Its composition is not precise, as it is clandestine and home-made, but it usually contains a mix of ether, chloroform, benzene, and ethylic alcohol.

[10] The campaign, called 'Crack, no way' (Crack nem pensar), is done by the government together with one of the most powerful TV media in the south - RBS TV.

[11] During interviews workers were asked about 'how would be the best way of dealing with hard drugs use' for them. General options were suggested to interviewees, together with the question, to assure more consistency in the answers, avoiding too broad comments. The options given were health care, social care and law enforcement. When considered necessary to complement workers answer, a more detailed probe was used for each one of the options. For health care, the probe was for abstinence-based treatment, harm reduction, methadone maintenance treatment, users' room, detoxification, and out-patient; for social care probe was financial benefits, housing, and work; and for law enforcement probe was arresting users, giving them fines, community work as punishment, and enforced treatment. During other parts of the interviews workers also mentioned what they thought would be best to do, and this material was also considered in the analysis.

4

Negotiating organizational structure and citizen's needs

4 Negotiating organizational structure and citizen's needs

For Lipksy (2010), the main reason why workers have dilemmas on how to put policy into practice relates to structural conditions they find at their work. Depending on resources, rules and regulations present in street level workers' organizations, they will find different types of constraints in their tasks. Lack of resources and ambiguity of goals, and an environment that is always more complex and uncertain than official policy guidelines can predict, are at the centre of workers' daily dilemmas in taking discretionary action.

Scholars in the field of street level bureaucracy define the exercise of discretion as also related to the values and attitudes of practitioners to the organizational official policies and practical procedures that govern their work (Evans 2013: 741). More specifically, when focusing on workers' relationship with the resources and regulations provided by the organizations in which they work, discretion can be seen as

> …the perceived freedom of street-level bureaucrats in making choices concerning the sort, quantity, and quality of sanctions and rewards on offer when implementing a policy (Tummers and Bekkers 2014: 5).

When performing their daily tasks, within their territories, street level workers receive both support and constraints from their organizations. Organizations define the goals workers are supposed to achieve and the resources available to do that. Depending on the organizational context, however, goals can be more or less clear, and resources made more or less available. Shifts in government or policies can bring a new configuration on how to work and what to achieve. Also, formal and informal local guidelines, and the system of rewards and punishment can be conflicting with new goals and expectations. In these cases, workers face challenges to adapt and find new ways to perform their tasks.

Not only constraints can modify street policy: many times, there may be more than one route to meet goals, and some routes might be seen as shinier or more rewarding than others by street level workers. As chapter 3 already showed, street level workers build their own interpretations and beliefs about what would be best to be done regarding drug use. Workers' interpretive beliefs, however, do not arise or stand in a vacuum. Structural support and constraints organizations offer can make some choices easier than others. Every time workers are faced with dilemmas, on how to put policies into practice, and on the different possible paths to get there, they have to make a choice. This is the point when they use their discretion. An interesting question to understand policy processes then is: how do workers decide on which path to take? How do they choose the strategies they will use to cope with the unexpected events of street policy when it comes to the relationship with organizational rules and resources? And how would organizational rules and resources influence workers' decisions about what to do with drugs?

The literature on street level bureaucracy proposes various explanations for what drives workers' discretion. These explanations range from assuming that street level workers are driven only by self-interest, or, at the opposite end of the spectrum, that they are driven solely by the interests of the people they assist. The present chapter draws on fieldwork data to investigate how street level workers relate to the organizational structure they find in their territories, and how they choose different strategies and tactics to deal with ambiguities and contradictions. Next section briefly describes how some scholars on street level bureaucracy explain workers' discretionary choices. Subsequent sections focus on fieldwork data to describe workers' main discretionary postures: first to describe the main organizational features found to bring dilemmas for workers and, second, to explore the strategies workers use to cope with dilemmas. In the analysis, the focus is on the reasons driving workers to make their choices. Differences between Amsterdam and Porto Alegre, as well as variations between and within sectors are brought into light. Literature from the field is brought to the descriptions when relevant, aiming at debating how and to what extent it can explain the experiences of street level workers participating in the present research. From this interaction, some conclusions on what drives street level workers' choices when negotiating organizational resources and regulations are drawn,

and a much more nuanced perspective is offered than the extremes of self-interest and concern for others.

Explaining workers' choices

Broadly, when talking about workers' discretion, two main debates cross-cut the field of street level bureaucracy: firstly whether discretion still exists or not, given the changes in government which took place over the last 30 years, and secondly whether discretion is considered good or bad. While the first debate approaches discretion from its aspect of freedom to choose, the second one focuses on the aspect of evaluative judgment. Two main perspectives in the literature focus on the 'freedom' aspect of discretion: the curtailment and the continuation perspective. While the curtailment position argues there has been a significant decrease on professional room for manoeuvre, the continuation position affirms that even with increasing rules and regulations discretion remains, being possibly even increased, since rules necessarily have an ambiguity which contributes to uncertainty and, therefore, the need for discretion (Evans 2010, Evans and Harris 2004). Exploring both the curtailment and the continuation perspectives as discussed by various scholars in the street level bureaucracy literature, Evans and Harris (2004) conclude that discretion is still an important part of street level workers' experiences. Instead of an 'all-or-nothing approach', the authors advocate the need to recognize different gradations of power and freedom existing in the relationship between managers and workers, within a complex set of principles and rules (ibid.:881).

As already stated in the introductory chapter, the present research departs from the assumption, which is confirmed by fieldwork data, that discretion is (or remains) a fundamental aspect of street level workers' daily tasks. Therefore this research emphasises the continuation perspective. The analyses here are concerned with how discretion is exercised, and how workers choose between different work practices and approaches towards drug use when meeting dilemmas.

When analysing the judgment aspect of discretion, Lipksy (2010) sees tensions and contradictions. For him, the helping orientation of street level workers is incompatible with their need to judge and control clients for bureaucratic purposes. Advocacy may be compromised by large caseloads, is incompatible with organizational perspectives (in terms of

resources allocation, rationing resources and treating all equally and is incompatible with the need to relate to clients (caring and ordering). According to Lipsky, 'the street level bureaucrat is almost always a judge, as well as a server. Yet, it is hard to do both at the same time' (Lipsky 2010:74). The main problem at the centre of street level bureaucracies, in this sense, is how to balance respect for the individual as user and at the same time negotiate efficiency and sustain adequate revenues. The author states that when trying to cope with the tensions and contradictions in policy, workers 'natural' intention – providing there are no strong mechanisms to promote the contrary - would be to engage in primarily self-interested strategies, deviating from the organizational mission and doing what he calls 'people processing'. Possible responses of workers in this regard are: limit demand on their time and energy by rationing services; modify their concept of their jobs by lowering or restricting objectives; and modify their concepts of the clients to excuse lower standard accomplishments. Strategies include limiting workers' availability in terms of time and effort spent on clients, maintaining bureaucratic routines to keep clients at a safe distance, and unequally administrating benefits by focusing in some (preferred and easier) clients than in others (Lipsky 2010). This materialist 'rational-choice' worker would be driven by economizing on time and efforts in work, trying to process work with 'minimal risk of disruption to routine practice'. In sum, for Lipksy

> At the very least, workers have an interest in minimizing the danger and discomforts of the job and maximizing income and personal gratification (Lipsky 2010:18)

Despite acknowledging street level workers often want to make an improvement in their clients' lives, the author contends that workers are mainly driven by their self-interest, and mostly use their discretion to profit to the detriment of the client and for self-protection.

A different interpretation for workers' main drive in discretionary practices is given by scholars such as Maynard-Moody and Musheno (2000, 2003). These authors' main criticism towards Lipsky is that, rather than always assuming a selfish behaviour, street level workers may pursue ideals towards the public they assist, and choose strategies that bring more challenges and difficulties than ease their tasks. Instead of being fundamentally bounded by self-interest, workers act first in response to individuals and circumstances:

> Street level workers discount the importance of self-interest and will often make their work harder, more unpleasant, more dangerous and less officially successful in order to respond to the needs of individuals (Maynard-Moody and Musheno 2000:329).

Maynard-Moody and Musheno (2000) state, as explained in chapter 3, that the decisions workers make are normative choices based on the judgement of the worth of the individual citizen they assist. The authors suggest that in the street level bureaucracy field there are two different narratives on use of discretion by street level workers: the state-agent, supported by Lipsky, and the citizen-agent, proposed by them. If these narratives are not wholly inconsistent, they differ in emphasis and meaning. The basic difference is that, from the citizen agent perspective, the clients' well-being assumes a fundamental importance as a reference for workers' discretionary choices. Street level workers base their actions and decisions primarily grounded on the judgement about what is going to be best for clients; even when the decision might be not the best option for the workers themselves. This, however, needs the client in question to be considered to be worth the time and effort.

A criticism to these contrasting perspectives is offered by Evans (2013a). Based on Friedson[1], the author describes the existence of two contrasting perspectives on logics of work decision-making: managerialism and professionalism. While, from the first perspective, workers are seen as motivated by self-interest, together with incentives and punishments, from the second perspective, professional groups are seen as value driven, and motivated by an ideology which focus on concerns of service and other's well-being, instead of pecuniary individual economic priorities For the author, most contemporary analyses of street level practice – including Lipsky's recently reviewed publication- tend to reflect the managerialism logic, seeing workers as primarily self-interested (Lipsky, 2010).

For Evans (2013a), however, discretion may reflect both concerns for the self and for others, and may also reflect different understandings and analysis of a problem and different ideas about the appropriate solutions. Though a philosophical debate around moral and ethics, Evans proposes that workers' ethical choices may entail a mixture of calculation of benefit, personal commitments, and sentiments that include concerns for others and a wider society. To engage with these questions, he says, it is necessary to move away from the two contrasting perspectives, and look

at possible combinations between self-interest and altruistic approaches. This perspective suggests that

> …understanding street-level practices require engagement with questions about practitioners' concerns and commitments, and issues such as the perception of need, the characterization of the problem at hand, and the views about the balance(s) to be struck between social and individual responsibility (Evans 2013a:4).

When looking at the street level, would workers combine different interests when defining their discretionary practices? Or would they simply assume, alternately, selfish or altruistic postures? And, either combining or not, what would be the factors influencing street level workers' decisions? Would the very different structural conditions in Amsterdam and Porto Alegre make a difference in terms of how workers exercise their discretion?

The following sections of this chapter debate these questions based on the testimonies and observed experiences of workers. Workers reported experiences which were structured in terms of perceived support and challenges to put policy into practice. If a good part of the support/challenges mentioned relate to the perceived adequacy of resources their organizations offer, another important part is related to the various and shifting goals pursued by organizations. Primary data is analysed trying to map the range of responses workers have to these dilemmas in both cities. The main supports and challenges perceived by street level workers can be divided into three categories: resources, local management, and shifting goals and expectations.

Resources

Number and availability of services

According to Lipsky (2010) there are never enough public service resources, as demand tends to increase to meet supply, and not the opposite. Therefore, it should be no surprise that lack of services to assist drug users was a common complaint for all street level workers. Lack of resources is perceived by workers as a challenge they have to face. However, the challenges reported by workers differed between cities and across sectors. Workers in Amsterdam did not complain so much about the number of services and the availability of assistance at a basic level,

but rather talked about the need for better quality of services. They, for instance, perceived that in recent years the availability of housing for users had strongly improved, bringing more stability and better quality of life to users. However, not only did workers wish for more places in shelters and pensions, but also 'real houses' for users.

> NL22: …People that go to a shelter stay there because they cannot go further. When somebody is totally clean and has a regular job, he shouldn´t stay in a shelter anymore. He should get a house and maybe once in a month somebody will look 'is he still clean? Is he paying the bills? Is the house OK? The neighbours are not complaining?'. So, then the shelters can get a bit empty and can have places to send people to. (Amsterdam, social worker).

Users' living conditions that street level workers confront in Porto Alegre are much more problematic than in Amsterdam. Users' sanitation conditions, housing, and nutrition are insufficient. They might need to work during the day in informal jobs (e.g. picking up paper from the streets), and are not able to arrive in time to get to a place in a shelter in the evening. They do not have money for a bus ticket to go to a treatment centre, cannot always take a shower before entering a care centre, might have an empty stomach and not enough warm clothes when they wait in line for an appointment. Social services providing basic needs such as food stamps, clothes, informal activities to make money or more formal employment, shelter, are not enough to meet demand in Porto Alegre.

Especially for outreach workers in this city, lack of services to provide basic care was perceived as a challenge. Outreaches are supposed to approach the most vulnerable users, and those who do not search for care by themselves. In recent years, many outreach services were created in Porto Alegre, but the number of services to 'back up' their activities with available places and resources for users did not increase proportionally. Consequently, many users who are approached by outreach workers cannot access services such as shelters, drug treatment, and even primary health care. Lack of services also affected police workers' practice. Military police workers are supposed, for instance, to enforce rules that do not allow people to sleep under viaducts or on sidewalks. However, due to lack of shelters, some workers felt they have no other alternative than just ignoring these situations.

> Int.: When you see drug users sleeping in the streets at night. isn't there a law that forbids people to sleep under the buildings and in viaducts? BR10**:** We have to deal with the lack of policies… there is no place for everyone that wants it… then you are going to tell me like this 'go and take him out of there'… what am I going to do? There is no way! It is simple, I take him out of your front door and I put in another house front door. (Porto Alegre, law enforcement worker).

When workers perceive a lack of conditions to perform their roles, this increases the chances that they divert from formal rules and guidelines. In the case of Porto Alegre, much more often than in Amsterdam, workers felt that lack of number and availability of services were hindering their most basic tasks with drug users.

Resources inside services

A similar difference applies to workers' evaluation of resources available inside the specific services that employ them. Street level workers in Amsterdam generally said they have in their own organization all resources they needed to work effectively. In fact, when compared to Porto Alegre, they have what their Brazilian colleagues would call luxury: ergonomic and well-designed work places, desks and computers for almost everyone, work-paid mobile phones, several training options, motorcycles or mini-buses for outreach workers, and so on. The few complaints about resources inside services that Amsterdam workers mentioned were not related to basic resources, but to less comfortable conditions.

> NL25: … we are now upstairs in the office, but we see the people downstairs, so we walk up and down all day. So you are upstairs, turn on your computer, log in and wait, and then somebody phones 'someone is here for you'. Oh! I have to go downstairs, turn off the computer upstairs, turn it on downstairs… so that's not good. (Amsterdam, health worker)

Overall, Amsterdam workers felt supported by their organizations in terms of resources inside their services: they believed to have all needed to perform their jobs.[2] In contrast, for workers in Porto Alegre lack of basic resources to accomplish tasks was a common complaint. This could be either related to lack of benefits to give to users - bus tickets, food stamps, medicines, basic care kits for homeless (soap, toilet paper, tooth brush, towels, clothes) - or lack of basic resources in their work environment, such as computers, toilet paper or bullet-proof jackets.

In the case of lacking benefits/materials to assist users, constraints were perceived as restricting the possibilities workers have to help users and to keep them inside the care system. Besides being scarce, resources might be irregular as well. Sometimes, for instance, a service runs out of bus tickets for clients, who then cannot get to the treatment place in the required frequency. Another example is when users' treatment involves medication. Drug users with poor economic conditions depend on medicines provided by the Brazilian public health system, as they cannot afford to buy it privately. It can happen, however, that in the middle of the treatment, a medicine stops being available in the public pharmacy, and thus, the treatment is discontinued. This can lead users to relapse into drug use, to boost psychiatric problems, or even to develop disease resistance to medication, as is the case for interrupted tuberculosis treatment.

Also in the cases workers lack resources which are more directly related to their work conditions, this was perceived both as impacting their own wellbeing and/or safety as workers, and their assistance to users. Porto Alegre workers lacked, for instance, sufficient computers and internet connection to plan and register their work, rooms for staff-meetings and client-consultations, cars to visit users at their homes, to transport them to other services or to do policing patrol, work mobile phones, and, especially police workers, personal safety equipment (such as bullet proof jackets or proper guns).

> BR10: ahn... there are not many police workers cars, and they break all the time, and you have to drive with a moderate speed. But if a colleague is asking for support, a citizen is being assaulted, you have to drive fast. And it is every day, it is 24 hours, you have to drive and drive. But then the car breaks and you have to send it to fix. But while that car is out, then you only have one [for the whole police workers station]. How many things that one car could be avoiding... (Porto Alegre, law enforcement workers).

Lack of human resources was another problem mentioned very often by workers in Porto Alegre. Not enough colleagues to share the work demand was perceived as having negative consequences on the quality of service workers can deliver to users. Workers mentioned to lack time to plan and evaluate their work with users, and also to register all their activities as they should. The biggest worry, however, was not being able to follow-up with people they assist, or having little time with each person.

> BR05**:** ... there comes the problem of the shelters. If a shelter has maximum of 10 persons per unit, the chances the user won't relapse and go back to homelessness is bigger. Now, if you throw the user in a shelter, as we have many, with 40 or 60 people in one shelter, then the chances of relapsing are much bigger. When you work with 60, the professionals can't have the same patience, [can't have] an individualized care; there has to be more automatized. (Porto Alegre, social worker).

The ways in which street level workers participating in this study experienced the availability of resources in their organizations presented similarities within each city, regardless of the worker's profession. The big difference, was related to how workers perceived support and constraints in the two cities: while Amsterdam workers felt backed up by their organizations, workers from Porto Alegre felt abandoned.

Training and know-how

Differences across cities also appeared when workers evaluated their experiences in training, but in this case, variations across professional sectors also occurred. Even though they had, on average, more years of formal (academic) education, Porto Alegre workers had many more complaints about lack of training and know-how with concerns on how to deal with drug users than workers from Amsterdam. Inside the organizations in Porto Alegre, however, the amount of training offered is much lower.

Social and health workers from Amsterdam mentioned having several types of training in the organizations in which they work: about the different types of drugs, psychiatric disorders, mental health, how to manage aggression, how to approach users, and how to deal with overdoses. More specific training, such as on cultural issues to deal with migrants or Dutch language courses for foreign workers could also be requested. In some work places, organizations provide workers with a yearly personal budget for training. Within this budget, workers can decide which training they want to follow. For the training promoted by the organizations to all or to new workers, in general, the tone was related to a harm reduction policy towards drug users.

In the case of police workers in Amsterdam, training was offered in community policing (specifically in the case of community-police workers officers, but not for patrolling police workers), on how to approach

violence, and other specific issues related to their profession. Despite some training on different types of drugs, there was usually no specific training related to approaching drug users. According to police workers, they learn this in practice.

In Porto Alegre the situation of training is quite different. In care services, the few times organizations offer training, these are usually only available for one or a few workers**.** In addition, workers mentioned the problem of a high level of worker turnover in the organizations working with outsourcing, instead of civil servants. Sometimes organizations promoted training to adopt a new policy guideline, but due to many changes in the team, and non-systematic training, the required knowledge never reached all workers.

> BR14**:** There is not a common understanding of workers that our service is focused on harm reduction, no. We already repeated that a lot, but we had a lot of turnover and maybe for some new teams they never worked on this perspective. (Porto Alegre, social worker).

Care workers from Porto Alegre, in general, wished for training on how to approach drug users and other clients; harm reduction; brief interventions; how to deal with crack; communitarian therapy and therapeutic monitoring. Especially care workers who were not from services specialized in drug treatment, lacked knowledge about drug use and dependency. The differences in the way services are organized, being in general specialized into drug use only in Amsterdam, but open to a broader population of vulnerable people in Porto Alegre, may also explain these differences. In specialized services, workers might be required to have (and get access to) more specific know how to deal with drug using population when compared to services where drug users are just part of the clientele. Due to differences in the target populations, the needs of workers regarding training are diverse.

Similar to Amsterdam, police workers in Porto Alegre reported learning how to deal with drug users through practice. Different from Amsterdam, they did not get enough (or any) training in a community approach, even though the organization is willing to change police practices into this direction. According to police officers, only 20 police workers from Porto Alegre were trained in community policing, but were not yet attached to specific communities. Since 2009, new workers get lectures on community policing in the welcome training, and the

yearly recycling courses include a five hour lecture on this subject. Even though this was considered far from enough to change current military mentality, it can be seen as a movement towards a new more caring perspective.

Both in the care providing and law enforcement sectors, workers from Amsterdam felt organizations practically endorse the changes they are ordering workers to make, by offering them enough instructions on how to perform in the new policy framework. In Porto Alegre, on the other hand, many care workers mentioned not feeling secure about what a harm reduction approach entails, while police workers mentioned being taught military practices in their basic training. Even if calling attention to the importance of training, many workers from both cities made criticisms of the ways in which they perceived most training offered by their organizations were made. Expressions such as 'the PowerPoint sessions' or 'the talks with coffee in the fancy rooms' were ironically used to call attention to a perceived distance between the way subjects were approached during training, and what workers face in their daily practices.

Local management

Some of the challenges brought up by street level workers related issues around local management practices.[3] These were concerns about increased paper work and regulations, high manager turn over, and unofficial punishment and rewards eventually applied by local managers. Differences across the cities were more important than variations between professional sectors in this regard. While increased regulations and paper work were a concern for workers from Amsterdam, manager turnover and unofficial rewards/punishments were concerns for workers in Porto Alegre.

Paper work and regulations

Increased bureaucracy and work regulation were constraints brought up by many workers from Amsterdam. New guidelines related to being accountable require them to explain how they spend public money. This means reporting and registering all their activities, which was felt as an increasing organizational control over their work. More important, workers felt that bureaucracy was delaying or hindering their main tasks.

> NL09 - One of the big problems I think is regulation. Everything needs to be regulated, everyone needs to know who is responsible for this when something goes wrong and it is a lot of paper work to get someone into a house. For instance I had a client who the place he was going to wanted to have him in the house, we wanted to have him in the house, he wanted to go in the room, but then … it was like 8 weeks waiting for an indication to be written. That´s totally stupid I think. (Amsterdam, health worker).

New financial rules for care in Amsterdam were also considered a source of problems. In the new system, the ZZT (Zorg Zwart Pakket), every client gets a score, from 1 to 7, depending on how independent s/he is perceived to be. The higher the guidance the client needs, the higher the score s/he gets, and the more money the facility gets; the less guidance, the less money. The difficulty comes when users already being assisted do not fit into the new payment frame, and the dilemma is how to keep care continuity and sustain the service at the same time.

> NL36: I get clients who scored low and they got too much care. So we have to rethink everything and… maybe if you want to make it financially sound you have to consider to take the one who has a highest score and lives by himself in his own apartment, [and get him] out in another kind of facility just because he has a high score, which is… Well, we don´t want to go that far, we don´t want to…change people´s life because of the system […] He functions well, he is happy in his environment, but because of the high score…I get a financial problem because [of] people who scored low, because I don´t get enough money… (Amsterdam, social worker).

In such cases, workers perceive that bureaucracy and regulations do not help them to help users: there is a contradiction between serving the client and serving their organizations, or, the state. When describing these experiences, workers focus mostly on the wellbeing of the users they assist. Regulations are described negatively, since they are perceived as hindering major goals. As stated previously, and as following sectors will show, the fact that workers feel an increased control over their activities does not mean they lost their discretionary power. More rules can, paradoxically, create more room for interpretation and choice.

Manager' turnover

A concern mentioned exclusively by street level workers from Porto Alegre was the perceived instability of guidelines inside services because

of the constant turnover of managers after governmental elections. Different from Amsterdam (and the Netherlands), in Porto Alegre (and Brazil) many managers, heads of services and street level workers are substituted after elections. Rather than being civil servants, these workers occupy the so called 'positions of trust', and in this sense, they particularly represent and are expected to put forward the new government's interests and ideas. Very often, government changes bring a different perspective on previous projects and ways of governing, and the area of illicit drugs is a very sensitive one in this matter.

In the last decade, for instance, Porto Alegre workers have faced several turns in terms of support and interpretation of harm reduction programs due to governmental changes. New managers who came with elections changed services' priorities and ways of functioning: outreach workers who were functioning with a harm reduction perspective, were suddenly requested to convince people to quit drug use (Rigoni 2006). During the fieldwork for this research (2011), new changes have split the group of outreach workers into different organizations, without clear instructions on their new roles. Workers were forbidden to go to the field, and felt that new regulations were clearly against their objectives of reducing harm.

A new manager's support for a certain approach on how to handle drug use may produce a sudden increase or decrease in concrete support to programs. Without clearly stating changes in the main goals of a service, new managers can produce concrete changes in workers' environment and conditions. Workers with less stable contracts (such as the outsourced), for instance, can be sent away and substituted by others more in line with the new government. Managers can also send away workers that are essential for a program, cut down payment of workers for some time, decrease material resources supply, or simply close down the service and relocate workers to activities considered to have higher priority at the moment. The opposite, of course, can also happen, and a new service might be opened or get extra support in a certain administration. A key challenge for workers here, besides possible clashes between their own interpretive beliefs regarding drug use, and the approaches adopted by the manager in question, is the perceived lack of continuity in their work. Changes tend to happen with services which are very much visible politically and/or deal with sensitive topics, such as harm reduction programs, programs directed to the approach to homeless people, and polic-

ing. In all these cases, instability and discontinuity impacts not only on workers discretion, but also the population targeted.

Additionally, since in Porto Alegre managers in positions of trust are (at least perceived to be) chosen for political reasons, more than for their competence or professional experience, street level workers tend to distrust them. They might be considered to have unrealistic and inefficient plans, not properly understand the policies they are putting into practice, and not being legitimate to run a service. These changes in support due to the different approaches adopted to drug use can influence, thus, not only the direction of services but also the willingness of workers to comply with guidelines and how to exercise discretion.

Unofficial punishments and rewards

Due to the mixing approaches and constant shifting goals, street level workers usually have room for manoeuvre in choosing different approaches on the ground. However, when they choose to follow different goals from the ones appreciated by their local/regional managers, another challenge might come: unofficial punishments can be applied to them by the managers. The most mentioned punishment used by managers is sending 'rebel' workers to the so-called 'punishment services'. Punishment services are considered to be very difficult to work in, either because of its target population or because of its distance and bad conditions regarding resources.

> BR09: **…** we work with users' autonomy, [but] that was in the opposite direction of the policy at that moment, that was one of just cleaning the city. And then there was all this persecution from the State with my colleagues and I also had persecutions and very strong moral harassment […] they started saying I would have to leave the team, and the manager called me to a meeting saying I would have to go to a shelter, that on that time was a punishment-shelter. It was abandoned, there were lots of adolescents and... They stole, use drugs, all in front of the service; it was a chaos. (Porto Alegre, social worker).

According to workers, holding different interpretive beliefs on what to do regarding drug use, and acting on those beliefs when local management guidelines go in the opposite direction, can create a disciplinary confrontation. In the case of police workers, since they work for a state wide organization, being sent to a 'punishment service' could mean being

sent to work in a very small, poor, and distant city, regardless of having family and house somewhere else. For workers from the care sector, where outsourcing happens more often, the more unstable the work contract, the more drastic the punishment. Instead of punishment services, outsourced workers disagreements with the ruling guidelines were more often dealt with by dismissals.

Supporting the guidelines from those in power, on the other hand, could be a reason for rewards. Public statements of support and carrying out a good job in the eyes of local/higher management, opened the possibility for promotions. Police workers officials, for instance, could be promoted by loyalty and merit, skipping many years ahead of colleagues promoted by length of service.

Street level workers felt that, rather than openly naming these strategies as punishments or rewards, managers were doing it under the counter, justifying it in different ways. Relocating workers was usually justified by stating a more urgent need in another service (so money and workers need to be allocated there). Changes in priorities because of supposed changes in the context of the population assisted could also serve as justifications.

Both punishments and rewards could drive workers to take certain decisions on whom to assist and how. The use of unofficial punishments and rewards could be perceived by workers either as threatening their role or possibly helping them to achieve private/professional goals. That would depend upon the match between new guidelines and workers' interpretive beliefs on what would be best to do. Besides that, the more consequences punishments and rewards can have in workers' careers, or relationship with peers and managers inside their organizations, the more chances increase that these features serve as their main drive.

Conflicting goals and expectations

Besides lack of resources and problems with local management, constant changes in goals and expectations were mentioned by street level workers as important challenges brought by their organizations. For Lipsky (2010), conflicting and ambiguous goals are an inherent part of street level workers' job. Goal conflict can have three sources: it can happen that a worker's concern for the client conflicts with the general social role of the employing organisation, bringing issues of equity for instance.

It can also be that client-centred goals conflict with organization centred goals, and workers have dilemmas on how to provide responses to individual needs, while being efficient on the terms of the organisation. Finally, there might be different expectations that clients, organizations, society and workers themselves have about street level workers' role, or society's value system produces contradictory impulses which are reflected in official policy ambiguity (ibid.). In the case that there are new rules, they might contain conflicting and confusing procedures that will have to be interpreted, prioritized or ignored, managed together with other rules (Evans 2013). Conflicts might, also, reflect changing expectations of professional role within welfare.

In the experiences of street level workers participating in this research, dilemmas around conflicting ambiguous goals had a direct relation to the different possible approaches to deal with drug use in a context of lack of consensus on the best frame to follow, and new policies and guidelines with shifting expectations. In different organizations across the ocean, these mixes of different approaches over the years created programs and services in the middle of an unclear position on which path to follow. Mixed goals, guidelines, and expectations were produced for workers. Both in Amsterdam and in Porto Alegre workers mentioned being challenged by conflicting goals and expectations. Which goals they perceive as contradictory, however, varies across the cities and the professional sectors. The differences can be explained by the mixtures of framings workers produced in their interpretive beliefs meeting the different policies and structure influencing the territories. The main dilemmas were around guidelines for clearing the city, reducing harms, being friendly but also strict towards users, and distinguishing between drug users and dealers. In all dilemmas, perceptions about what would be best for the people they arrest and for themselves as professionals were at stake for street level workers.

Clear the city and promote users' well being

When referring to activities for clearing the city, street level workers participating in this research defined it, in general, as supressing or at least to decreasing the presence of identifiable drug use, users' gathering (and related noise) in open public spaces, or other drug-related 'visual nuisance', such as not being clean or not wearing proper clothes. Promoting users well-being, on the other hand, was described as providing

users with access to basic rights and needs (such as feeding, housing, personal documents and health care). The extent to which street level workers perceived these goals as compatible or not vary between the cities, regardless of their professions. While Amsterdam workers are more prone to see a balance between these goals, workers from Porto Alegre tend to see them as contradictory. The different interpretive beliefs held by workers regarding what is best to do about drug use, and the variations in practices in workers' territories explain differences in actions.

As it was already explored in chapter three, public nuisance is an important concept in Amsterdam street level workers' interpretive beliefs. Since the 70's, decreasing public nuisance plays a big role in drug policies in Amsterdam (Blok 2008), being crucial to the very acceptance of a harm reduction approach and strategies such as user rooms, walk in centres, shelters which allow drug use, methadone substitution and heroin prescription. In the words of a key informant, public order was important…

> NL19:…especially among politicians. Because what the population of Amsterdam was really worried about, is these guys on the streets, that they didn't feel safe. The people of Amsterdam were not worried about the health of the individual junkie, they couldn't care about it. Ok, we translated that we had to do something for the health of these people. This was the translation we made. For example, in political terms, politicians in the city hall from the right, [the] conservatives, they supported all these ideas because of public order problems. On the left, they supported it because of health reasons. But they all agreed something should be done. So, we got the full support from the whole range of politicians. But they all had different reasons to do it. And, of course, in those days, I used to say: 'Well, I don't do this, to fight public order, no, we do this for medical reasons'. Of course I said that, because I was from a medical organization. I'm a [health worker], I'm not a police man. But you knew it had a lot of effect on public order. (Amsterdam, health worker)

In this sense, the goals of clearing the city and promoting users' well-being were built as compatible in Amsterdam by most workers from the three professions studied here. For care workers, since clearing the city from users' presence means workers providing users with shelters, social housing, walk in centres, user rooms, and/or benefits, both tasks are not perceived as contradictory. For police workers, clearing the city by punishing unwanted behaviours is part of their role. In the case of drug us-

ers, the fines applied to their (so perceived) nuisance-causing behaviours, are understood by police workers as pushing users into care, and therefore, helping them. A financial fine corresponding to €50 or 2 days in prison. As users in general do not have money to pay or decide not to spend money on a fine, prison is an acceptable punishment. Alternatives can be offered for users instead of prison, such as drug treatment or community work. When a user commits repeated offences, s/he can be sent to prison for two years, or, alternatively, choose to go into drug treatment and rehabilitation for one year. The role of keeping the city clear from 'bad elements', however, was not an issue for police workers in Amsterdam; specially for those who were not working as community police officers:

> NL33: […] But I always think, when I'm walking here with my child, they don't have to see drugs using; they don't have to see addicted persons, hé? The streets is not of them, the street is of everybody, and they have a problem, so that's not very nice for them. Not everybody can do something about that problem, but it must not become a problem of us, of everybody. Let them go into the user room, hé, don't do that on the streets; not everybody has to see what is happening with him. (Amsterdam, law enforcement worker)

Important to remember that homeless and homeless drug users are, in general, very different visually in Amsterdam and in Porto Alegre. In the last city, homeless and homeless drug users can be easily recognized both by their clothes, dirtiness and health aspect. According to workers, that used to be the case in Amsterdam 30 years ago, when users had no assistance. Nowadays, however, users are not clearly distinguishable from the rest of the population. Even then, visual nuisance still plays a big role on Dutch drug policies. In Amsterdam, thus, law enforcement and care workers see themselves as contributing both to clear the city from undesired behaviours, and to help improve users' life.

In Porto Alegre, differently, most street level workers strongly criticise clearing policies. As already stated by Brazilian police worker BR10, see page 123, this also includes police workers, whose explicit task is to keep the city 'clear from bad elements' by curbing crimes and other misbehaviours. The main point for disagreement is the perceived lack of effectiveness of these policies in tackling the drug problem and/or changing users' lives.

> BR09: Ah, people call here and say: 'You have to come here to collect', as if it was not a human being, but an object that is there on the side walk, in the park, bothering, and has to be removed! Where is he going to be taken, people have no interest, as long as they are taken out from the front of their building, their square. There is no concern that you can, somehow, work with this person, discuss his situation with him, so he can develop the necessary organization to survive (Porto Alegre, social worker).

> BR03: The police workers worker is the garbage men of society, collects the garbage that nobody wants to see. (Porto Alegre, law enforcement worker)

Lack of alternatives for users is the main reason for workers' disagreement with clearing policies in Porto Alegre. Police and care workers do not find enough vacancies in shelters or other care services to refer users who are taken off the streets, and their task is perceived as just moving people around from more to less visible places. For most care workers, the state guideline of clearing the streets is perceived as carrying no concern to what would happen to the ones considered to be garbage. For most police workers, this is a non-effective way of achieving the goal of decreasing crime and public nuisance: ultimately, there is only a temporary displacement of users, and a loss of time for workers who see the same people coming back into the streets. In the Brazilian case, workers do not perceive their organizations as providing sufficient support to achieve these goals. In these cases, workers tend to assume either a more citizen driven perspective, or a more worker-driven perspective (worrying about their own well-being), which can mean putting less effort into meeting their organizations' demand.

A few care workers from Amsterdam similarly mentioned perceiving clearing policies as contradictory to their role of improving users' well-being. That was the case when investments in community safety were perceived as decreasing resources for care support. Some services, for instance, are obliged to hire safety staff to keep users away from the premises, but these workers consider that money spent on guards could have been spent on care instead. In addition, they thought guards can frighten users, keeping the most vulnerable (such as undocumented migrants) away from care. In these cases, tensions between a citizen rights to care and a state approach to order arise, and these workers tend to

assume the perspective of the citizen: safety for others should not be achieved at the expense of care for their target group.

Finally an important note is that, in both cities, a strong criticism on cleaning policies is found among users and user representatives. In Amsterdam, especially criticized are the APV rules (Gemeente Amsterdam 2008), which state police workers should fine people who: are 'walking without a purpose or defined objective'; have drugs or even instruments (such as a lighter) to use drugs in their hands; are with more than four people standing together at any place; have 'their eyes closed' on a park bench. For drug users and their representatives, this represents a selective surveillance by police workers towards poor and homeless drug users; selectiveness is said to be increased before festive and royal events (such as Queen's day), and when police workers have to meet the monthly quote of fines. In their view, the focus on public nuisance produces a coercive way of treating users, running the risk to deprive them of basic rights to city spaces. The same view was shared by drug users and homeless people in Porto Alegre, who perceived a selective surveillance towards them by displacing them from public places to avoid visual and olfactory nuisance for society at large. Regarding clearing policies, a slight variation across the districts was found, in both cases studied. Clearing actions were more often reported by workers established in the city centre than in the districts: it is more important to keep junkies out of sight of the tourists and 'ordinary citizens' than from non-user population in less economically favoured communities and slums.

The different structural resources workers have and the support their organizations offer in terms of resources and regulations, combine with different mixes of frames on what to do with drug use to account for the differing practices in Amsterdam and Porto Alegre.

Be tough and be friendly

Another common dilemma for workers from both cities and from all sectors is the one related to a perceived double expectation of being friendly towards drug users, but strict at the same time. Intensities and features of the dilemmas vary within and across cities and sectors. The more involved workers are in users' care, the more they perceive this double expectation towards their role.

For most social and health workers from both cities, dilemmas on being tough and being friendly consumed a good part of their daily activities. These are mainly related to decisions on balancing bonding with users and bending services' rules to guarantee access on one hand, and being strict in order to educate users and change their lives on the other. In workers' perceptions, thus, organizations ask from them a contradictory role: be strict by enforcing service's rules, but be 'soft' to avoid users 'escaping' from welfare. Many community police workers from Amsterdam had similar dilemmas, with a focus on how to become close enough from drug users in order to develop a good contact with them, as asked by their community police role, without losing the necessary strictness to enforce the law when needed. These issues concern more directly the daily relationship between workers and users, and will be analysed in-depth in a specific chapter for this issue (six).

In Porto Alegre, for most military police workers, being tough is the rule to be followed and a need in order to be respected in the streets. These workers, however, feel there is a misunderstanding regarding their role coming from society in general, and from many of their care workers' colleagues: they expect them to be tough to enforce the law, but also to be friendly with the community. Again, here, conflicts reflect double expectations of a professional role. These dilemmas mostly relate to the relationship of workers with their colleagues from other services, and will be analysed in-depth in the chapter about networking (five).

Finally, the few police workers involved in drug prevention in schools (PROERD program) and few civil police workers (working in crime investigation) from Porto Alegre reported dilemmas on being tough and friendly which were related to a perceived 'work culture' coming from their organizations. In these cases, the contradiction was between workers' interpretive beliefs and practices towards a more friendly attitude with users (without losing necessary strictness, in their perception), and an organizational culture favouring tough behaviours and punishing the ones considered 'too soft'.

According to interviewees, the main culture in police stations is that efficient police workers are supposed to be feared to be respected: they should be tough, fearless and have many arrests. When a worker escapes this pattern, official and unofficial systems of rewards and punishment might be operationalized by their bosses and colleagues.

> BR07: You shape yourself so people like you, you know? [But] here I always get very much into conflict with colleagues who think that kicking butts goes for everything. If I'm going there to give a glass of water to a victim: 'Oh, you'll give a glass of water to the victim? What's that? Tomorrow they'll be back and wanting something else ...'. So you cannot treat them well, you cannot be nice. (Porto Alegre, law enforcement worker)

The dictatorship period in the country left a military culture as heritage: techniques, punishments and rewards used at that time are still perpetuated. According to workers, during dictatorship soldiers were punished for inattention and unprofessionalism if talking to citizens when on duty. Violent acts and even torture were part of activities police workers had to perform. This contrasts with a community policing culture, prevention programs, and caring relationships with users. Even though the organization has been trying to support PROERD and develop community policing in the last decade, previous military culture is still strong among most of its street level workers.

Especially police workers giving lectures for children on drug use prevention and abstinence, as part of the PROERD, mentioned being targets of prejudicial jokes by their colleagues:

> BR22: But there are comments, right? That is one person less in the streets to work, to combat crime […] 'Ah, you go there play with children; we are here arresting, while you are there playing'. (Porto Alegre, law enforcement worker).

Besides prejudice by colleagues, workers from PROERD also felt there were contradictory speeches inside the organization about the program. Since 1998, Porto Alegre's military police organization officially support this drug prevention program, and in 2010 succeeded in transforming it into a state policy (Rio Grande do Sul 2010), to prevent it from vanishing due to manager's turnover. Practical organizational support, however, is perceived as still missing: lecturing for the program is a voluntary choice, and workers have to assume the costs of training and trips this might require. Besides, it depends on managerial discretion on priorities to decide if workers can lecture during their working hours, or only in their free time. If police workers organization supports the program verbally and on official policies, it does not provide enough support and incentives for workers to perform it on the ground.

Besides creating dilemmas for workers, lack of organizational support can have consequences for workers' health and adaptation at work. According to participants from Porto Alegre, care sensitive police workers end up either getting emotionally stressed, moving to more administrative functions, or leaving the force. The ways in which an organization is structured can not only produce dilemmas for workers, but also make these hard dilemmas to bear. In the absence of (or with doubtful) support from organizations, workers tend to doubt about carrying on organizational rules.

Interesting to note that a friendly approach towards drug users, and a focus on pushing them into care rather than punishing or arresting, was also considered 'too soft' in Amsterdam about a decade ago. In the words of a community police officer:

> NL17 - they [colleagues] thought that I was more a social worker. And they said 'you are a police officer and now you try to be a social worker; it is not a police job!' 'You are here to arrest people and now you are doing the other way around'. […] And now we have a lot of younger colleagues coming in, but they are getting this also at the police school, so they know how it works … not a way of my thinking, no, it is the way how everybody needs to do it. (Amsterdam, law enforcement worker)

According to community police workers officers from Amsterdam, a cultural shift in the organization towards approaching drug users from a public health perspective (meaning pushing them into care instead of only arresting or fining), profited from organizational training and clear guidelines. It took some time, however, until the new rules were successfully accepted by the majority.

Make users abstain and reduce harms

Goals of making users abstain from drugs and/or reducing the harms of drug use were a concern for care workers in both cities. However, the extent to which workers perceived these goals as conflicting with other goals differed. These differences relate both to the different ways services are organized in the territories and the different interpretive beliefs workers hold on what to do about drug use. Services separated between low-threshold (or harm reduction oriented) and abstinence oriented in Amsterdam facilitate workers to perceive abstinence and harm reduction as two different, but possibly complementary, approaches. A disputed

field between these approaches with unclear goals inside services in Porto Alegre, leave decisions to negotiations among colleagues and managers.

> NL02**:** We don't want people working here to really get to people saying 'oh, you have to quit doing drugs'. [...] because in here we accept them within the way they are; and if they want something else then it is fine, but we are not pushing them to do something they don't want to do. So, you can have the ideal 'I really want to help them', and you can also offer people help but, always leave the choice to them (Amsterdam, social worker).

> BR30:... we work with harm reduction also, to decrease or to substitute [drug use]. But here we don't...we don't say this. Our policy is not to say out loud that we indicate to people that they substitute crack for marihuana. But we do that. [whispering]
> Int**.:** Ok. But why don't you say it?
> BR30: Because there are people in the institution that think this is bad. […] there are people who think that it has to be abstinence, that the person has to stop. But many can't stop… (Porto Alegre, health worker)

In Amsterdam the goals and roles of workers are clearer: in services such as user rooms, walk in centres, shelters, methadone or heroin prescription services, workers are clearly not supposed to insist for users to stop drug use. The same goes for law enforcers helping users to get into these services. If users want to quit drugs, specific treatment clinics work with abstinence.

In Porto Alegre, on the other hand, at the same time that harm reduction is supported in policies governing care services, local guidelines forbid drug use inside facilities. Even being drug effected can stop users from participating in groups and keeping individual appointments, entering a walk in centre or a shelter. In the case of drug treatment, there is a supposed division between in-patient services and emergency detox centres as focused on complete abstinence , with out-patient clinics supposedly supporting a harm reduction approach. As it was already shown in chapter three, in many cases out-patient drug treatment services assume complete abstinence, or at least crack cocaine abstinence, as a goal. The period of development of a harm reduction approach has an important role here. Official support for harm reduction came to Brazil in 2006 (Brazil 2006), while this is part of Dutch policy since the 70's (van der Gouwe et al. 2009, VWS 2003). More than the support on official poli-

cies, the wider availability of harm reduction based services in Amsterdam, with distinct goals from the abstinence based ones, promotes more clarity in goals for workers in this city.

In Porto Alegre, contradictions inside care services send conflicting messages to workers, creating dilemmas, hampering harm reduction practices, and leading to personal doubts on what is the best approach to users. In trying to cope with dilemmas, workers end up transforming the meanings of harm reduction: either seeing it as partially applicable perspective (as a possibility for some drugs, but not others), or as a perspective related to quantification (reducing the quantity of drug use, instead of the harms associated to it). As stated in the literature (e.g. Evans 2013) conflicting goals, indeed, leave more room for workers to decide on what to do about drug use, increasing the chances organizational rules will not be followed.

Help users and arrest dealers

Both Amsterdam and Porto Alegre pursue different treatments for drug users and drug dealers in their official policies. Also on the ground, street level workers agree to a certain extent that dealers should have a different destination than users: users should be helped, dealers arrested. The problem comes when this differentiation becomes blurred, as when drug users deal in exchange for drugs, or to pay for debts with their dealers. When a person is both a user and a dealer, what exactly to do? While in Amsterdam social and health workers face this dilemma, in Porto Alegre law enforcers confront it. Differences in workers' territories explain these variations.

In the streets of Amsterdam, small-scale dealing is not a priority for police workers: big dealers are the focus of a special team. According to police workers' guidelines, in the case of possession of small amounts for personal use, drugs will be seized but prosecution normally will not occur; in case of hard drugs, prosecution might occur though possibly including diversion to care. Small amounts of cannabis are defined as up to 5 grams, and of hard drugs as one wrap or ball (of heroin/cocaine), tablet or ampule (van Laar et al. 2012). The few small-scale street dealers circulating in the city are regarded as known by community police workers. For them, no help is offered: dealers are, in first place, dealers.

NL06: I see them on the streets… Some of the guys here are really criminals, they are addicted but they are also dealers. That's their world… they don't get help from me. They are a problem for this neighbourhood and they will get their penalty… (Amsterdam, law enforcement worker)

If police workers in Amsterdam have no doubts about arresting drug dealers, regardless their potential addiction, the same does not apply for care workers in the city. As drug use is allowed inside many care facilities in Amsterdam, small scale dealing becomes a problem inside services. In health services with methadone treatment or prescribed heroin, workers have to ensure users do not steal the drugs to sell outside. In shelters and user rooms, the challenge is to prevent drug dealing inside and outside the premises. The boundaries between dealers and users become more blurred in these places, and to manage this, care workers constantly negotiate local rules and guidelines with users. Sometimes, negotiations have to be done among care and community police workers from the neighbourhood. In these cases, the main roles of workers are usually kept: while for care workers helping users comes first, for police workers arresting dealers assumes the priority. [4]

In Porto Alegre the situation is different: as drug use is forbidden inside services, small-scale dealing happens mostly in the streets, being military police workers the ones to face it's consequences. Since 2006 (Brazil) drug users in Brazil cannot be arrested for using drugs, but should receive an administrative or alternative punishment. Instead of arresting users, military police workers have to make them sign a 'consent term' where they agree to present themselves to the judge. According to street level workers, small-scale dealers are taking advantage of the new law to pass themselves off as (only) users.

BR10: ... so what has changed is that once you had the *boca* [drug selling point] from Zé and the *boca* from João. So, you knew it, it was easier to identify who was a drug dealer and who was not. Nowadays no. Now the user makes many thefts, and then get, let's say about R$200 or R$300. He goes to the dealer, buy 300 crack stones and starts to sell […] People get caught and they get smarter. Instead of buying 300 stones, and stand with 300 stones [in the street], they go to a small hotel, pay R$25 a night. They let the drug inside, go down the street, and sell a stone for R$10. And if you get him, he is a user… (Porto Alegre, law enforcement worker)

Police workers worry about being fooled by dealers, and not catching them as they are supposed to. An additional problem comes with police force division between street work (military police workers) and crime investigation (civil police workers). Military brigade makes a catch and do a first decision on whether the case is of personal use or drug dealing. In case of dealing, civil police workers investigate and make a final decision; also in case of doubts, civil police workers will decide. Official policy procedures to detect a *flagrante delicto,* however, are quite challenging in a street context of small-scale dealing and non-undercover police workers. To catch, in the same scene, the seller, the buyer, the drug and the money in a clear drug trafficking situation is very difficult for military police workers. Besides, since the law does not define exact quantities configuring drug possession or traffic, it depends on both military and civil police workers' judgements to decide which role –user or dealer - will prevail in each case.

Moreover, the organizational division of police force in preventive and investigative is perceived by both as challenging work continuity. The dealer accused by military police workers is many times released as a user by workers from the civil police. If military police workers feels their civil colleagues do not recognize or understand their work, civil police workers thinks their military colleagues are not able to judge properly the cases they find in the streets.

> BR36: So it's very complicated. I've had a man who had nearly 100 grams, but it was like, he went out his job, they had received the salary, the two worked on a construction site. One was on a corner and the other went to the slum, got 100 grams and got back. The military brigade found them dividing the 'brick'[5] on the corner. Each of them had a more or less large portion of money as well, so a reasonable amount, R$100 and the other had R$300. So, they brought them as dealers and initially it seemed to me that yes. Then I saw, the guy had his pay check, on his pocket. He gave R$70 from his money; he paid, and next time the other will pay, they do it each 15 days. So, each case will be a case, right? (Porto Alegre, law enforcement worker)

When military police workers brings in a supposed dealer to a civil police station, and this person ends up being released as a user, they feel as they are doing a useless job. Their actions do not go forward and are not effective in curbing crime or changing users' lives. Besides, users who were arrested by them and released by civil police workers might

become an extra challenge in the streets, searching for revenge. Conflicting goals and expectations decrease workers' trust in their organizations and the rules they put forward.

Table 10 summarizes the main organizational features bringing challenges or support for workers and compare perceptions across cities and professional sectors.

Table 10:
Support and challenges organizations bring to workers

	Organizational feature/goal	Amsterdam		Porto Alegre	
		Perceived as	By	Perceived as	By
Resources	N. and availability of services	Support	Most workers	Challenge	Most workers
	Resources in service	Support	Most workers	Challenge	Most workers
	Training and know-how	Support	Most care	Challenge	Most care
		Not a concern	Most police	Not a concern	Most police
Local manage-	Bureaucracy and regulation	Challenge	Most workers	Not a concern	Most workers
	Manager's turnover	Not a concern	Most workers	Challenge	Most workers
	Unofficial punishments and rewards	Not a concern	Most workers	Challenge	Most workers
Conflicting goals and expecta-	Clear the city and promote users' wellbeing/ safety (police)	Compatible	Most workers	Contradictory	Most workers
		Financially contradictory	Few care		
	Be tough and be friendly	Contradictory	Most workers	Contradictory	Most care and PROERD police
	Make users abstain and reduce harms	Compatible	Most care	Contradictory	Many care
		Not a concern	Most police	Not a concern	Most police
	Help users and arrest dealers	Not a concern	Most police	Contradictory	Most police
		Contradictory	Most care	Not a concern	Most care

In general lines, Amsterdam workers report to be much more satisfied with the support offered by their organizations in terms of resources than workers from Porto Alegre. Few were the cases of workers who thought not having enough resources to do their tasks with drug users.

In this case, variations occurred between the cities, regardless of profession sectors. Differing structural economic conditions in a developing and a developed country play an important role in defining the type and extent of dilemmas street level workers will have when focusing on the resources they have available to include drug users in the welfare system, or ensure they obey the laws. The only similarity across cities regarding resources and dilemmas they bring was that police workers are less concerned with training in how to deal with drug users than their care colleagues: they expect to learn this in practice. However, it is clear that in conflicting goals (such as be tough and be friendly), lack of a more intense community police training increases dilemmas for some police workers in Porto Alegre. Local management, concerns and dilemmas also vary across the city. Major concerns in Amsterdam relate to a perceived increase in bureaucracy and regulations, while in Porto Alegre, management discontinuity and unofficial punishments/rewards generate most dilemmas.

Finally, conflicting goals and expectations brought different sets of dilemmas, both when comparing workers across cities and professions. Here, local policies and guidelines, together with the ways in which services are organized in each city and the interpretive beliefs held by workers play a big role in the variations. In a city where care and order are perceived as integrated, such as in Amsterdam, dilemmas on clearing the city and improving users wellbeing are practically non-existent, but dilemmas on being tough and friendly at the same time are also part of Amsterdam's police workers' daily activities. When care and order are seen as more separated, and contradictory, as in Porto Alegre, lack of concrete support for users when clearing them from public spaces, ordering and caring activities are seen in opposition.

The ways in which services are organized in the cities also influence whether workers will have dilemmas, as well as the type of dilemma in question. A clear separation between harm reduction and abstinence oriented care services make these goals to be perceived as complementary in Amsterdam, but contradictory in Porto Alegre. Since, in both cities, police workers are not directly involved in treatment, these services are not a concern for them. Goals on helping users and arresting dealers also vary according to different organizations in each city. Since in Amsterdam small scale dealing is not a concern for police, and drug use is allowed inside care facilities, differentiations between dealers and users

become a problem for social and health workers. In Porto Alegre, on the other hand, police workers are the ones involved with drug dealing (including small scale), since drugs are strictly forbidden inside care facilities. The different ways in which dilemmas are shaped across the cities and the professions studied will have also a role in shaping variations found regarding the discretionary strategies they choose, and whether a selfish or an altruistic-oriented behaviour will be at stake.

Strategies used to negotiate dilemmas

When looking at which strategies street level workers develop to manage the dilemmas they find in practice, Lipsky (2010:83) mapped three general responses: workers create routines to limit demand and maximize utilization of available resources; they modify the concept of their job to lower or restrict objectives and/or they modify the concept of their clients, to make more acceptable the gap between practice and expectations. Workers can, for instance engage with what Lipsky calls 'rationing strategies', either by limiting or reducing the level of services they provide, and by producing differentiations among clients to define eligibility, culpability and suitability for intervention. In all cases, Lipsky claimed workers would be driven by a self-interested posture.

For Maynard-Moody and Musheno (2000), on the other hand, workers' discretionary choices are driven by an altruistic posture: they are, mainly, concerned with the wellbeing of the people they assist. To pursue these goals, workers might increase their workload and divert from rules and guidelines. These divergent explanations have been already criticized (Evans 2013), more attention to street level workers' professional attachments is needed. A more comprehensive understanding including the different nuances of street level workers practices is necessary. How could the present research, while bringing a comparison between two cities in very different settings and three diverse professional sectors in the drug field, contribute to a more nuanced perspective?

When experiencing challenges produced by their organizations, street level workers participating in this research came up with different discretionary strategies, which are described in this section. Sometimes, these strategies were described by workers right after mentioning challenges, either referring to their own behaviour or to how they perceived their colleagues responded. In other cases, strategies were observed by the

researcher first, and then probed with street level workers later. The same perceived challenge can trigger different strategies for workers in the different cities and professional sectors

Creating priorities

To cope with challenges such as lack of services and resources, but also with goals perceived as contradictory, street level workers can choose to use a strategy of creating priorities on whom to assist. Despite this strategy resembles what Lipsky (2010) has called 'creaming the clientele', at least for the workers participating on this research, it assumes a much more varied perspective. For Lispky, creaming the clientele is one of the ways in which street level workers would ration services, or, establish the level or proportions for services and resources' distribution in order to cope with the unavoidable lack of resources. When confronted with more clients then they can assist, workers would respond by choosing those whom are most likely to succeed (according to organizational criteria of success) (ibid.). This means workers would usually choose for the easiest clients to assist: the ones who would take less effort and would offer higher chances of rewards for both workers and organizations because of their most-likely success.

In the present study, the strategy of creating priorities can also assume different meanings and reasons when applied by street level workers. Workers can, indeed, prioritize to assist/approach those considered easier and more probably successful ones, as Lispky said. This is the case when workers choose those they judge as 'more deserving'. The most deserving users are often identified by street level workers as the ones who 'really want' care and make an effort to fit into higher standard rules of behaviour. High threshold requisites to join and remain in care services, for instance, are a way to assure that the most willing and deserving users are the ones inside care. Since they are willing and obedient, they are easier to deal with. Prioritizing the 'deserving' ones puts the burden of the choice on the user: is not the worker (or the system) who is responsible for letting some people slip out; users exclude themselves by not behaving according to requirements. Selecting to assist the most deserving ones was a strategy referred by some care workers in both Porto Alegre Amsterdam. This quote from a health worker illustrates how the judgement of deserving users works:

> NL19: In the next 4 years or 8 years, we have to save billions and billions of euros, also, in the health system. […] So, with the harm reduction, we manage to keep users alive. Great! But, keeping them alive costs a lot of money. And, then, in the end the discussion will be: Ok, how much money are we willing…[to spend]? So… for those who have Hepatitis C, at one point they might need a new liver and then, automatically, people will say: 'well, we're not gonna give a 'brand new' liver to a person who has ruined his own life. We rather give it to somebody who is functioning well'. Then, that person dies of a liver disease. […] individual doctors, nurses will make those decisions. And it could be very subtle, you know, it could be 'ok, you have to be back here in two weeks from now - or at 8:30 in the morning - for your next appointment. If you don't come we can't do anything for you.' Then, that person doesn't show up, because he can't remember that he has to be there at 8:30, or whatever. And then, doctors say: 'yeah, but he didn't come. You know, we can only treat people who are on time, because, otherwise, we're not going to keep this sort of expensive treatment'. (Amsterdam, health worker)

In the choice for the most deserving ones mixes of moral, financial and medical arguments take place in defining who is entitled to priorities. When describing strategies that prioritize most deserving users, workers were mainly describing what they think other colleagues do, rather than their own behaviour. This judgement seem to be influenced by what Lipksy (2010) would call 'worker bias', or when workers respond to society's general orientations and stereotypes on whom is considered worthy or not. In comparison and competing with other citizens 'in need', drug users are considered to be less worth the effort. When choosing to assist the most deserving cases workers are, indeed, trying to ease their tasks. However, as these cases are most likely to increase the successful rate of their services, the present study argues that this choice accommodates also the needs of their organizations.

Another possibility is that, instead of choosing the most probably successful cases when they lack resources to assist all, workers can decide to prioritize the most vulnerable users. These are the ones judged as 'more needy', which are, in general, considered the most difficult ones, both in terms of relationships with workers and in terms of possible organizational success. This relates, than, with the type of citizen-driven behaviour described by Maynard-Moody and Musheno (2000). When

workers choose those users judged as more needy, they do not necessarily get the most willing and obedient ones, but quite often the opposite.

The most needy are those who usually have multiple problems and are considered as a 'priority inside the priorities'. In social services from Porto Alegre, for instance, street level workers defined pregnant, young and HIV positive users as having the preference among all homeless users in need of a food stamp.

> BR40: …you have to prioritize. Ah, you give it to a pregnant woman, to a youngster…, so you end up creating the priority inside the priority, because you need to have some criterion, there is not enough for everyone. (Porto Alegre, health worker)

Caring for a pregnant, HIV positive, and homeless drug user is certainly not an option workers make to ease their jobs. The main drive workers have in choosing the needy ones is to make their work meaningful for their clients. This perception of workers that fully implementing a policy has value for their own clients is what Tummers and Bekkers (2014) call 'client meaningfulness'. Having to choose which cases are getting a food stamp, a bus ticket, an appointment with the doctor or medicine for treating tuberculosis means other users are left without treatment or with a discontinuous one. This is not something street level workers enjoy doing, or that decreases their work stress. Rather, it makes them feel their work is not effective, or not enough, due to the professional commitments they have to increasing users' wellbeing.

Despite the focus that both care workers from Amsterdam and Porto Alegre give to prioritize the most needy, the ways in which services in Amsterdam are organized make it easier for workers in this city to prioritize the most needy without necessarily having to bend the rules. Facilities with low-threshold rules make it easier to assist them. On the contrary, stricter rules in many care services in Porto Alegre make easier for workers to prioritize the most deserving.[6] In any case, overall, in Porto Alegre workers suffer more with lack of resources, and more often use the strategy of creating priorities.

Many police workers in Porto Alegre and some in Amsterdam also mentioned creating priorities as a strategy. Since it is impossible to approach all that would be considered deviating from the rules, police workers carry out a selective surveillance of society. In both cities, the selectivity clearly connects with clearing the city from stereotypical be-

haviours which are not desired to be seen in public. Here, selectivity does not make police workers' life easier, since they can choose also for more needy subjects and more complex situations. The main drive for workers to perform selective surveillance usually includes accommodating organizational and societal needs, even when they perceive this as not being the most useful way of achieving professional goals of safety and decreasing nuisance.[7]

The strategy of creating priorities can also be used by workers to cope with goals perceived as contradictory. When workers perceive a certain action as not meaningful for the people they assist, they may choose to perform another activity in its place. Instead of openly opposing to orders, workers justify the refusal to obey the rules as a choice for priorities. They are making a better use of their time and of resources of their organizations. This is the case of many police workers in Porto Alegre, who choose to focus on crimes they consider more harmful to society instead of investigating people using drugs in public places or guiding drug users towards signing the consent term:

> The police man tells me it's not worth it to make drug users sign the consent term: is a waste of public money. While they spend time doing the term, the street will be uncovered and someone may be killed or robbed. This has happened already. He was with a colleague in the police workers station doing the term with a user and there was a fight in the area they were supposed to cover. A public servant died in the fight, he says, 'while we were doing a useless work'. Work is considered useless because besides being considered less severe, after the term is signed, the user is usually not called by the justice, since judges do not consider processing drug users a priority (Field notes, Porto Alegre, 25 October, 2010).

When creating priorities to cope with contradictory goals, workers' main drive are usually the meaningfulness the policy they enact have for the people they assist, together with a feeling of usefulness they would like to have as workers.

According to the experiences of street level workers in this research, when choosing for postures which make their work more difficult, workers are oriented not only by perceived worthiness of people they approach, but also by a possibility of result. Regarding judgment of users' worthiness, Maynard-Moody and Musheno state that:

> Cops will ignore serious offenses committed by someone they identify with and judge as a good person (for example the marihuana dealing of a poor, hardworking immigrant who is a responsible family man) while treating harshly the trivial offenses of someone seen as a bad person (for example a pregnant prostitute). (Maynard-Moody and Musheno 2003:20)

In the present study, however, when police workers ignore offenses such as using cannabis in a park or drug dealing, it is usually not because they judge the user or dealer as a poor, hardworking migrant or family man, but because they judge this action unworthy of their efforts in terms of results. They do not see their actions will finally lead to changes, since users and dealers will just be displaced to another area. In police workers' rationality, they better invest their time in more serious criminal problems, which means that their discretionary choice is also not related to a self-interested behaviour of decreasing work stress.

Finding partners

Even though Amsterdam workers constantly build partnerships between and within the professional sectors (as chapter five will describe), Porto Alegre workers were the ones describing finding partners as a strategy to cope with challenges.[8] Finding partner services and workers to collaborate is often used by workers from Porto Alegre as a discretionary strategy to deal with lack of resources and training, or lack of safety. The strategy is used both to alleviate work burden and to assist users in a more effective way. Many partner services lend each other cars to transport or visit users and share part of its monthly quota of medical examinations, bus tickets or food stamps. When a service misses workers with a specific knowledge –such as how to deal with drug use- a partner service can 'lend' a worker to do a group session with users about the subject, or to answer some specific questions on how to proceed. Partner workers can also make joint visits/approaches to users both for safety reasons and to provide quicker access to appointments in their own services. Collaborating (or networking) is also part of organizational rules, so, in these cases, it is possible for workers to meet both users' and organizational needs, while also alleviating their own work burden.

Besides partnerships among workers and services, in Porto Alegre collaboration happen also among street level workers and the people in the districts they work. Outreach workers find local partners to cope with lack of personnel and the need some users have for closer guidance.

Local volunteers are used by primary health care programs, for instance, to improve users' adherence to tuberculosis treatment. Many users cannot organize themselves to take medications at the required times. Since outreach workers cannot do this daily guidance, they found local people who volunteered to store users' medicines and control medication as given on a spread sheet. Besides coping with lack of personnel, this strategy also promotes solidarity, local populations' participation in health care, and may reduce prejudice against drug users. Particular needs of different actors (workers, users and organizations), thus, can be met with this strategy. In Amsterdam, many social services use volunteers as a way to increase human resources. In this city, however, volunteers have a more social role for users, not sharing the work burden with those who have a formal contract.

Referring to the specialist

A special form of 'collaborating' with other services relates to workers' strategy of referring users to a specialist. Some care workers from Porto Alegre see partnership as the possibility of referring users to another service. When street level workers identify someone as a drug user, most of the times they believe a drug treatment is needed. As it was already debated, this judgement relates to certain interpretive beliefs workers hold regarding what to do with drug use which prioritize a treatment focused on a medical frame as the best option. In Porto Alegre, only drug treatment clinics specialize, since shelters, primary health care and outreach workers focus on broader populations, including but not restricted to users. In this non-specialized context, referring to the specialist can assume the meaning of getting rid of difficult clients, excluding drug users from shelters, primary health care and outreach services, and freeing up space for more deserving and collaborative people. In this sense, the search for a 'partner' service to assist the user assumes the meaning of 'getting rid of the problem'. Different from the strategy of finding partners, in this one the service receiving users do not consider this a partnership, but an increase in their work burden.

This strategy finds resonance in Lispky's (2010) described patterns of practice of street level workers to control clients and the work situation. According to the author, workers use referrals as a way of decreasing their work load and also as a protection of agencies by providing 'symbolic' service when actual services are not available (ibid.:132). In the

case of workers participating in this research and using referrals as a way of 'getting rid of' difficult clients, indeed, workers' private goals of decreasing work load can meet the expectations of organizations of decreasing waiting-lines and unsuccessful cases.

Changing services' functions

Changing service's function is a strategy used by many care workers both from Porto Alegre and from Amsterdam, but for different reasons. In Porto Alegre, care workers change in-patient services' function to provide a safe place for users involved with violence. When crack users work as small-scale dealers, they can end up involved with debts, crimes and violence, culminating sometimes in being life threatened, and unable to go back safely to their neighbourhoods. In the absence of other means of protection, care workers use detox clinics or therapeutic communities as safe places, running the risk to reduce the abstinence success rate of these services.

> BR32: Sometimes they come here [detox] in a risk situation, to run away from some situation in their community, right. And they end up using the internment more as a protection space. [..] Just like the family, also sometimes services are using these internment spaces as a strategy, right, to take youth out of risky situations. (Porto Alegre, health worker).

In this case, workers' main drive is to protect users, at the expense of organizational rules and resources. It can also be, however, that workers enjoy the opportunity to meet their needs for decreasing their work load, and transferring the problem to other colleagues.

In Amsterdam, many social workers change user rooms' function to cope with the possibility of these facilities being closed. User rooms were created to provide a safe drug use place for homeless and roofless users. Since nowadays most users have a roof over their heads, there are increasing debates on whether user rooms are still needed. For social workers, much more than offering a safe place to use, user rooms provide a social environment that prevent users from being isolated. Furthermore, these services would have the function of offering stability to users who are often diverting from care.

> NL01: There is a small group of people that they are the hard core, they want to stay on the streets, they don't accept help and they don't accept treatment, so they keep on going to prison and going back to the user

> room, going into therapy an going back to the user room, and not changing basically. The user room is the only thing that give them stability in a way, and if you take that away they go back using in the streets and making problem in the streets. (Amsterdam, social worker).

Changing user rooms' function to social and stable places for users, instead of only safe use places, justifies the inclusion of non-homeless users in them, securing a target population. This, ultimately, prevents facilities form being emptied and keeps the service useful in the eyes of the government and community. Also, the strategy tries to secure a service that is perceived as having been useful for users. Both workers and users' needs are accommodated in these cases, at the expense of organizational resources.

Corruption

When workers lose their hopes of achieving something useful either for the state or for the citizens, they may start pursuing only personal benefits which are not related to a commitment to a certain professional logic. When the system is perceived as failed, workers have a general disbelief in the organization's efficacy to achieve its goals. Searching for personal advantages, some workers end up becoming corrupted. Corruption was mentioned by street level workers as a strategy being adopted by other workers, not themselves. In general, ideas about corrupted workers were related to police workers. Many police workers from Porto Alegre and few from Amsterdam were believed to be corrupted. 'Diverting' seized drugs and allowing drug dealing through bribes were the main examples given.

For many police workers in Porto Alegre, corruption of other law enforcers and politicians is believed to be a reason why their work is not effective as it should be. Even if they fight crime and drug traffic, corruption acts against their job. Drug seizures are 'diverted' from police stations to be sold in the black market, drug dealers are allowed to keep managing traffic from inside prison, and people who are supposed to be arrested get a free pass by 'greasing the correct palms'. In sum corruption makes it difficult to achieve justice. Corrupted system also involves police workers 'planting' drugs to arrest someone, communities which protect dealers from being discovered, hierarchy and agreements between institutions hinder denunciations of corruption. In Amsterdam, since the

police force is well paid, workers believed the amount of money diverted or involved in bribes in this city has to be bigger (than in Brazil) to be considered worth it. The underlying belief is that, to take a risk in corrupted activities, workers have to perceive it as financially worthwhile relative to their salaries. In this sense, corruption is believed to occur in Amsterdam more often in a higher level of drug traffic than the one street level workers intervene.

Few police workers from Porto Alegre described that, when a corruption scheme is part of a service, a worker who does not join the scheme might have serious problems. Besides lack of recognition or exclusion from the group, this can lead to displacements, prejudice inside work, and even harm career development. In more extreme cases, this can lead to life risk, such as not being backed up by a colleague in hazardous events or being killed for knowing too much. Threats, together with the advantages corruption might bring, make resisting corruption a daily exercise.

> BR03: The access is very simple. Many times I had the unpleasantness of arresting people with big quantities of drugs. If I corrupt myself, like, I got the guy with 70 [crack] stones. I can corrupt myself and get 5 to me, and sign 65. It is indifferent because… from the moment that I seized it from him, it is on my power. I´m not going to give him to count back and say to the delegate 'no, it is missing 5'; I do my report on paper, and the paper accepts whatever I write. (Porto Alegre, law enforcement worker)

On the delegate's side, some complaints were made about corrupted police colleagues who would seize a certain amount of money from dealers and report only part of it to the police station, supposedly 'filling their pockets' with the rest. On the users' side, those formerly involved with drug traffic reported that corrupt police workers can oblige them to sell drugs to get the profit, threatening to arrest or kill them in case they deny. When the strategy chosen to deal with challenges is corruption, only personal needs are being fulfilled.

Fooling around

A 'lighter' form of seeking personal benefits reported by workers is what they call 'fooling around'. In these cases workers might simply ignore some of their duties and pretend they work while they do not. The main reasons for workers to use this strategy are a perceived lack of effect of

policies in citizens' well-being and/or disliking the job. Similar to corruption, the strategy of fooling around was more often mentioned as being done by other workers. In any case, it was observed both in Amsterdam and in Porto Alegre, in all sectors, for some workers.

When workers do not believe in the effects of activities they are supposed to carry they might fool around in different ways. Outreach workers can go to the streets and fool around without approaching anyone; care workers can stay inside staff room or can pretend to lose more time with paper work than actually needed in order not to be in touch with users; workers in general can extend the lunch hour, leave earlier or fake sick leaves; and police workers can pretend not seeing someone committing a fault.

> BR07: …the child is born without a father, lives in slum, has no education…what he will become? And then, to change that person in a prison, it's impossible! Even if the police workers acts, that person will leave the prison and will be trapped into a vicious cycle, if there is not a policy to cut this cycle […] Then the police worker thinks 'oh, what's the point of arresting if he'll be released tomorrow?' (Porto Alegre, law enforcement worker).

Besides the frustration regarding the meaningfulness of the activities workers are supposed to do, another underlying belief in fooling around is that organizations ask much more from workers than what they can or are supported to do. Therefore, it is perceived as fair to lower their contribution to organizations and ease their work, so a balance is achieved between what they give and receive. The main drive for workers when choosing fooling around as a strategy is to decrease their efforts and secure more private benefits.

'Paying to work'

Going to the opposite direction, when trying to overcome lack of resources for users and for themselves, some workers choose to work with full commitment and personally supplement resources, being determined to achieve good results no matter how bad work conditions might be. This tended to be the case when workers actually believed in the goals and the organizations they were working for. These street level workers, which were present in both cities, differentiate between those who work for a higher goal and those who work just for the money.

> NL04: Some people work with their heart, some people work with their wallet. You know what I mean? They just [say] 'I make my hours and if the result is there, the result is there; it is their responsibility, everybody is responsible for their own problems, I just can guide'; you know? I don´t think like that. (Amsterdam, social worker)

Paying to work was more often used as a strategy in Porto Alegre than in Amsterdam, and it was observed in two different situations: to cope with lack of resources for users, and to cope with lack of work conditions. In the first case, few workers from Amsterdam, mentioned to make extra efforts to find users a vacancy, a benefit, or to get an appointment. Sometimes, this led them to work extra non-paid hours and to perform tasks beyond organizational requirement. In Porto Alegre, many workers mentioned to work extra without receiving financial benefits for it, perform tasks beyond organizational requirements or responsibility, or literally pay to work:

> BR35: We have a team of professionals who do everything so that things actually work. […] we have the occupational therapists who do candle workshops [with users]. But then it is missing the material: wax, all that stuff you need to workshops. They take out from their pocket to be able to keep the workshops. (Porto Alegre, health worker).

Trying to cope with lack of resources, Porto Alegre workers from all sectors sometimes pay from the own pockets to give users benefits such as bus tickets, food stamps, or a prize for a sport contest. Not rarely, workers stay non-paid extra hours or do extra shifts to be able to approach missing users, or to accompany them to other services. When paying to work to cope with lack of resources for users, workers are driven by the idea of benefiting users in the first place, even if this means increasing their work load without financial compensation. Besides that, even if they are not getting any strictly personal reward, they are fulfilling their professional commitments of increasing drug users' life quality.

Another reason leading workers to use this strategy was found in Porto Alegre, where paying to work also involves workers paying for conveniences to improve their work conditions. Buying fans, coffee machines, fridge, micro-wave and even toilet paper is common among workers from all categories. Paying for work-related training done on their private time is a common way for workers to cope with lack of training offered by the organizations. In all these cases, street level work-

ers are trying to make their work more comfortable, but this well-being is also improving the condition of the services they work for, without costs for the system.

When paying to work, street level workers do not necessarily choose a few deserving ones to benefit from their efforts. Rather, they may do that for several different users or for a group of them, including those considered non-deserving or difficult to deal with. Not always, thus, extraordinary services would be given to those deemed worthy, as Maynard-Moody and Musheno state (2003). More than choosing for the worth of a person, workers choose for what they consider to be a worthwhile situation. Not only morality plays a role here, but also a balanced assessment of interpretive beliefs, resources, peers perspectives and their relationship with users. If a candle workshop is perceived as benefitting users; seen as possible in terms of extra resources needed; perceived as good by some peers and managers; and is well received among users, all these will increase the chances that workers take a decision of paying to work.

Opposing to orders

When street level workers believe a local rule or guideline hinders their goals with users, and thus the performance of their work function; or when they do not have enough resources to perform a certain action, they may as well oppose the orders. Different from when workers choose to fool around or to create priorities as a way of not following rules, in this strategy workers openly oppose to orders, even when this might bring professional consequences. This was the case of some care workers from Porto Alegre.

Some care workers in this city, refused to operationalize clearing policies of removing homeless from parks without giving assistance to them. The refuse usually brought consequences for workers, such as pressure or harassment at the work place.

> Tamara, an outreach worker, tells me 'You can't imagine the things they have asked us to do, it is disgusting' 'they want us to clear the city'. According to her, the new municipal government also asked the team to count how many homeless children were at [avenue], without giving them any assistance. Managers threatened to punish the team with a written advertence for denying to do their work. Tamara replied to the manager 'well I want then that you get my job description, if this is there I'll do that,

> but I know it is not; otherwise I will do only if I receive a written request'. Smiling triumphant she says 'of course they won't write a request like that, it is not part of my job'. (Field notes, Porto Alegre, 25 October, 2010).

The reasons to oppose to rules here are not only driven by a judgement about users' moral worth: they also include workers' interpretive beliefs about what would be the best to do regarding drug use. In this case, no matter if the users are perceived as 'good' or 'bad', the action in itself is perceived as outrageous from a professional perspective. Here, Evans (2013a) proposal of analysing workers' discretionary choices by looking at their conceptions of the purpose and aim of their professional work is valuable. As Evans says, workers might criticize local managers for interpreting their guidelines as unethical towards people they were assisting, when they feel they are not acting according to 'basic ideas of good practice in their profession' (ibid.:9). Workers, thus, are concerned with the meaningfulness of policies for their clients, but, what is considered to be meaningful depends on workers interpretive beliefs around what a best practice is in their professional field.

Another point of variation here refers to workers' concrete conditions of work, more specifically, the types of work contract they have. When opposing orders, workers usually go further to openly debate it at work in formal participatory interactions, seeking to change the rules by official means from 'below'. Assuming more active positions against an order, as it was already said, depends on the importance the subject has for the worker in terms of interpretive beliefs and professional background. The type of work contract, or stability, however, is also crucial: civil servants, when compared to outsourced workers, have more room for negotiating non-compliance of goals. For outsourced workers, to openly debate and contradict a managerial goal, brings much higher chances of dismissal.

In the revised edition of his book, where Lipsky (2010) considers the changes which occurred in the government in the last 30 years, he mentions the widespread use of contracting for public services with non-profit organizations. If this new configuration created a new kind of street level workforce, he says, these workers still fit the street level bureaucracy profile (ibid.: 216). When analyzing the experiences of street level workers in the present research, we found that, indeed, outsourced workers do not differ from civil servants in terms of their overall treatment to drug users. However, their less stable (or more vulnerable) posi-

tion regarding work contract reflects on their discretionary decisions, or postures they take, when conflict arises. Outsourced workers tend to be less critical towards organizational norms and rules, and, more than civil servants, tend to accommodate organizational needs to the needs of the clients or their own. Very rarely these workers mentioned to disregard or go against the rules, at least in an open manner.

A 'less open' way of opposing the rules is when, considering that following the rules is unfair towards users, street level workers manipulate official procedures to obtain the desired result. This may imply making rules flexible for users, or even using rules to favour instead of punishing users. This was understood by street level workers as 'taking justice into their own hands', and expression used very often by law enforcement workers.

In the case of police workers, this might mean, for instance, deciding not to arrest a user who just started to work for drug traffic, based on a disbelief of prison as useful to help 'recover' the person.

> BR36: It can prevent some injustice. For instance, a brigadier comes here presenting someone for traffic. I make an analysis, very fast, but I realize that there are strong evidences for dealing and I let him in possession. Because, that's the thing: if he is a dealer, in six months, a year from now he'll be arrested for drug trafficking. [So] In doubt more or less grounded, in a matter of logic, I make justice. (…) That is the justice you can do, right, not to put [the person] immediately in that situation of the prison system. Even though he had already begun selling, was at the boundary between sell and use only; [he] had begun to sell to be a consumer. [So] I alleviate to him. (Porto Alegre, law enforcer).

In this case, the worker may be assessing users' character as well, but, overall, the main justification for bending the rules comes from a disbelief in the organization. The same justification is usually given by the many care workers who make rules flexible in order to benefit users. In their opinion, the rules made flexible are not adequate to promote users' well-being and life changes.[9]

The five postures driving street level workers' decisions

This concluding section builds on the challenges and support workers mentioned getting from their organizations, in combination with the strategies they develop to cope with dilemmas to produce a more nu-

anced understanding of what influence workers' discretionary choices. Table 11 summarizes the main drives and strategies adopted by workers, bringing illustrative examples of the postures/strategies adopted. In the following pages, examples of each posture are further explored, together with a comparison between the cities and professional sectors.

Table 11:
Drives and strategies to deal with organizational challenges

Main drive	Strategies	Examples*	Problem
Organizations +workers +users POSTURE 1	None (follow rules)	Clearing the city and helping users (Adam)	No problem
Workers + users POSTURE 2	Prioritizing (one guideline)	Not signing consent term, enforcing abstinence of one drug only	Contradictory rules
	Finding partners	Joint house visits, share bus tickets, exams, cars (POA)	Lack of resources, training, safety
	Changing service's function	Use detox as safety place (POA) User's rooms as social places (Adam)	Lack of services (POA); danger of closing down facility (Adam)
Workers + organizations POSTURE 3	Prioritizing (most deserving)	Choose the easiest cases: compliant, less dangerous	Lack of services and resources
	Paying to work	Paying for training, toilet paper, private guns (POA)	Lack of work conditions
	Referring to the specialist	Send users to treatment to 'get rid of' them	Lack of training and resources
Workers (personal) POSTURE 4	Corruption	Accept bribes, divert seized drugs or money (police)	General disbelief in the system
	Fooling around	Avoid approaching users, work less than official working hours	Lack of work conditions; dislike the job
Users POSTURE 5	Paying to work	Pay for bus/ food ticket, non-paid extra hours (POA)	Lack of resources for users
	Prioritizing (most needy)	Choose the hardest cases: more problematic (care) or dangerous (police)	Lack of services and resources
	Opposing orders (diverting rules)	Not arresting small scale dealer	Contradictory rules
	Opposing orders openly	Refusing to displace homeless users	Lack of resources, contradictory rules

* Adam= Amsterdam; POA= Porto Alegre

In the two cities studied, street level workers can chose to take, in general, five different postures to negotiate challenges and support brought by their organizations: 1) simply follow the rules; 2) try to find a middle way between what they think the client needs and what the or-

ganization demands and offer; 3) try to find a middle way between what the organization demands and offer and what can benefit them as professionals; 4) deny the possibility of either helping users or following the rules and try to benefit personally from the system; 5) deviate from the organizational system and use discretion to assist users as citizens with rights, even when this means facing more difficulties.

Rather than having a unique and steady pattern of behaviour, workers can decide for different postures depending on the extent to which they believe in the goals and support their organizations can provide them and the users they assist in specific situations. For each posture, a set of different strategies was found to be used by workers participating in this research. Sometimes, similar strategies are chosen for different driving reasons, resulting in a variety of examples of discretionary practices. Virtually all postures and strategies could be found in both cities, but these were applied by workers in different extents varying according to perceived support workers receive from their organizations, and their professional goals. The five postures are now described.

Follow the rules

The more satisfied workers are with the organization in terms of both perceived support and meaningfulness of policies for the users, the bigger the tendency for them to follow organizational rules (posture 1). In these cases, workers trust the system and the organizations they are working for, and see a meaning for users and for themselves as workers in following the rules. They do not perceive their tasks as bringing dilemmas for them, and therefore, do not need to use their discretionary power to change the way they are expected to act.

This is the example of most care workers in Amsterdam regarding placing users in the different services when they are satisfied with the number and availability of services and resources inside the services. Also care workers in Amsterdam, mentioned to just follow general rules on how to get training promoted and/or supported by the facilities they work. Goals of clearing the city and promoting users' wellbeing/safety for society, and making users abstain and reduce harms. This is also the case of most police workers in Amsterdam that arrest dealers and do not worry with helping them if/when they are users, and care workers from Porto Alegre who do the opposite: help users regardless the fact they might be also dealers.

When workers trust the rules are benefitting the clients, and perceive the procedures as fair and feasible to be performed in their daily work, they tend to follow the system. Following the rules, thus, does not mean a choice driven by a willingness of workers to decrease their work and increase personal benefits. Nor it means disregarding the needs of the citizens workers assist. Rather, it seems to be a balanced decision, where workers ponder the possibilities of meeting their organization's needs, users' needs and their own perspectives as professionals.

Finding a way between citizens and professional needs

More often, workers find tensions between what is offered and expected from their organizations, what is needed or expected from the people they assist, and what they can (or think they should) do as professionals. In these cases, workers try to find a way between needs. The common feeling workers have in these cases is that it is difficult to accommodate different needs and perspectives, but it is possible and worth trying.

One of the possible posture workers take is that they try to balance citizens and their own professional needs (posture 2). When perceiving rules as contradictory in terms of what they would produce for the people they assist, and also in terms of what workers believe themselves to be the best to do with drug use, some social and health workers from Porto Alegre, and many police workers from both cities prioritize other activities than the ones required by their organizations. Police workers from Porto Alegre choose not to approach drug users in parks, and not guide users towards making a consent term so they have more time to fight more important crimes. In Amsterdam, community police workers choose 'not to see' when drug users are sleeping in the public space or making light nuisance when they know users are already in care and perceive as not functional to give them a fine. Some care and police workers from Porto Alegre, might decide not to approach homeless people when they do not have something to offer (care) and would just displace users (police). In all these cases, workers are using a strategy of 'prioritizing', but not necessarily with the intention of rationing resources, as Lipsky (2010) contends. Rather, workers are basically caring about the citizens they assist –as possibly Maynard-Moody and Musheno (2003) would state- while also following their professional commitments (Evans 2013).

It can also be, as the case for many care and police workers in Porto Alegre, that workers try to find partners to cope with lack of resources to assist users, lack of training and lack of safety. In these cases, workers exchange benefits their organizations offer, share their time with other services, and make joint visits or approaches to users. From a strict organizational point of view, sharing resources might not be the most efficient way to secure higher performance. For workers, however, this means sharing their work burden, temporarily improving work conditions, and better assisting their target population.

Finally, some workers can also change their services' functions as a strategy to both try to prevent facilities to close down (and so to secure their jobs), and to provide what they believe is best for users. This was the case of social workers from Amsterdam working in user' rooms, who broaden these facilities purposes to include them as social places for users, so they do not to get socially isolated. In Porto Alegre, many care workers also change the function of services to protect users, and possibly to decrease their work load, when using in-patient drug treatment as a safety place for users in situation of violence. This allows the acceptance (or continuation) of users who have a more stable housing situation and have user rooms as an important place in their life organization. At the same time, it prevents facilities from being emptied and workers dismissed or diverted to other services. When finding partners or changing service functions, besides caring about users and about their own professional ideas of 'best practice', workers are also investing in their personal safety and trying to release some work stress.

Finding a way between professional and organizational needs

Another way of trying to accommodate different needs and perspectives, is when street level workers try to balance their own professional needs with the needs of their organizations (posture 3). This was typically done by workers when trying to cope with lack of various resources. Therefore, was found more often in Porto Alegre.

One of the strategies used in this path is to create priorities. This is the case of most police workers from Amsterdam and Porto Alegre who created priorities and performed selective surveillance to deal with the gaps between demand and human resources. By selectively approaching drug users, especially the ones who more obviously look like homeless and socially vulnerable, workers comply with organizational expectations

of clearing the city, while being personally rewarded by the feeling of accomplishment coming from organizations and society. Many care workers from Porto Alegre and some from Amsterdam adopted this posture when deciding to cream the clientele by choosing the considered 'most deserving' users to be assisted. Since the most deserving users are usually easier to work with and offer more chances of success, workers make sure to decrease their work efforts and the lines in their organizations while increasing possible organizational rewards for successful cases.

Another strategy used to accommodate workers and organizational needs is referring drug users to the specialist. This was done by some social and health workers from Porto Alegre that, when finding a drug user, immediately referred them to a drug treatment place as a way of getting rid of a problem. In these cases, workers either did not believe they had appropriate knowledge to deal with drug users, and/or did not have enough vacancies for them. Finally the strategy of paying to work was also used to benefit both workers and organizations in some circumstances. This was the case for many workers in Porto Alegre who bought fans, toilet paper, coffee machines or paid for their own professional training to cope with lack of resources from their organizations. In these strategies, many times it was possible for workers to combine their professional commitments with their professional needs in terms of releasing work stress and creating a more comfortable environment.

Seeking personal benefits

When workers do not believe in the system and its rules as a way to achieve something useful for users or even for the organizations they work with, they may start pursuing only personal benefits. Non-official or illegal ways of achieving collective and private goals are, then, used by street level workers as ways to deal with challenges. This was the case when workers used strategies of becoming corrupted or fooling around instead of fulfilling their activities. In the first case, many police workers from Porto Alegre and few from Amsterdam were believed to accept bribes and divert drugs seized from traffic to make money. Small bribes to promote selective arrests were also said to be accepted in Porto Alegre.

In the case of fooling around, some care and police workers from both cities would pretend not to see people committing a fault in the streets or inside a service, or simply pretend to be busy with paper work

or something else not to assist users or make appointments. Faking sick leaves, extending lunch hours or working less hours than required are also part of this strategy. Clearly, neither users nor organizations benefit from this type of behaviour. Workers also, were not following any higher commitment to a certain professional goal. In this case, they were more bluntly assuming the so-called selfish' position.[10]

Benefiting users

Finally, when dealing with dilemmas, workers may choose to bend the organizational system to work in favour of what they believe to be the client's needs, to provide users. When workers make this choice, Maynard-Moody and Musheno (2003) would say, they are being basically citizen driven. In these cases workers may prioritize to assist users who are considered more difficult or 'needy', as it was the case of some care workers from Porto Alegre and from Amsterdam. Workers may also work beyond organizational requirements even without receiving financial compensation, in a strategy of paying to work, which was adopted by many workers from Porto Alegre to deal with lack of resources for users. It could also be that workers clearly oppose to organizational orders, as when some care or police workers from Porto Alegre refused to displace homeless people from parks and commercial establishments, or when care workers refused to ask users to become abstinent when they believed harm reduction was the best option for them (or refused to work with harm reduction when they believe abstinence should be the solution).

These strategies were adopted even when causing problems and increasing work burden for workers. Workers were being, thus, 'altruistic', or citizens driven. In their discretionary choices, however, workers were not being driven by a simple selfless attitude towards drug users. In their decisions of bending or opposing organizational rules to support the population they assist, were present underlying beliefs about what best practices in their field would be in order to achieve this goal. In this sense, the common idea guiding workers' choices for these strategies, was not a judgement on the moral worth of the citizens they assist as Maynard-Moody and Musheno (2003) would say. What mainly drives workers to be citizen driven, in this case, is the perception that organizational rules and support work against their main professional role and

objectives with users. Professional attachments, thus, influence on workers' drive towards users' wellbeing.

What drives workers' choices for a path

Overall, when workers believe the system is able to respond to users' needs, and is feasible in terms of what is asks from workers, they tend to follow organizational rules and goals (posture 1). Most of the times, however, workers perceive the tensions between organizations' demands, citizen needs, and their own limits as workers, and try to accommodate their actions to meet different needs as much as possible. The posture they choose to take, more often, is to try to accommodate users' needs and their own interpretive beliefs (in terms of professional attachment) and comfort as workers (posture 2). Another response, is to give less importance to users and their needs, and more to their organizational rules and expectations, combined with their professional needs and interpretive beliefs (posture 3). Even perceiving these combinations as difficult, workers regard negotiations possible.

In the fourth and fifth cases, however, discretion is seen as too costly or impossible to make and two more extreme and less frequent postures emerge as possible for street level workers. When workers disbelieve the system's capacity for effective action in users' lives, and this meaningfulness for the clients they assist assume a critical importance, workers try to cope with the gaps by increasing their efforts. They will be driven by the needs of the users they assist, opposing organizational rules, and often increasing work and efforts for themselves beyond required to pursue what they believe is best for users (posture 4). However, when workers disbelief the system in terms of changing users' life, and also perceive it as making unrealistic demands upon them, they might try to take personal benefits out of it (posture 5).

What the present study found, regarding street level workers' reported and observed experiences is that more often than not, workers tend to combine both concerns for the users they assist and for themselves as workers, possibly also with concerns for the organizations they work in. Indeed, in some cases workers assume self-interested behaviour and choose a posture and strategies that would only benefit them personally. Strategies of 'fooling around', for instance, are comparable to what Lipksy (2010) describes as rationing services and limiting workers' availability in terms of time and effort spent on clients. In other cases, however,

might assume a posture of defending the interest of the user, even when this brings a higher workload for work. In these cases, workers might work extra-hours, oppose orders, and choose the most difficult users to assist, for instance, making their work harder, more unpleasant and less officially successful, as Maynard-Moody and Musheno (2000) would say. However, most of the times, workers combine concerns for users, organizations and themselves as workers. The notion of professional commitments is important here. Workers do think about themselves most of the times in which they take decisions on which posture to take. Considering their own perspective and well-being, however, does not necessarily mean ignoring organizational or users' needs. When thinking about themselves, workers can be driven not only by the willingness of decreasing their efforts: they might also be driven by strong interpretive beliefs about what to do with drug use, and the professional feeling of fulfilment when working towards what they believe is best.

In this sense, the findings of this study approaches the perspective offered by Evans (2013a) that discretion may reflect both concern with self and others, and may also reflect different understandings and analysis of a problem, and different ideas about the appropriate solutions. Indeed, it is fundamental to look at workers professional commitments to understand their discretionary choices. In this regard, however, it is necessary to map the different nuances within professional groups. What is considered to be best practices in a field are usually under dispute, not only in official policy documents and between actors in different levels of policy, but also within street level workers' professions. In this regard, mapping the different ways of framing a given policy issue, and how workers adopt/mix the frames in their interpretative beliefs can be essential to understand some of their choices. At least in fields where 'best practices' are not strongly agreed. In the case of the workers participating in this research, for instance, a guideline of clearing the city or decreasing public nuisance might be very welcomed as consistent with workers' 'professional moral project' or 'ethical concerns'; while for others this might be an affront. These workers might be coming from the same profession, and even be working in the same service, but they frame problems and solutions in different ways, based on different possible interpretive beliefs about what a best practice is. While some would feel to be following higher professional goals when decreasing public nuisance, others would feel this as outrageous to their professional commitments. For some

workers, control is what will benefit the citizens they assist, while for others, empowerment is the way to go.

Comparing street level workers practices across two different cities and three different sectors, allows us to see how the different environments shape their discretionary choices in different ways. Overall, when compared to Porto Alegre, Amsterdam workers tended to find easier to achieve a balance between organizational, users and/or professional needs (postures 1, 2 and 3). When compared to Amsterdam, Porto Alegre workers tended to find these balances more difficult to be achieved, and assumed more often extreme postures of pursuing the needs of users (posture 5) or their own needs at work (posture 4). Lack of resources and work conditions in Porto Alegre make workers from this city more inclined to assume extreme positions when compared to Amsterdam.

When looking closer, even more nuances were seen. Both regarding resources and local management, differences across cities stood out more than differences across professions. While, in Amsterdam, workers' felt backed up by their organizations, in Porto Alegre they felt abandoned. These challenges led workers from Porto Alegre to engage in some discretionary strategies which were not mentioned or observed for workers in Amsterdam. Street level workers from Porto Alegre, coming from all professions, mentioned literally 'paying for work' on order to cope with lack of resources. This could be driven by two postures. In one case, workers were more strictly attached to provide users' needs (posture 5), and reported to pay for bus tickets or food stamps to drug users, and work extra non-paid hours to accomplish their tasks. On the other, workers would take a posture of combining their wellbeing as workers with benefits for their organizations (posture 3), as when they engage in strategies of paying for resources to increase work quality – such as work training, fans, coffee machines or toilet paper. In Porto Alegre, workers mentioned to engage in strategies of searching for partnership to borrow resources from other services in order to assist users and release a bit of their workload (posture 2).

Besides, more often than in Amsterdam, workers in Porto Alegre mentioned to oppose rules they believed were not useful for the clients they assist, even when they had to openly face conflict with their managers and/or colleagues (posture 5). The type of contracts the workers had influenced on the extent workers would use this particular strategy. Room for negotiation was bigger for those who had more stable con-

tracts (civil servants) than for those hired as outsourced workers. Extreme attitudes towards an opposite posture of self-interest (posture 4), were more often believed to happen in Porto Alegre than in Amsterdam, especially in the use of corruption in the law enforcement sector. Higher salaries and better of work conditions in Amsterdam were understood as the reason why less workers would engage in corrupted activities in Amsterdam.

In the case of conflicting goals, besides the different resources available for workers, professional attachments were very important factors in explaining workers' discretionary choices. Especially in the case of conflicting goals, interpretive beliefs of workers regarding what was considered to be best practice were important to explain the dilemmas they had and strategies they chose. The case of disputes around harm reduction and abstinence based approaches is one example. In Porto Alegre, much more than in Amsterdam, workers believe crack cocaine has too strong properties to allow users controlled use of the drug. In Amsterdam, on the other hand, a controlled use of crack and heroin is pursued by substitution treatment and users' rooms. Only in cases where users are willing to stop, or are repeating offenders, is a total abstinence treatment pursued, in different facilities. In Amsterdam, services are clearly separated between those low-threshold (or harm reduction oriented) and those abstinence oriented. This division facilitates workers to perceive abstinence and harm reduction as two different, but possibly complementary, approaches. A disputed field between these approaches with unclear goals inside services in Porto Alegre, bring daily dilemmas for workers, and leave decisions to be negotiated among colleagues and managers.

In sum, the professional attachments and interpretive beliefs across sectors, and also the different support workers receive in terms of resources and clear goals to execute their tasks, shape their discretionary choices in different ways in Amsterdam and in Porto Alegre. In workers' relation with their organizations, the structure and conditions they are offered define the possible range of actions workers have, and also influence the way they judge users and their rights as citizens. In doing their discretionary choices, workers judge situations based both on the users they assist, their professional commitments and interpretive beliefs, and the rules and resources at hand.

Notes

[1] See Friedson (2001) *Professionalism: The third logic*. Cambridge: Policy Press.

[2] Despite having few problems with resources in the period of fieldwork research (2011), workers from Amsterdam had a fear for future financial cuts, due to the economic recession. This was, however, more a matter of trying to predict problems that could arrive than something that was currently happening.

[3] The present study does not focus on street level managers or their relationship with workers, only on perceptions street level workers have from their experiences. For a discussion on the importance of local management in street level workers' discretion see Evans (2010, 2011).

[4] Negotiations and flexibilization of rules between workers and users are analysed in chapter 6; negotiations between police workers and care workers are analysed in chapter 5.

[5] In Brazil the term 'brick' is used to describe a bigger quantity of marihuana. Marihuana usually comes pressed, to decrease volume during traffic transportation. When in bigger quantities, the appearance resembles a brick from a construction site.

[6] However, it is very important to remember that, given territorial differences in socio-economic terms, the considered most needy in Amsterdam are, usually better off than those considered 'deserving' in Porto Alegre.

[7] Drug users associations, however, had a different point of view in Amsterdam. For them, police workers would use selective surveillance towards users to facilitate their lives when having to fulfill their fine-quotes. Drug users were considered to be easier and less-complaining targets when compared to other citizens who might use drugs and make nuisance on the streets.

[8] This chapter briefly describes how partnership is used as a strategy to cope with lack of resources, training, and safety. Chapter 5 brings an in-depth analysis of collaboration among workers from different sectors when assisting/approaching drug users. More than a strategy, collaboration (or networking) is a way of practice in the territories, with important consequences for policies.

[9] Flexibility of rules is part of the strategies used by street level workers in their daily interactions with users. These negotiations are going to be discussed more in-depth in chapter 6.

[10] One can discuss, however, the extent to which these attitudes were really benefitting workers. Most of the workers making use of fooling around strategies, for instance, were clearly not comfortable or adapted in their jobs, and seemed to present a degree of work-related mental suffering.

5

Negotiating meanings and goals: ambivalences in networking

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Inter-agency collaboration has been considered of fundamental importance to achieve successful drug policies. An integrated approach is understood as resisting fragmentation along organisational boundaries, to increase cost-effectiveness for organizations and assure better access to resources for drug users. Lack of collaborative relationships between services and the different professional roles may confuse users and increase unit costs for services and waste workers' time and energy. In their official drug policies, it is rational for governments to claim to pursue an integrated approach, as in the cases of the Netherlands and Brazil.

At the street level, however, collaboration between social, health and law enforcement sectors can be difficult. As previous chapters have shown, organizations approach users in a variety of ways which challenge workers faced with putting these differing approaches into practice when dealing with the same user. Thus, the drug field carries a myriad of possible approaches towards drug use. Very often, when building networks to approach drug users, workers with different practices and interpretive beliefs around what is the best to do have to work together. They need, then, to negotiate different meanings and objectives. Sometimes, however, negotiations around what is best to do might not be regarded as possible with some partners, and workers may decide not to work together, even if official policies and guidelines do incentivize that. In other cases, workers with a similar understanding of problems and solutions around drug use, might have difficulties to build partnerships due to lack of resources in one or both organizations.

Different territories and professional sectors bring specific perspectives to street level workers' practices, and therefore, also specific dilemmas to workers on how to build collaboration in the streets. Here, an interesting question arises for analysis: how the different territories in Amsterdam and Porto Alegre, and also in the three analysed sectors influence the types of collaboration built by street level workers? And fur-

ther, why and how workers would use their discretion to decide on whether to build networks with other colleagues and services or not? What are the outcomes of different patterns of collaboration for the workers and users involved? These questions are analysed in the present chapter. The focuses is on social, health and law enforcement workers' interactions in their daily approaches to drug users, to investigate how and why these encounters happen, and how meanings, resources, and goals are negotiated by workers daily.

Respecting a grounded theory approach, the analysis follows workers' experiences with collaboration in the search for conceptual tools emerging as valuable to further explore their practices. In this case, the concepts of network (Musso 2004) and power (Foucault and Gordon 1980) were chosen, together with some contributions from studies around collaboration in the organizational field. The following section presents a brief literature review around inter-agency collaboration and the importance of street level workers' interactions in the making of policies, together with a framework for analysis of workers' interactions based on a grounded theory approach of their experiences. Last sections look at how flows between services and workers are structured and how network dynamics happen in Amsterdam and Porto Alegre, respectively. The main challenges workers face at the street level and their reasoning for discretionary choices around networking are described. Finally, an account of what networking produce for the different actors in the studied cities is provided. Attention is paid to how the different environments shape workers' discretionary choices regarding collaboration within and between sectors.

Workers' interactions and networks at the street level

Street level workers from Amsterdam and Porto Alegre used expressions that can be broadly translated into English as 'networking' when describing their experiences of collaboration with other workers and services. At the street level, coordinating the flows between the different services approaching drug users is said to be fundamental to put the Dutch *integrale aanpak* (integrated approach) and *samenwerking* (collaboration) and the Brazilian *integralidade* (integrality) and *rede* (net) into practice. Both in Amsterdam and in Porto Alegre, networking is seen by most street level workers as an important part of their daily work.

Also in the official drug policies, the concept of 'network' assumes importance for the cases studied. Brazilian and Dutch drug policies (e.g. Stadsdeel Zuidoost 2010, Stadsdeel Zuidoost 2006, Brazil 2011) refer to integrated networks as a goal to be achieved in policy implementation. Similarly, the literature debating policies in Amsterdam and Porto Alegre (Zambenedetti and Silva 2008, Plomp et al. 1996), advocate developing collaboration by 'building networks', or promoting an integrated approach for users. Scholars have used the concept of networks (or integrated systems of services) to analyse the ways in which public policy is implemented in Brazil and the Netherlands, and to propose improvements in the delivery of care (e.g Mendes 2011, Zambenedetti and Silva 2008, Cecilio 1997, van Raaij 2006). Their work brings the possibility of thinking about networking in public policy terms, seeing workers interaction inside a developing system of welfare focused on a target population.[1]

Also in in public administration studies, 'inter-organizational networks' are seen as fundamental from a management perspective, both to build local public networks (Span et al. 2012) and relationship changes among health organizations (Wendel et al. 2010). Providing social support and integral health care in the public system, for instance, is seen as requiring dynamic and complex networks, since discretion and a variety of connections between organizations are needed to customize complex and varied service demands (Span et al. 2012).

At least in the care sector, the concept of integrated service delivery networks is influenced by definitions of the World Health Organization and its regional offices, which advocate for more integrated health services in developing and developed countries. Integrated Health Service Delivery Networks[2] are defined by WHO as

> a network of organizations that provides, or makes arrangements to provide, equitable, comprehensive, integrated, and continuous health services to a defined population and is willing to be held accountable for its clinical and economic outcomes and the health status of the population served (OPS 2010).

Within this frame, an integrated network of services is supposed to be more client oriented and to contribute to achieve continuity of care over time and to increase access for users. Since networking is also meant to

fight services' fragmentation, it is seen as being more cost-effective and equitable (Mendes 2011, OPS 2010).

At least in official documents, thus, networking is pursued in both Amsterdam (and the wider Netherlands) and by Porto Alegre (and wider Brazil), and is supposed to bring a balance between organizational, professional and users' needs. In principle, thus, networking should bring to workers the possibility of decreasing work load, achieving professional goals, meeting the needs of users and making their organizations satisfied with the results. Would that also be the case in practice?

Multi-disciplinarity has been regarded as fundamental in the field of drug policies (Malet et al. 2006), and specially the collaboration between social, health and law enforcement sectors has been advocated to contribute to the success of policies (Limbu 2008, Cameron et al. 2006, Hammett et al. 2005). Nevertheless, studies analysing workers' interactions on the street level found collaboration in the drug field to be difficult. Divergent goals and meanings about what is the problem regarding drug use and how to solve it influence the ways workers communicate, act and circulate across the territories. Contradictions can include, for instance, repression through crackdowns and intensive policing in areas where health services are offered to this population, or by police confiscation of drug using instruments given by health programs (e.g. Beletsky et al. 2005, Rigoni 2006). These law enforcement activities might be at odds with the aims of harm reduction programs: they hinder access to health care for people who use drugs by driving them underground; induce drug use in riskier environments; unsafe disposal of syringes (in case of injected use); and compromise the functioning of outreach work and harm reduction programs (e.g. Hammett et al. 2005, Small et al. 2006).

In Porto Alegre, Brazil, the adoption of a harm reduction approach, for instance, leads pro-change social and health workers to have difficulties to be heard and respected in meetings with abstinence based workers (Rigoni 2006). Different professional 'jargons', goals and expected roles are also mapped as fundamental difficulties in building networks between social, health and law enforcement workers. In these cases, workers' interpretive beliefs intermingle with institutional and organizational features to shape the way workers interact daily. Some studies point, for instance, that police workers have to deal with a double role of being repressive towards drug use and collaborating with harm reduction pro-

grams at the same time (Beyer et al. 2002, Bull 2005, Lister et al. 2007, Lough 1998). In these studies, conflictual interactions are reported among and between care and law enforcement sectors.

Besides interpretive beliefs, other important influential factors in the way collaboration happens or not which can be drawn from studies are workers' practices, and organizational structure. Lack of resources and productivity pressure are also found to hinder workers' willingness to collaborate (Connolly 2006, Vermeulen and Walburg 1998). Workloads, for instance, influence the extent to which police workers collaborate with harm reduction projects and refer arrested drug users to care (Hunter et al. 2005). Lack of material resources and services for people who use drugs, are listed by health workers as difficulties in terms of collaborating even with other health services (Rigoni and Nardi 2009), and also make collaboration between police workers and health services difficult (Connolly 2006, Vermeulen and Walburg 1998).

In the organizational field, studies about front-line workers define workers' interpretive beliefs as an important factor influencing collaboration across services and between organizations. Sandfort (1999), for instance, maintains that workers share a collective assessment of their potential collaborative partner agencies. Assessments are based on past relations and daily experiences workers developed with these agencies, and also on clients' stories about them. These assessments become the parameters workers use to interpret encounters with these agencies and to justify their actions when deciding on whether to collaborate or not with them (ibid.). Maynard-Moody and Musheno (2003) also state workers create a local culture of shared beliefs to develop 'occupational identities'. They go further in exploring diversity of beliefs among workers, which would be represented in different subgroups related to workers class, gender, generation, religion and race, for instance. The focus of their analysis, however, is more on investigating how occupational identities influence client's assessments than the type or existence of collaboration among workers.[3]

Organizational studies also contribute to the analysis of workers' interactions in their concern with conceptual definitions. In a multidisciplinary review of studies about collaboration, Bedwell et. al (2012: 130) define the term as an evolving process whereby two or more social entities (individual, teams, departments, functional areas, organizations) actively and reciprocally engage in joint activities aimed at achieving at least

one shared goal. Collaboration, thus, has to be reciprocal, and the different parties have to work interdependently towards reaching a mutually defined/agreed goal. If there is no reciprocity, or one party is seen as controlling or dictating the other, the interaction is not classified as collaboration, but as 'delegation of work' or 'coercion' (ibid.). Other studies in line with this approach (Mathieu et al. 2000), state that shared mental models are also said to influence collaboration processes. These models are understood as organized knowledge structures that allow individuals to predict and explain the behaviour of their teammates. Expectations serve as a basis for workers to select actions that are coordinated with those of the people with whom they want to build collaboration (ibid.). Workers, thus, would chose collaborative actions based on predictions about other workers and organizations.

Even though these studies shed light on important features of workers' interactions, literature still presents important gaps. First, organizational studies point at a lack of consensus among scholars on the meanings of collaboration (e.g Bedwell et al. 2012, Thomson et al. 2009). Many of the previous studies analysed either lack a clear concept of their analysis of workers' interactions, or use the term collaboration for that matter. Studies in the drug policy field frequently use expressions such as collaboration, interaction, networking and negotiation interchangeably, without a concern for defining their meanings or the theoretical basis that informs them.

Second, given the importance attributed to the integration of different agencies in the success of drug policies, the area has been understudied. Drug users often meet with a mix of social, health and law enforcement workers in their daily circulation; so the same person might be approached by different workers during the same period. But, how do workers deal with that? Are these interactions connected to each other, or are workers separately approaching users independently of what is being done by their colleagues? There is a need to look at these dynamics and to understand them as, to the date of finalising this thesis, no studies were found to analyse the interaction of three sectors in multiple services, and also no comparison between the cities studied here.

Third, the studies available are usually narrow in their understanding of how actors interactions shape policy processes. They usually consider just one side of the coin, addressing only health workers' views on the interaction; little is known about how social workers and, even less, how

law enforcers perceive this process. Furthermore, the few studies which address the relationship between health, social and law enforcement workers generally focus on one specific program and not on multiple daily interactions at the local level.

A fourth gap from these studies is that they present collaboration and its influential factors in a rather black and white manner. Similar interpretive beliefs and enough resources would always lead to increased collaboration, while diversity of interpretive beliefs and lack of resources would lead to difficulties in collaborating. Also, when assuming workers' interpretive beliefs as collective assessments of other agencies, some studies on inter-organizational collaboration lose the perspective on diversity. Assuming that all workers from a certain service share a similar understanding of another agency and its workers leaves no room to explain why some workers in a same service would be more prone to network than others. These pictures have to be more nuanced.

A fifth gap is that very few of these studies address the role of power in workers' interactions. By not touching upon this concept, studies lose perspective in that not all different sectors have the same room for negotiation, as their niches of expertise can count with different legitimacy in the territories and society in general for specific issues. Here, the definition of collaboration as needing reciprocity runs the risk of shadowing the myriad possible power relations involved in actors' interactions. In some, workers encounters might not be classifiable either as 'reciprocal' or as 'coercive', but even then, are part of a network of contacts through processes which need to be mapped in order to be understood. Bringing power into the debate, thus, allows us to analyse how and why difficulties in collaboration are shaped by different notions of knowledge and their importance for different territories. In the end, it allows an answer to the question why and how workers would decide whether to collaborate or not with others and, in case they do, on how different meanings and objectives are reconciled.

Finally, a sixth and, perhaps, more important gap has to be mentioned: in general, studies depart from a point of view that collaboration between workers and agencies is essentially good and produces circulation of workers and users within and between territories. As a consequence, a better work environment for street level workers and their agencies, and a better quality of assistance for users would be achieved

by the desired integrated approach. But would that always be the case in street level practice?

In the present research, data on networking was gathered both by observations and in-depth interviews. Theoretical sampling of the interview data starting from the concept of networking set up the basis for mapping which services collaborate or not with each other in practice and how. At the end of each in-depth interview, workers were asked to refer the researcher to services and workers they collaborate; would like to collaborate but cannot; and/or collaborate but with problems. During the interviews workers were asked to talk about how they perceived the relationship of their service with other health, social and law enforcement services and workers, regarding daily activities related to illicit drug use. Their perceptions of if and how these interactions changed over time were also investigated.[4]

At the street level, when describing the reasons why they network with other services and workers (or not), street level workers from Amsterdam and Porto Alegre usually developed explanations around similarity (or differences) of logics of work. Although the actual availability of resources was also mentioned and observed as influencing these relationships, workers' focus was usually on how negotiations of meanings and goals were perceived as possible or not. The focus on work logics expressed workers' concern about whether these possible partners could offer solutions for drug use which were compatible with their own interpretive beliefs around what was considered to be best to do in a certain case, with a certain user. When faced resources scarcity, however, workers sometimes had a more pragmatic attitude towards structural boundaries. They would focus, rather, on what was considered to be possible given the resources at hand, and the ways in which flows between services were organized.

These descriptions made by workers resemble the concept of 'network' as proposed by Pierre Musso (2004). As developed by this author, the concept allows engagement with the structural and the 'ideological' and relational factors workers mentioned to be at the core of their discretionary decisions around collaboration. For Musso, networks have a structure (a way of organization), a dynamic (connections and movement among actors) and a rationality, representing and determining the structure and the possibilities of connections. A network defines the geographic organization and communications between workers and services;

and also the production of meanings governing these communications (Musso 2004). The analyse of workers' interaction, thus, looks not only at the spatial organization of services and the flows between them (a more organizational or structural view of networks), but also at the rationality that lies behind the spatial organization's design and the flows allowed inside them (beyond the idea of homogeneous collective assessments).

This means that the goals, interpretive beliefs and activities produced and reflected by official policy and street level workers' practices define some structural connections as more possible than others in a network. In the case of drug policies and connections between different workers, this means that, for instance, certain interpretive beliefs and organizational structures make it easier for social and law enforcement workers to build agreement in approaching drug users.

In street level workers' descriptions about their interactions, workers perceived an imbalance in the room for negotiation between different professional fields in these relationships, due to the specific type of knowledge certain professions (are supposed to) have. In this context, the concept of power and its interrelatedness with knowledge (Foucault and Gordon 1980) becomes a useful tool to analyse network processes. Foucault states that, instead of being neutral, knowledge carries notions of value and worth, being connected to power relations. Power, for this author, is not something that is 'owned' by one actor and thus 'lacking' for the other. Freedom to reverse the power relation, or, potential for resistance, is always present (otherwise it characterizes a relation of dominance rather than power) (ibid.). Power thus, happens always in relation, and can be seen at the micro level: for instance, in the definition of what is considered to be valid and who is considered legitimate to talk about a certain subject (such as drug use) in a given space and period of time. Rationalities underlying the construction of circulation and flows, thus, also connect with power: which may result in a hierarchy between services/professions and their respective knowledges, making some actors more powerful than the others in negotiating daily practices and meanings.

The concept of power as developed by Foucault, thus, allows to analyse how the different professional sectors are connected to certain disciplines and ways of framing problems and solutions to drug use. In this chapter, the concept is used to analyse how different knowledges at-

tached to social, health and law enforcement institutions and professions play a role in shaping connections between workers and their justifications on how and why to network or not. There are preferred and avoided connections in the way actors choose to move within and between territories. In these connections, some paths are perceived as more possible to be crossed than others, and some actors have more room for negotiation than others. The type of connections created, will produce certain types of care and enforcement in the territories with consequences for workers and users approached by them.

Besides the concepts of structure, dynamic and rationality, another important theoretical input brought by the concept of networks is the possibility of thinking about its ambivalence. According to Musso (2004) networks bring, embedded in their existence, a double identity, or an original ambivalence: they can serve both to facilitate circulation and control. Would it be possible that networking does not only increase access for users and decreases work load for workers, but rather, increases work load and managerial control over workers and also workers control over users? And in these cases, would then workers be still willing to network? These and the previously stated questions will be investigated in the present chapter, focusing on workers' experiences and bringing theoretical concepts into light when helpful.

The concept of network, in sum, is used to approach workers' interactions in the present chapter both for its use and importance on official drug policies and in workers' experiences and discourse at the street level. Besides, as described by Musso (2004), the concept brings interesting practical and theoretical inputs to the analysis of workers' circulation in the territories. Looking at both structure and rationalities as influencing networks' dynamics respects the ways in which street level workers in this research described their experiences, accounting also for the ambivalence found around positive and challenging perspectives brought by networking.

The ways in which workers' interactions happen in practice are now analysed. The following sections describe the variety of reasons workers give for networking or not networking with different services and professional sectors. These will show the differences in workers' 'territories' in the two countries, plus differences within the cities and the sectors, which involve different challenges and support for workers in term of building networks. These different environments, therefore, create a va-

riety of dilemmas for workers, which end up shaping the ways in which discretion happen at the street level when comes to networking. The ways in which workers' discretionary attitudes towards networking are shaped by their different environments and professional sectors are the foci of the rest of the chapter.

Chained networks in Amsterdam

In Amsterdam, street level workers seem to be very close to official drug policy statements of integrated networks. In this city, social, health and law enforcement workers reported to be working together in a chain and to have very good results from it.

Overall, workers move along the territories to personally contact other workers, and to exchange information about services and users. Actual movement includes visiting other services, approaching users together, and having meetings with other workers to debate about treatment plans for users connected to multiple workers. Information exchange relates to knowing about services and activities offered by other sectors, contacting them by phone, and connecting to users and services' information through computerized systems; but a good deal of information exchange is done during face to face meetings. This continuous and repeated contact is what some network studies in public administration (e.g. Romzek et al. 2012, Bryson et al. 2006) call 'facilitative behaviours': frequent communication, information sharing and follow-up commitments that facilitate networking building and maintenance.

Specifically in the care sectors, networking among health and social sectors is perceived by workers as well developed. As it was observed by the researcher, social services such as shelters, hostels, walk in centres, user rooms and services that manage benefits and promote inclusion into the labour market have strong connections with each other in coordinating activities and benefits offered for users. In the health sector, substitution treatment (methadone) and heroin prescription clinics, and outreach work teams also build networks among themselves and with social services.

In several of these networks, and in accordance with local guidelines, there is a central figure called case manager, who is responsible for monitoring the treatment or care of a given number of users. It is part of these workers' activities to contact different social and health services

who are already approaching users or might have something to offer. Case managers have been, indeed, reported in the literature (e.g. Biegel et al. 1995, Siegel et al. 1994) as being central figures in integrated networks, serving as a bridge between services and workers. In many services, the case managers are also outreach workers, the ones who actively search for users in the cities. Nearly all care services in Amsterdam, including clinics, shelters and hostels, have outreach workers, and active search is regarded as very important, complementing office-based work. When case managers are present in a service, networking is centred on them. Care workers in particular often mentioned having part of their working time specifically dedicated to developing and maintaining networks. The ways in which network structure is, thus, helps a dynamic of collaboration among actors from the different sectors.

When asked to describe their networking behaviour and the ways in which they perceive other colleagues could influence their work, street level workers put emphasis on networking rationality. The reasons why they invest on networking are said to be related to the benefits they can get in terms of pursuing their professional objectives with users, which are considered to be, in most of the cases, similar to users' needs. In these interactions, social workers usually expect from their health colleagues inputs regarding drug treatment: either a vacancy for drug treatment (usually in an open substitution/prescription clinic) and/or follow-ups regarding how users are benefiting from drug treatment. Health workers, in their turn, expect from their social colleagues vacancies and follow ups related to shelters, user room, financial benefits and daily activities. In a nutshell, health workers are seen as drug treatment providers, while social workers as social-benefit managers.

Through these networks and the benefits that come with it, care workers understand their work becomes more efficient, as it prevents different services promoting duplicated or contradictory activities with a given user. Workers feel their work, thus, becomes lighter and more effective, preventing unnecessary waste of time and money. For these workers, networking helps to achieve a balance between organizational, professional and users' needs.

The networking pattern of care and law enforcement workers was also understood as well developed and compared to a chain. Police workers get frequently in touch with drug users making and having problems in the streets: nuisance, open drug use, theft or robbery, homelessness,

among others. The way community police respond to these events in Amsterdam is by making networking efforts with the care sector.

> NL10: Well, in my profession all problems when they are not an emergency, I'll look at the problem and say 'hey, that's something for the [municipal health care], that's something for the [social organization], or the psychiatrist…' So I go very often [to] people addicted to alcohol or drugs… or [who] live in a house and give problems to the neighborhood. Then I'll try to take people [social and health workers] with me, to help them. (Amsterdam, law enforcement worker)

Not only can police workers refer users to a social or health service, but they can also ask care workers to have a joint approach to a case, can bring users to care facilities themselves, and can frequently visit care services, either for planned meetings or just to strengthen daily connections. For community police workers, what justifies pushing users to care are the perceived results both in terms of improving users' life and decreasing repeated arrests and preventing nuisance and crimes in the streets.

> NL28: And… their lives have improved a lot since they are in care. Then they don't want to go out, most of the times. Sometimes they are fighting inside [care services] because one of them has taken a little bit of drugs of another one, or something like that. But, most of the time it's inside and we don't even hear about it. Only when it's getting consequences we come. But we try to put them in care, on these institutions, because as long as they are in there we don't have anything to do with them. If we didn't cooperate with the helping institutions, we would have much more work to do. It's not like you don't want to do work, but when we don't see any result of it that's not a good feeling. (Amsterdam, law enforcement worker)

As already shown in chapter three, providing users with basic needs and/or drug treatment is seen by police workers as more effective than just arresting or giving them fines. Rather than an extra burden, collaboration with care is seen as releasing energy. Through offering drug treatment in an open place, or a supportive setting for users to use their drugs and sleep, police workers perceive they are also fulfilling their professional commitment to increase populations' safety, besides releasing some work burden. Besides, a friendly attitude towards drug users together with activities such as periodic visits to user rooms, shelters and

walk in centres is considered to increase respect between users and police workers:

> NL11: What I see is, the group I know from here [walk in center], that they are ashamed if they get a ticket from me. It's worse for them to get a ticket from me than from another police man. Because they know me, they respect me … (Amsterdam, law enforcement worker)

In this sense, a close network with care services and workers is also seen by law enforcement workers as allowing a balance between both organizational, professional, and users' needs (both drug users, who get a better life quality, and non-drug using citizens who are protected from drug-related nuisance and crimes).

Social and health workers also believed their collaboration with the law enforcement sector had good results for all parts: increasing users' access to care and care continuity, and decreasing public nuisance and criminality in the streets:

> NL08: I work very much with the police from [city area] because there are a lot of drug users making public nuisance, making problems, robbing tourists and that kind of things. So those people didn't come here [care facility] because they make their money in [city area]. But our problem is that we work with these people and we build something up - they get a place to stay, we arrange something with income and that kind of things, but then they have problems with the police and they go to jail. And then everything we built with the client is gone. So that is a big problem for us; and for the police workers also. They get many tickets [fines] for everything, but people don't go away from the neighbourhood, so the problem was still there. So that's why we found each other, because (laugh) we need each other. (Amsterdam, social worker).

In Amsterdam, many care workers perceive that the success of some of their activities with drug users, depends on the connections and negotiations they are able to establish with police workers. These agreements usually involve a certain bending of law enforcement rules to benefit either users and/or care workers and their plans with users. Sometimes, for instance, a user is excluded from a certain area in the neighbourhood for a number of days, weeks or even months by a police worker, as a punishment for a wrongdoing. Very often, however, this area also leads to a drug treatment location or a user room were the user is supposed to go. Care workers, then, negotiate a 'corridor' with police workers, a path

inside the forbidden area where users are allowed to cross in order to get to their treatment place. When negotiation is successful both interests are kept: punishment still happens, but does not stop treatment. Both care and police workers feel they are meeting their professional commitments and the needs of the users they assist/approach.

Rationalities behind care and law enforcement networking are, therefore, manifold. Both from most police workers and from social and health workers there is a lack of confidence in positive outcomes in users' lives from pure punishment, and their languages have converged significantly. When combined with care, however, punishment it is seen as bringing benefits for both. Police workers' repression can be an artifice to bring users, who would otherwise not seek treatment or benefits, into care. In addition, it can also help enhance continuity of care by locating people who have left services and bring them back.

Besides this function of circulation which would bring access to users and decrease work load for workers, the function of control provided by networks is evoked by workers from all sectors in Amsterdam. In their descriptions, controlling users through networking assumes an important role in justifying collaboration, both between law enforcement and care sectors, and within care. A chained network prevents users from manipulating the system and increases workers' control over users and resources management:

> NL02: … And for instance, one of the things to see is that clients tend to shop around when it comes to getting help, so it is really important that we check with other organizations if they… they come here saying 'oh, they are not helping me' and they are badmouthing other organizations and then 'Ok, let us give them a call' and then we call then they say 'Oh, no, but this guy has being committing abuse towards people working here' and then they have a whole different story that the one the guy is telling you, so that's always important to check things out, if they are proper. (Amsterdam, social worker)

The duality of network is clear: at the same time it opens up fluidity of communication among workers and possibilities of care access for users, it increases the control workers have over users, limiting their possibilities of running away from care or playing out with different actors and resources in the field. Workers in Amsterdam not only recognize this double meaning of the network, as they see both circulation and

control, as beneficial and functional. When the rationality for networking tilts toward its controlling effects, the apparent posture driving workers' decision for collaboration is one of focusing on their own needs in achieving clients compliance, and an organizational need for success rates and accountability for resources. Here already an important consequence of networking starts to be seen: users' rights of privacy and choice may be hindered by one controlling force pushing them into services, and not always willingly, and by restraining their room for negotiation with different sectors. In these cases, the extent to which chained networks enhance the pursuit of users' needs might be questionable.

Besides focusing on benefits or control over users to justify their choices for networking with police workers, care workers also mentioned benefits for organizations and for themselves in terms of safety, which would also bring benefits for users more indirectly. Especially for office based care workers, collaboration with police workers also serves to ensure the smooth functioning of services. This relates not only to work with police force stopping aggression and violence inside facilities, but also in preventing abuse of police workers' authority. Arrangements are made to reduce police workers' interventions, searches or seizing drugs and people wanted by the police workers within care service premises. For care workers, this prevents users stopping use of the care system and avoid disrupting care activities.

> NL02**:** We are really lucky because he [community police worker responsible for the area] is a great guy. He is pretty strict, well, he is a police worker, so he has to be, but he also help us out. Like if there is a problem or aggression in the room, and he is in the neighborhood, he comes in and …. (imitates someone with a very serious face, the arms standing as arches, the chest inflated, and making a sound like grgrgrgrgr) he just help us. Sometimes it happens, for instance, if he sees somebody in the streets who is not supposed to be there, he takes him here [service] and introduces people. […] If police workers are against your organization or your place, they can really make your life miserable. For instance, just standing outside of the door checking everybody coming in. A few years ago, we had another agent who didn't like us. We had the police workers coming in, like nothing was happening but, all of a sudden, there were like 20 police workers, marching in, nobody could get in or out, everybody had to show what they had on to them… A lot of people were taken, suspected for being dealers. That was really hard for all the staff and people coming here. And if it happens a lot, ultimately, they can close us down, if they want to.

So, it is important to have a good contact with police workers. (Amsterdam, social worker)

Despite police workers having power to take some actions, it is at their own discretion. Given the illegal status of drug possession and drug dealing, social services might have problems if a police worker decides to follow the law in a really strict way. In walk in centres, user rooms or shelters in Amsterdam, it is not hard to find users with more than the allowed quantity of hard drugs inside their pockets, people carrying pocket knives (used to prepare the drug), or users buying drugs for them and their friends (which can be seen as small scale dealing). In this context, keeping a 'good neighbours' policy with law enforcement workers is a networking strategy care workers can find to make functional use of police workers' power. Good relations increase the chances that rules can be negotiated and bent.

According to social workers, having or not a good relationship depends on how different community police workers behave: the different ideas and attitudes they can have towards users and care services. Not all workers from the same sector, thus, are perceived or judged in a similar way, as Sandfort (1999) contends with her concept of 'collective beliefs'. Although in some cases there is a main pattern of expectations and attitudes towards a certain service or sector, relationships between street level workers are much more nuanced than collective stereotyped beliefs can explain. This issue will come back later on in this chapter.

It is worth saying that this state of chained networks was, according to workers, achieved in the past decade. During this time, workers mention a big shift in the ways they think about networking:

NL24: In the old days we hated the cops and health workers and now it is all professional-based, good cooperation. (Amsterdam, social worker)

NL06**:** […] the police workers was saying: 'they are addicted; they are patients'. So there must be a big role for the health care. The health care said: 'no, they are criminals, and they are using drugs'. So, that was a big difference in the way of thinking. (Amsterdam, law enforcement worker)

At that point, the rationality (Musso 2004) guiding the dynamics between workers was one of pushing away responsibility to another. In street level workers' opinion, the main shift allowing for the chained

networking pattern is that, now, workers perceive it as creating a win-win situation.

What workers in general do not mention, but it is interesting to note, is that the formal structure (Musso 2004) of the network helps to define this dynamic, both in terms of workers' job descriptions and of special collaborative programs designed in line with local and national guidelines. Community police workers' job description includes knowing and having contact with social and health services in a network. Networking programs between law enforcement and care were built specially for the population with mental illnesses (such as *Vangnet* & *Advies*) and/or frequent problems with the law (like the *Keten* Units and the *ISD* policy). Even though these programs are not specifically directed to drug users only, many of its attendees are users. In the case of *Vangnet* & *Advies,* police workers can call a social psychiatric nurse when a drug user is, for instance, having problems with neighbours, being aggressive, or making nuisance in the streets while intoxicated (usually aiming at less nuisance and controlled drug use). In the *Keten* Units and *ISD* policy, police workers invite drug users who are committing crimes for a joint meeting with them and care workers in order to decide on an action plan, usually guided towards alternative (non-prison) punishment or exchanging prison for care (drug treatment).

The rationality (Musso 2004) underlying these network programs, as stated on official guidelines, policies and job description, relates to networking (or *samenwerking*) as a way of building an integrated approach for drug users (Gemeente Amsterdam 2006, Stadsdeel Zuidoost 2010, Stadsdeel Zuidoost 2006, Voorhuis, et al. 2007). Care is supposed to have the leading role regarding drug use, though a balance between repression and care is said to enhance users' health and decrease nuisance and criminality for society at the same time (ibid.). Similar rationalities are found in workers' testimonies when justifying the need for collaboration, even though not always workers fit into this main pattern.

Some exceptions were found, for instance, in a few police workers who did not believe networking with care helped their job or those who had several conflicts in their contacts with care, as mentioned above. These workers usually held interpretive beliefs towards drug use which were more connected to punishment and coercion as solutions, and were regarded by their colleagues and users as strict. When these were community police workers, they would still make contact with care services

and workers, since these tasks are part of their job description. These were less collaborative connections, however, which usually brought conflicts around different goals and attitudes. In addition to that, also 'normal' police workers were regarded by users and care workers as being stricter and less collaborative than community police workers. They indeed neither saw networking as an advantageous activity, nor had networking with care as part of their daily tasks or their job description. They also shared stricter views towards drug use, seeing users as potential criminals and deviant rather than as victims or patients as most of their community police colleagues.

Also among care workers, mainly social workers, exceptions were found in some workers who disagreed that networking with the police would bring them good results. For them, colleagues who worked closely with the police could not be trusted by other care workers, and were certainly not trusted by drug users. Again, these differences among workers' judgements of their colleagues, and its consequent differences in their discretionary attitudes towards networking, contradict the idea of collective judgements (Sandfort 1999) about other organizations. The subsection about dilemmas in chained networks will bring these issues to further analysis.

Holed networks in Porto Alegre

Different from Amsterdam, in Porto Alegre networks among the three sectors are not described as operating in a smooth way. In general, while social and health workers have a network they try to develop further, law enforcement workers are marginalized in the picture. The metaphor of 'holes' was widely used to describe the main feature of networks in this city.

Regarding networking among care and law enforcement workers in approaching drug users, both care and police workers realize there is no networking between them, and they think it should remain this way. Networking is not regarded as useful, and even harmful to their work:

> BR03: I think this contact would disturb. Because, what happens: the person [worker] who helps, has on his mind, on his heart, this idea of helping. And many times we have the idea of arresting. And the person is not going to like to see us arresting the user. Other situations, when they [users] are violent with us and we have to make use of moderate force, … they

> [care workers] understand this as police aggression. […] But then they see what the citizen had done, and the citizen just killed someone because of the drug. Then they change opinion: 'No, so you have to do it'. So, because of that variation in their ideas, they wouldn't have their psyche prepared to work in our side, no. (Porto Alegre, law enforcement worker)

> BR06: We do not get close, we try not to link our approach to the police. We prefer not to be seen with the police by the kids, not to confuse them [to think] we called [police workers]. So, our interlocution is little. I can even call a police worker for some cases with extreme violence, and generally when it is not one of our cases, but we never go together with the police. (Porto Alegre, social worker)

In their relationship with social and health workers, police workers feel judged and not recognized, and believe care workers are too soft to deal with people who commit crimes. Social and health workers, in turn, avoid being associated with their law enforcement colleagues, afraid of hindering their trust-building with users they assist. They regard police workers as too hard on people with social problems. This perception is partially rooted into a history of conflicting contact between these sectors. Military dictatorship left its marks in Brazil, building a view of police workers as violent, corrupted and intolerant, held by workers from other sectors and by society in general. Since the times of the social movement for redemocratization that took place at the end of dictatorship, where professionals from the care sector fought for a universal health care system and defended principles of collective health, police workers were seen as being 'on the other side'. In many demonstrations, police workers were called on duty by the state to act coercively towards protesters. The same still happens nowadays, when care workers join users and homeless for demonstrations to defend their human rights against police workers' violence.

The relationship between care with law enforcement workers slightly varied depending on whether the latter were street police workers, police workers from PROERD, or members of Tutelary Councils. While contact with street police workers is, in principle, always avoided, few contacts with police working in PROERDs could be seen. These contacts were still rare and limited to some meetings to know about each other's actions. In the case of social and health workers working with youth, contact with Tutelary Councils[5] might be made, but very carefully. Even though Councils were created to protect children and youth rights, they

ended up assuming a more repressive role, being involved mainly in cases where 'crack mothers' are not able to take care of their children in a proper way (from workers' point of view). Most care workers from Porto Alegre have a critical view on the Councils, based on the reasoning that what was supposed to be an exceptional intervention –enforced sheltering for children- became the rule. For them, Councils act only when it is time to take children from their parents, instead of acting preventively. This rationality led to a tentative view of not associating care activities with law enforcement activities, both for the Tutelary Councils and police workers; even when some formal contact between services was happening.

> BR38: […] our big worry is that we arrive and they [users] think… in the beginning of the program a lot of them confounded us with the Tutelary Council. Then they think we are from the [military] brigade or the [Tutelary] Council and 'what are they going to do? They are going to pick me up and leave me somewhere'. So you arrive and until you can explain that you are not from the Council… they run away, go into the middle of the cars, and it is dangerous. (Porto Alegre, social worker)

Not harming trust with users is the main reason for keeping the distance, since law enforcement workers are seen as representing a controlling and disciplinary power which would scare users from contacting care services.

For law enforcers, on the other side of the line, besides not seeing advantages in working with care workers given the different objectives and rationalities, they also reject the idea of referring users to the care system based on an idea of lack and ineffectiveness of services.

> BR10: There are the municipal shelters, so we tell them 'listen, you have to go to the municipal shelter, you cannot stay in the streets'. But it happens that, there are few shelters, right, and there is time and rules inside them. And if you get, I don't know, if 70 or 80%, but the big majority of homeless people don't go to shelters because they have to shower, change clothes, and there is a time schedule you know? So you have to follow rules. It is not to get there at 4 AM, drunk, and 'I want a bed', you know? (Porto Alegre, law enforcement worker)

Police workers have a practical experience of seeing and talking to users who have been into care services and drug treatment and are repeatedly back to the streets, which makes some police workers not to believe

the benefits of these services, as explained in chapter three. Perceptions of care organizations as ineffective, thus, justify and legitimate non-networking behaviour. Here, besides seeing care services as not equipped enough to assist users in their needs, police workers do not have guidelines including helping users as part of their tasks, and hold interpretive beliefs about users as lacking willingness to follow rules. All these, leads police workers not to push users into shelters, even if this could be a way of pursuing their goal of decreasing (visual) nuisance for the wider society.

As explained in chapter four, this environment makes police workers divert guidelines of 'removing' (homeless) drug users from the streets to, instead, focus on those crimes considered to be more serious and threatening for society. In this sense, non-networking with care is perceived by police workers as better to pursue, at least, organizational and workers' needs. If drug users are considered to be actual or potential 'criminals' in need of control for their own good, discretionary choice of not networking can be considered to help achieving 'users' needs as well. In terms of drive, the same can be said from care workers. For them, not networking with law enforcement workers is seen as better for users and for them as professionals. Here, different from Amsterdam, police workers in Porto Alegre do not see pushing drug users into care as their role, as much as care workers do not see decreasing nuisance as part of their objectives.

An interesting and quite unexpected posture from care workers is that even if they complain about law enforcement workers' strictness, they might use law enforcer' disciplinary force when they consider necessary. Tutelary Councils, for instance, can be used as a threat to push users into care.

> BR16: It is not something that we usually do … not to link up with the Council, but sometimes it necessary for us to use the fear. 'Ah, so maybe I'll allow people to denounce you', but not many times. It is more a way to see if they adhere to our work, so we don't have to count with them [council], you understand? It is something we say like that 'After me is the Tutelary Council. We are knocking at your door: 'come on, come on, come on, come on'… in the tenth or ninth 'come on' there will be no talking anymore; because I won't have anything else to tell you and you won't have anything else to lie to me'. (Porto Alegre, health worker)

Threatening with the Tutelary Council is seen by care workers as one of the last cards to play in trying to make users who are parents change their behaviour and adhere to care. In some cases, when the threat does not work, care workers make an actual use of Tutelary Councils by denouncing crack mothers who are not able to care for their children. Whether to use this repressive power or not was very often a dilemma for workers. If on one hand it could help to achieve their objectives of care, it could also hinder their bond with users; not only with the denounced ones in particular, but also with the whole community, since they could come to know who denounced their neighbours. In this sense, Tutelary Councils' capacity to use force is used as a threat to push users in a direction perceived as good for them (so seen by workers as in the interest of the user) from their professional perspective. However, since users will probably disagree from workers posture, this might lead to an increased difficulty at work in terms of accessed credibility with other users.

Care workers might also use police workforce as a safety buffer in risky situations, when a stronger disciplinary power is perceived as needed. In cases of violence, or in areas perceived as too unsafe, care workers may call police workers for help. Yet, they make an effort not to be associated with the call by users and their neighbourhoods, afraid of ruining their bond. From law enforcers point of view, this can breach their professional ethics.

> BR34: […] Then they were with a child, the parents, crack users. And the child was being reclaimed, because the parents had no conditions to keep the child anymore, right? They [care workers] call us, because they don't have the minimum safety conditions to enter in places like that [a slum]. […] is like that: the brigade does so many things! (laughs) I am not saying that because I am a brigadier, no, but because I'm seeing this for such a long time. The brigade is… covering all the holes that the State should cover… (Porto Alegre, law enforcement worker)

Besides feeling they are used for actions that should be taken by other parts of the State, police workers also feel they are expected to play a role which is not in their knowledge field. In this sense, they complain about not having health workers' support in situations where they do not have the expertise.

BR10**:** ahn... when they use drugs and they start breaking everything inside the house and then we go there, we talk with the family and we call [the ambulance]. But sometimes they don't come, and then we have to do everything to conduct the user. But sometimes is not easy because they are aggressive[...] and then the brigade has to be very careful, because he is not… a thief, but you have to be careful with him, you know? And maybe is his mother or father who is there, and they can turn to be against the brigade. Because I went already to a house where the boy was with an axe in his hands, breaking everything inside the house, you understand? And then?
Researcher**:** and then?

BR10**:** and then you have to use the force! You understand? But then you do that and you drop the person [in the floor] and then the parents are against the brigade! So you have to be careful, get the boy, contain him, he has to be on coffins and sometimes it hurts him… (Porto Alegre, law enforcement worker).

As the police worker points out, it might be expected that a health worker will have techniques to handle a person during a violent crisis or under effects of drugs; but the same cannot be assumed from a police worker, or at least, not by using similar techniques. In this situation, for instance, police workers feel the double expectation of being friendly and partners in care, and at the same time strict, and enforcing the rules. When police workers accept the role of covering 'State holes', they end up being blamed for doing it in a wrong way.

Regarding relationships between social and care workers in Porto Alegre, networks are established, even if difficulties still produce holes between services and sectors. Virtually all social and health workers from Porto Alegre mentioned collaborating with each other. Network dynamics includes many 'facilitative behaviours' (Romzek et al. 2012, Bryson et al. 2006) such as phone calls, meetings to debate about users being assisted by both, and joint activities such as groups, street approaches, or house visits. Similar to Amsterdam, also outreach workers have an important role in Porto Alegre regarding the approach to drug users. Different from Amsterdam's network structure, however, in Porto Alegre outreach workers are usually part of basic care services, not specialized ones. Therefore, most outreach services are not focused on assisting drug users only, but vulnerable populations in general who are found in the slums and the streets. This, as already explained, leaves more room

for workers to engage in 'creaming' strategies and choosing the 'most deserving' cases for assistance, e.g., those users who can show up on time and in satisfactory 'visual and olfactory' conditions.

Another structural problem brought up by many workers is the number of people to assist, compared with available human resources. Even though the Brazilian public care system has guidelines on integrated assistance for users and networking, workers do not have specific hours of their work allocated to this activity, as is the case in Amsterdam. Also different from Amsterdam is that in Porto Alegre workers do not find so many (or enough) vacancies and benefits to meet users' demands as a reward for networking. This is due to lack of vacancies and other benefits to share by other services, and lack of time colleagues might have to spend meeting others' demands. Given time and demand constraints, workers in Porto Alegre sometimes are more inclined to invest their time in directly assisting users than in contacting colleagues, visiting services, or attending meetings. The rationality (Musso 2004) operating in these cases is that the first priority is the (usually) urgent need of the users who search for help, rather than contacting colleagues which would probably bring even more work. Networking represents spending non-existent time in trying to build combinations that might not be effective. In some cases, on the other hand, lack of resources may triggers ad hoc cooperation. In search for sharing the few means available, workers from different services sometimes do joint house visits to share a car, or invite workers from a specialized service to help in doing a group to debate about drugs or whatever speciality that worker has. In this sense, different knowledges considered useful and legitimate (for instance, about drug addiction), also serve as reasons for workers to decide upon networking.

Similar to Amsterdam, the rationalities (Musso 2004) for networking choices were somehow different for social and health workers. Overall, health workers' main reasons to invest in networking with social workers was to get benefits for the users they assist in order to facilitate or complement drug treatment: bus tickets to go to drug treatment centre, shelter for the homeless, benefits, help to obtain personal documents, and to get food stamps. Social workers, on the other hand, contact their health colleagues mostly to refer users into drug treatment (usually in in-patient treatment clinics); and, to a lesser extent, also to get basic health care consultations. Interesting to say here, is that different from Amsterdam,

social workers from Porto Alegre dislike being seen by their health colleagues as benefit managers. Their role, for them, is much broader than that, and relates to promote users' citizenship by a more participatory and reflexive positioning in society. Workers' discretionary choices for in and outpatient treatment services reflected a focus of most care workers from Porto Alegre put on solutions centred on the drug with the focus on abstinence. Once someone is identified as a drug user, the main aim workers assume is to refer the person to a drug treatment centre in order to achieve abstinence from crack; other (social) benefits are seen as only complementary to it. This rationality leads to a focus on specific services and workers, limiting networking possibilities.

Besides that, the network between specialized and basic care services[6] was considered as especially problematic in the interactions between social and health workers. The flows from basic services (primary health care and outreach programs and walk in centres) to the specialized ones (shelters and in/out-patient treatment clinics) was regarded as very difficult. Between basic and specialized services care workers saw the most harmful holes in their networks, leading to a higher work load and stress, and to lack of access for users (specially the 'most needy' ones). As the next section will show, in the end this pattern might lead to further marginalization of the most vulnerable users, which tend to slip through the holes of the network and fall out of the care system.

Dilemmas of holed and chained networks

From this initial description of networks, one could mistakenly conclude that in Amsterdam there are no difficulties or challenges in networking, while in Porto Alegre there are very difficult conditions with little room for improvement. Taking a closer look, however, one can see that challenges and dilemmas related to networking are not only related to lack of a network or to impediments to collaboration among actors. The very act of networking brings dilemmas for workers, and sometimes, the stronger the network, the stronger the challenges.

What is interesting here is that the various territories in which workers operate in Amsterdam and Porto Alegre brought different challenges and patterns of networking. These varied patterns brought different dilemmas for workers in the cities, leaving room for discretion in diverse aspects of networking bringing different consequences for workers and

users involved. While chained networks brought dilemmas around information sharing, holed networks brought challenges on how to close holes and avoid users slipping out of care.

Despite the very different patterns of networking in the cities of Amsterdam and Porto Alegre, also some interesting similarities were found across the cases. There were mainly related to tensions between different professional sectors, where different knowledges and commitments in the drug field were perceived as bringing an imbalanced room for negotiation between workers. The following subsection address four of these challenges.

Information circulation and trust

Information pathways in a basically close network are still open to workers' discretion in a variety of ways. Having access to information held by other services is seen as a very positive to plan work with users in a more effective way.

> NL22**:** [Our relationship] It's good with health workers from other organizations. We often give each other information about clients and if somebody doesn't follow appointments, or they don't see this person anymore, or they don't know where this person is and what are they doing, and we know it, we can share the information. We also try to find the person and bring them back to the organization if we can. (Amsterdam, social worker)

> NL17 **-** …there is an agreement to work together and to give that information to each other. […]We wanna know from them [care workers]: is he [drug user] dangerous for people or dangerous for police workers? Do they have like mental diseases or something, or do they need more social help or something like that? And they wanna know… we are giving them information like we are seeing him robbing people, he was arrested for that so many times. (Amsterdam, law enforcement worker)

Information exchange is perceived as helping an integrated assistance for users, increasing access to care, keeping track of users, and avoiding they fall out of the system. The knowledge and techniques that workers from each sector possess are perceived by their colleagues as potentially enhancing the ability of achieving their own goals. Sharing information, in this sense, is seen as an evenly balanced distribution of valuable specialized knowledge. It is a feature that enhances circulation (Musso 2004)

in the network and, indeed, seems to allow a balance between the needs of organizations, professionals and users.

In Amsterdam, however, all categories of workers brought up challenges when deciding about which information to share and with whom. Sometimes, information is supposed to be shared among colleagues and sectors, but street level workers perceive this as not being helpful for the users they assist. Many of these dilemmas concerned users' right of secrecy versus other workers' needs of obtaining data on users to plan their work. In these cases, workers might bend rules and negotiate justifications for not following the network. If in some cases professional secrecy law can be helpful to protect users, in others workers have to find other justifications.

> NL03**:** You cannot tell others about personal activities of a patient, that's out of limit. For instance, we don't tell the police workers 'this man has been stealing there and there'. Of course if he says 'I'll murder someone tomorrow' than we have to tell because that's very serious crime, otherwise we have the professional code… (Amsterdam, health worker)

Health workers are not allowed by privacy law to exchange information about their patients, which, among other things, includes knowing the patient has a drug addiction and is being treated for. Police workers officers, in their turn, are not allowed to share hard criminal information, related to crime investigations. Care workers from office-based facilities, therefore, can have unspoken/informal deals with police workers of not giving criminal information about users unless the offence is really serious. Police workers, on their side, agree in respecting user's space inside the facilities, and give first a warning to care workers (who will warn users) in case users are wanted by the police for criminal acts. Not always, however, the agreement is perceived as possible; and sometimes, even though agreement in principle is present, it is not fulfilled in practice by one or more of the partners. In these cases, workers develop other strategies to deal with information sharing.

Workers may choose, for instance, to be loyal to users instead of to other colleagues. One strategy for doing that is by hiding information which they think can be harmful for the users. Some care workers, for instance, hide from their colleagues who manage benefits that a given user has found a temporary job. When users are working, they are not entitled to receive financial benefit anymore, this being considered an

abuse of the system; once the social worker managing benefits knows about a working situation, benefit has to be immediately cut. Other workers, however, consider that many times these jobs are just temporary, and the user won't have the capability of following a full time work schedule for a long period. Losing the benefit is not considered as useful for users from their professional perspective and is, thus, avoided by concealing this information from their colleagues.

Using the same posture, social workers might lie to police workers to protect a user who is wanted and is inside a care facility at a given moment. They can simply say users are not there at that time, or have not been seen for the last weeks. Hiding this type of information is not an easy decision, as it might create problems in the relationship between services and between workers, in case the truth comes to surface. However, when convinced that exchanging information will have bad consequences for users in terms of care continuity and bond, workers may choose to be loyal to users rather than to colleagues or organizations. Losing a benefit without a perceived sustainable basis to keep a job or being arrested while inside a care facility are perceived more as risks to care than as benefits; therefore, risking trust building with colleagues is justified, and the network is ignored.

Another possibility is that when some information perceived as useful for workers is not allowed to be shared by law, usually because of professional secrecy reasons, and when convinced that information sharing will be useful for their tasks, workers might choose to bend rules:

> NL25: And, for instance, I got a patient, he disappeared and he turns out to be in [country], and we know that. Then his sister comes here 'my brother's been missed for three months, I don't know where he is, my brother's sick, I want to see him', she was really sad, and crying and worried. I'm not allowed, as a [health profession], to say it, but then I phoned someone from outreach work who also knows this person and they can talk together and he's allowed to tell her, so that's really handy. (Amsterdam, health worker)

> NL16: The law says they [health professionals] cannot say anything. There are professionals they say 'It is possible', but the law says is not. Also for the police workers, they cannot tell… then we say, OK, we have a chain system so we have to cooperate, so we do it…so we do it. And we know that the law is not completely connected with what we are doing, so we

find each other on the basis of trust... (Amsterdam, law enforcement worker)

Even though workers realize they are breaking professional and organizational laws, their decision of sharing information which should be protected is justified by their good intentions regarding the user and his/her well-being, and the need of keeping a good relationship with their partners. In this way, workers develop an argument to protect themselves from being judged as not complying with professional conventions: it is to benefit users and enhance network, which are, ultimately, professional goals. These workers are critical on secrecy laws and the difficulties they create in terms of networking. Breaking the rules by not respecting these laws is seen more as a compromise with work goals than as wrong; networking helps achieve a higher purpose. At least in their own narratives, workers are bending the rules because of their drive towards the users they assist, and the need of keeping a healthy network with their colleagues.

Yet, other dilemmas arise when information which is not supposed to be shared by workers, in order to protect users' right to secrecy, is understood by workers as a powerful tool of negotiation with other colleagues. Breaking secrecy laws to share information, in these cases, can be used to protect workers' power and loyalty between sectors, and bring advantages to workers and organizations ways that might be questionable from users' point of view. Some agreements between social and police workers, for instance, may include sharing criminal information about users under their care, or using users to get information for police workers without consent.

NL34: I worked this whole morning with the police. We had a meeting [whispering] and they are trying to track on dealers, and what they do is that they trace our clients... [researcher makes a surprised face]... they don't do anything, they want to get the dealers, and what we do about two or 3 times a year, is that we inform. The police worker is standing outside somewhere and we call them, we say, 'this and this client, they are just going that way, and he just had [done] a telephone [call] to his dealer', and they will trace them and they will get the dealer. […] It is a good communication with the police; because police workers have more important things to do than chasing after our clients, but if they don't have enough information they will do it, and that's a win-win situation. (Amsterdam, social worker)

When facilities have been suffering with police workers' crackdowns searching for drugs and weapons, and no better agreement could be achieved with the responsible police officers in the area, this type of collaboration may appear as a solution. The worker, in this case, understands that breaking secrecy laws or ethical codes is beneficial to keep a positive relationship with police workers, and would, somehow, protect clients from non-planned or regulated police approaches with the same aim of getting dealers. Potential harms for users of this approach, however, are not taken into account.

Not all workers, however, would agree with this approach. Few outreach workers from Amsterdam actually criticized their colleagues who share information with the police, since they perceived it as not beneficial to the clients.

> NL18: One more thing, because that's important. We work with the [service] here, and they are not to be trusted. [researcher makes a surprised face]. I just have to say it…And our clients now that, they feel it, because they [other workers] share information with the police, with the police on the other side.
>
> Researcher - But they are not supposed to share?
>
> NL18 - Ahn…it is a little bit grey, a little bit grey. Some things are supposed to be shared, and then they make it bigger and bigger and bigger, and when you start to do a few questions they say 'Ah, doesn't matter!' but they don't even realize that they do something wrong. But our clients they feel it, they feel it in their face, they feel it in their blood… (Amsterdam, social worker)

Similar to care workers from Porto Alegre, these outreach workers from Amsterdam feel that working with the police can hinder their trust building with users. They also believe that their colleagues who work with the police are not driven by users' best interest, but an interest in organizational and personal purposes. For these cases also, Sandfort (1999) approach of 'collective beliefs' loses its explanatory power. Not all workers from a certain sector or even service share the same approach on how to deal with drug users. While for some, users are understood as childish and in need of external control to be able to get over dependency, for others, a controlling approach is disrespectful of users' rights of choice.

As it was already said, networking can also have a function of control, and in this case, information sharing is a powerful tool. By having the correct information about users from other colleagues, workers can prevent, for instance, being fooled or misguided by users seeking to make profit or cheat the system. If no information is shared between workers, users might lie to different services: they can pretend to one service that they cannot do a certain activity they are being required to because they have to be at another service at that time; and then they can lie to the other service by saying they have been mistreated in a certain facility, while actually the user did not follow the rules and was suspended/expelled. If workers communicate, they are able to confirm whether users are telling the truth or trying to play with the rules, which gives users less room for negotiation.

In this case, a shared information system gives workers from different services information which, without networking, would be held by users only. Information systems, joint meetings and frequent contact between workers to share information about users in Amsterdam creates a type of virtual *panopticon* (Foucault 1977). Foucault describes Bentham's *Panopticon* as an instrument to induce in the observed a state of conscious and permanent visibility: they know they are been watched, but cannot be sure how and when, since they cannot see through the observation 'tower'. Surveillance, thus, is permanent in its effects, even if it is discontinuous in its action (ibid.), assuring or at least increasing the chances that the observed will behave in the expected ways at all moments. Through a chained network, users are being potentially observed and controlled at all times, without knowing exactly by whom and when.

According to few outreach workers, and to users and users' associations from Amsterdam contacted during the research, the close network established between workers can ultimately limit users' participations in decisions about how they want to live their lives. In joint meetings, where an integrated care plan is discussed and agreed upon, there is often little room for users to choose a different path from what is designed by workers. If in one hand users may be satisfied with the level of benefits and services they receive, on the other many feel that once part of the care system, their autonomy is compromised. Rules and requirements from services and workers dictate the direction they should live their lives. The risk here, is that power relations become too static and hard to be resisted by users. Users, then, might lose their autonomy and room

for negotiation of their needs, becoming dependent (maybe not on drugs), but on workers and welfare. At this point, there may be imbalance between organizational, professional and users' needs. Workers from Amsterdam see as positive the control that information exchange produces because its perceived help in work effectiveness and prevention of system's misuse by users. The main drives here, are the organizations' needs and their own needs as workers, rather than users' citizenship rights.

Short circuits between specialized and basic care

A challenge found in Porto Alegre regarding networking relates to the short-circuits where few connections are over activated while other points in the net have no communication. The main short-circuit, already mentioned, is the one between specialized drug treatment services and the basic care. In these, drug treatment clinics (mainly for inpatient treatment) are the key nodes with short-circuit connections. The insistence on a few connections or services as a way to solve drug problems makes workers from these places feel flooded with demands. Too much demand without the necessary resources ends up creating big holes in the net, through which many users fall away from services.

As it was already described in chapter three, many care workers in Porto Alegre believe that once a crack user gets in touch with the care system, the most urgent action (or the only possible one) is to refer him/her to a drug treatment clinic. As crack is perceived as being extremely difficult to control, many workers give priority to in-patient drug treatment. For those workers, detox is seen as the solution: a matter of going to a psychiatric emergency unit and asking for a vacancy, given the perceived urgency of the situation. In some of these cases, workers perceive they are balancing their professional goals and aims of the organization with the needs of the user (when users want an abstinence based treatment). In others, however, users' willingness is not taken into account (and enforced treatment might be made), since workers claim that due to their drug dependency, users are 'not in condition' to decide what would be better for themselves.

In any case, pressure on access to an emergency unit for closed detox services makes these services flooded, which ends up producing long waiting hours for admission at the front desk by workers and users. Also, the eventual screening is not always guarantee of a detox vacancy for us-

ers. Among different workers, there might be disagreements on what would be better for a given user at a given time.

> BR13: health is very complicated, like, when you have to take a kid to be in detox. You get there, you die [waiting] there. Some workers already left from a detox emergency at one in the morning; they arrived at six in the afternoon and left at one in the morning. […] And when you get there… the kid has to be interned, he is a crack user, he is saying he has difficulties, and the psychiatrist says he doesn't need to, he can go back. And he is not well. So, it complicates a bit. Only you know the time you spent convincing the kid to go to a detox. And they, there are some that want that, that is their moment. And you go and try all your ways, you borrow a car, you go by bus […] and then you get there and they [doctors] say that he doesn't need to be interned… (Porto Alegre, social worker).

These non-negotiable disagreements on what to do with users leads to frustration both for users and workers. It wastes workers' time and effort, and also puts users into a situation of being ping-ponged from one service to another without a proper assistance. Most of the times, this leads to users' withdrawal from care services. When holes in the network lead to disagreements, neither the users nor the workers (and the organizational) needs might be fulfilled.

This 'bottle neck' at the entrance of specialized services was a great source of worries and dilemmas for workers from basic services in Porto Alegre. Rules and requirements for users to get into drug treatment clinics and remain in treatment, or to get to shelters and have a room, are perceived as too demanding. Many care workers mentioned, for instance, to be willing to refer users to outpatient clinics instead of inpatient detox, since they perceived these places as more respectful towards users' needs and context. In these services, however, access was perceived as very difficult:

> BR08: So I have a criticism to these [out-patient] services, because in the majority they make the access too difficult. For instance, in one institution that is our reference for [drug treatment]… the appointment to evaluate medication is from 7 to 8 in the morning, on Thursday and Friday. And the user has to be there, and has to be well [not under drug effect], and accompanied by someone…[laughs] (Porto Alegre, social worker).

Strict time schedule and forbidding of being under drug effect creates difficulties for drug users in general to access and stay in specialized drug

treatment or shelters. The difficulties, however, may be even bigger for the most vulnerable drug users. In drug treatment clinics, the need of having documents, having an address, and being accompanied by a responsible person to have access to vacancies, sometimes, makes homeless users' access to care a very difficult mission. In the case the users are under age, there is an extra-requirement of having someone to sign as responsible for the user in order for him/her to be interned. For most of the children assisted, however, the family is not there, either because kids are homeless or roofless, and/or because they lost/avoid contact with their family. The worker bringing the child to the detox, therefore, is required to sign as responsible. This creates a strange situation where the worker becomes personally responsible for the child s/he assists.

> BR31: …even if the user is not under age and has documents, he needs to be accompanied by one relative. […] Well, but we're talking about people who have broken their ties with their family, which...Well, maybe going through a treatment is part of a long process of rescuing these family ties as well, and to establish others. Anyways, how can this be a condition for people to access this level of attention? (Porto Alegre, social worker)

Strict rules from specialized services are perceived by workers from non-specialized facilities and users as representing prejudicial attitudes based on stereotypes. Prejudicial behaviour is perceived mostly towards homeless users' needs and situation. Workers report prejudice in many different ways: rejections based on lack of documentation and/or lack of address, clear prejudicial statements or claims not to have vacancies when they actually exist.

> BR05: He [a young user] was destroyed in the street, and we took him directly there [detox clinic]. The physician, she said, in front of the kid: 'Ah, I'm not going to give my vacancy, to him. I know he is going to die, he is not going to treat himself anyway!' […] talking out loud in front of the kid (Porto Alegre, social worker).

A possible consequence when prejudicial attitudes inform rules and strategies of selectivity, is that the most vulnerable population of users may face higher difficulties to access care. In the case of shelters, where drug users have to dispute vacancies with non-drug using population, the chances for a selectivity against drug users may be increased. When services are flooded with demand, the chances that workers will use 'creaming' strategies (Lipsky 2010) to selectively prioritize to assist those con-

sidered easier – or 'most deserving'- may be increased. This can happen, for instance, by setting up a high standard of rules for drug users to comply. High-standard rules increase the chances that users will not be able to comply, and will be perceived by workers as 'not willing' enough. As Lipksy reminds us, self-fulfilling prophecies contribute to the persistence of what he calls 'workers' bias'. They provide spurious confirmation of the validity of differentiation made by workers between 'deserving' and 'non-deserving' users (Lipsky 2010:114). In the case of Porto Alegre, where drug users have to compete with non-users for many welfare services, exclusionary differentiation criteria play an even bigger role. In a context of such a competition for resources, discretionary acts from workers can contribute to the creation and continuity of certain stereotypical interpretations of drug users, which might end up harming the most vulnerable ones. In this scenario, workers from basic care services feel they are at the hands of workers specialized services, who would hold the key for solving drug use problems but would, many times, not be willing enough to collaborate.

On the other side of the net, workers from specialized services question what they perceive as an 'emergency behaviour' approach by their basic care colleagues. For them, this behaviour is what produces the short-circuit around drug treatment.

> BR33: It doesn't work because the aunt of the guy says 'Ah, João da Silva, who is my nephew is using crack and I wanna take him to drug treatment'. Then the worker sends them here. Then the guy comes here and 'Huh? What? How?' He has not been evaluated. […] So I think they [basic care workers] should get training. Because, why does the person do that? Because he knows nothing about drug dependency. If they knew, they would know it is a waste of time for the worker, the service, the user and the aunt! So, do not refer directly, but say 'look, there is a service like this, works so and so. Would you like to take a look, see how it works?' Yes or no! If yes, then send them here. […] So, do an intervention, a screening. (Porto Alegre, health worker)

Workers from specialized services perceive that many users arrive drug treatment clinics without a clear information about what type of treatment and requirements they will find. This misinformation gets in the way of users' access and adherence, in their view, this could be prevented if their basic care colleagues provided a first screening and basic information for users. For them, workers from basic care do not realize

that they could focus on providing users with a supportive setting, while preparing them to be willing for an eventual drug treatment. Having the user assisted by basic services for a longer period would be, in specialized workers' opinion, better to balance organizational needs of more successful rates of treatment, as well as decrease their work load and the frustration of users in non-successful/ping-ponged referrals around the system. Some workers from the basic care, mainly outreach workers, actually agree with this posture, thinking that much more should be offered to drug users than just drug treatment: improving their setting and promoting a reflexive attitude towards their choices in life can serve as well to increase users' quality of life, even while using drugs. Here, different perspectives on the best approach lead workers to different discretionary choices on with whom and for what to network.

Even though not so much mentioned by workers, part of the difficulties in the dynamics between specialized and basic care might also relate to network structure (Musso 2004): flows between basic and specialized services are not always clear, and also change very often. In many cases after elections and/or changes in the managing team, managers in power decide to close down a specialized service which was the reference for basic services in a certain region. This information is poorly distributed along the welfare system, and workers spend a lot of time and effort trying to find out where they should send users to. It is possible also that the official flow is known, but it does not work in practice. So workers build side flows and partnerships with different services that can, actually, receive users. Besides that, some regions in the city do not have a specialized service as reference, and basic services depend on other region's services willingness to accept their users or on their capacity to assist people from outside their territory. Specialized services, in their turn, get flooded with demands from different regions. This makes it difficult not only to match resources and demand but also to build networks, since they have to know and build collaboration not only with services from their own region but also from neighbouring ones. Many times workers in specialized services do not know if they are supposed or allowed to assist someone from a given region (outside of their own territory). The lack of information happens very often, leading both workers and users to stressful situations.

In official guidelines, however, network structure does offer support for connecting specialized to basic services. Specially in the health sector,

a specific activity for this connection is the *matriciamento*. In this activity, health workers from specialized mental health services assist their colleagues from social and health basic care services in issues related to mental health, which includes all services related to drug treatment. The Centres for Psycho-Social Care in Alcohol and Drugs (Capsad) are the specialized out-patient drug treatment clinics offering support to basic care services. The support is supposed to happen through phone calls, meetings, and joint activities. Workers at the specialized clinics, however, mentioned lacking time to meet demand, while workers from basic care complained about the difficulties in getting help from their specialized colleagues.

Another problem adding to the short-circuit related to drug treatment is the perceived lack of follow up after treatment. This is considered specially problematic in the cases of in-patient clinics. In Porto Alegre, emergency units and Therapeutic Communities do not focus on networking with other services to refer users to after they have finished their treatment. Even in the cases when they do and users manage to enter an out-patient service, social care (such as shelter, benefit, bus ticket to go to the treatment centre) is perceived as not present to an extent that allows users to be there continuously.

> BR17: One thing that is very difficult is that the patient leaves detox and then starts attending [outpatient care], but he's back on the streets, back to the same environment where he was before. […] In a little while, *tchum*, all goes downhill again; you have to start all over again. […] Because there has to be the social part, with shelter, with benefit. Because we try to do as much as possible, but we're health, right? (Porto Alegre, health worker).

Not having social benefits and minimal conditions for users after a drug treatment is perceived as hole in the net, with the risks that users who were abstaining will relapse, and hindering continuous care for others. Besides that, users' adaptation from an inpatient to an outpatient treatment with insufficient support is perceived as risky. Workers feel that users do not have enough time and coaching to adapt to a new situation of more independence or autonomy, and end up getting back to an abusive pattern of drug use very quickly. At the end, however, even knowing all the challenges and recognizing the flaws of a holed network around a specific type of service, workers keep referring drug users to inpatient treatment due to a perceived lack of alternatives.

Who knows better?

Interestingly, despite the very different networking patterns in Amsterdam and Porto Alegre, also similarities were found across the cases. There related to workers' perceptions of uneven relationships in terms of room for negotiating meanings and objectives while networking. Tensions were identified between social and health workers, and outreach and office based workers from the three sectors; tensions between care and police workers were also mentioned in both cities. Uneven relationships were perceived by workers from both Amsterdam and Porto Alegre in the networks linking social and health care workers, as well as between outreach and office based workers. In Porto Alegre, since police divisions regarding drug use approach and investigation occur between outreach (military police) and office based (investigative police), this perception includes also contacts between this sector.

In the case of care workers, social workers from Amsterdam and Porto Alegre perceive health workers as having much more recognition and power in daily negotiations. When jointly building a care plan for users, for instance, social workers mentioned having disagreements with their health partners regarding which plan to develop, or, what is considered priority in a given plan. In trying to negotiate different objectives, social workers and outreach workers from social and health sectors feel that the opinions and priorities of their health and/or office based colleagues always prevails over theirs in an unfair way.

> NL35: The bad thing is that the [public health services] sometimes you have to put them backwards...(laughs) they think they are the boss... they think of us, 'well you are social worker, we know better', and every time, every now and then you have to put them backwards 'well, we work together, that was the success, don't get ...' How do you call it? Well, you know what I mean, I think. […] sometimes they make a decision about the client although we want something else, we don't agree with the problem. We have a whole other pattern drawn for the client and suddenly the [public health services] cross through, and 'we know it better'. Because everyone by the [public health service] has HBO [university of professional education] and by us, most of the workers who work for us have MBO [medium level of education]. It is a type of hierarchy I don't understand at all, but, anyway. (Amsterdam, social worker)

Educational level is one of the factors producing a hierarchical relation around who knows better what to do with a user. This directly influences those care workers whose jobs require only a medium level of education, instead of university level. That is the case of most social and outreach workers in Amsterdam, and the case of many outreach workers in social and health fields in Porto Alegre. Different from Amsterdam, however, being a social worker in Porto Alegre requires a university level, similar to health workers. Also, even though (similar to Amsterdam) the role of an outreach worker in Porto Alegre does not require an university education, many outreach workers in this city are either currently doing an university course or have already finished their undergrad degree. Due to a higher level of unemployment, it is common to have over qualified people performing jobs which require less formal education than they have acquired (as exposed in chapter two). Educational level, thus, cannot explain all hierarchical differences.

Besides the formal educational level, also the type of knowledge the worker has, influences on his/her power for negotiating with others. Here workers' interpretive beliefs about what is the best solution to deal with drug use has an important role. The rationality (Musso 2004) in which drug treatment is the main solution for drug use, and that workers specialized in 'curing' are the ones with the best knowledge on how to handle drug users, defines the room for negotiation workers have when networking. Different professions and work sectors have their own specific knowledge field, which can trigger uneven power relations among workers and a dispute around 'who knows better'.

As explained in chapter three, workers from both Amsterdam and Porto Alegre focus on drug-solutions for drug use. Even though this means referring users to different types of services (high threshold in Porto Alegre and low threshold in Amsterdam), still health workers are the main ones who decide whether users can get into the services or not, and what is required from them to stay. In negotiations with their health colleagues, social workers felt their professional aims with users were not respected. The aims of health workers and their organizations would usually prevail.

> NL34: If you [as a drug user] live with us at the [shelter] you have to do things. We start at 8 o'clock and someone [a user] has to put the breakfast table, first thing. But if someone [the user] says, 'no, but at 9 o'clock I have to get my medicine and my heroin'... he won't be there. That's the first

> problem. So what we say is 'OK, but then you do the lunch'; 'No, because I'm still at the heroin project'. So that's the sort of an escape for someone, to have a reason not to do it [...] what I see, is that it doesn't work for me, for the [shelter], it doesn't really work. Because, yeah, you get a contract with two things, and the one you need is heroin, and we are also an organization who wants to achieve things, and that ends up in conflict. (Amsterdam, social worker)

When having to negotiate priorities and tasks, social workers from Amsterdam perceive that their health based colleagues disregard activities developed in social facilities. Guiding users on how to become more organized and clean (by setting up a breakfast table, for instance), is perceived to be less important than drug-focused solutions such as getting their prescribed heroin at a specific time. Foucault contends that discourse does not occurs freely, but it is bounded by procedures of exclusion which define what can be said in a certain context and time and who is considered to be legitimate to say it (Foucault 1981). By doing this he puts power at the centre of the analysis, and also brings the notion that knowledge is not neutral, but connected to power (Foucault and Gordon 1980). This connection can be seen in what he calls internal procedures of discourse control, where different disciplines (such as medicine or psychology) determine the problems which are worth to be analysed, the procedures or methods to do it, and define who are the legitimate experts to carry this work (ibid.). In the situation of dispute around who knows better described in this study, medical knowledge is considered higher in the ranking of those legitimate to define ways of judging and healing drug addiction than its social counterpart. Historically, medical discourse has a central role in distributing people in mentally ill or sane categories (including drug addiction), and in defining the legitimate ways of dealing with and healing those considered 'abnormal' or 'sick' (Foucault and Gordon 1980). Health workers' knowledge, thus, is perceived as more legitimate to deal with drug addiction and drug use issues. In this context, social workers feel their health partners do not hear their voices, do not value their professional opinions and do not recognize their role properly.

Specially in Porto Alegre, social workers had a critical view on understanding social work as basic needs provider. They feel their health partners emphasise their role of giving benefits, but do not recognize their

role in promoting citizenship. This view is considered a narrow-minded view of what they are able to provide.

> BR11: social care has the big potential of accompanying the [users'] family, and working other things that are related to organizing a life project. This allows also to talk about health promotion in a broader way, right? On the other hand… in health… they have an immediate demand, you know, to social care. As if social care didn't have all this power to act in the person's life, you know? They just want to know about those things of getting the bus ticket, getting a shelter vacancy […] But this thing about building life projects, to build together… I think the health network doesn't see social care as partners. (Porto Alegre, social worker)

The role of welfare resources managers, alone, is perceived as a continuation of a paternalistic view of a welfare state, where social workers would act as charity givers towards users. This type of relationship is perceived by social workers as perpetuating relations of dependency, where users assume a passive position in order to receive benefits from a donative state. Rather, most social workers from Porto Alegre would prefer to be seen as promoting citizenship and a more active position from users, which includes not only managing benefits, but also promoting reflexive and responsible attitudes in the people they assist. These views are influenced by the principles of the collective health movement in Brazil and its repercussions in the social care system (Mendes et al. 2009), with the creation of the Unified Social System as explained in chapter two. A collective and transdisciplinary approach, instead of an individualized and hierarchical model centred on physical doctors is pursued, as well as the participation of users as citizens in their social assistance and society at large (ibid.). Increasing social and political participation of users as citizens with rights, besides providing them with benefits, is part of most social workers' professional commitment in Porto Alegre.

In Amsterdam, on the other hand, social workers had no criticism towards being basic needs providers for users. For them, their professional role is focused on providing users with their basic needs, and this means giving them concrete resources such as money, housing, feeding, among others. Trough resources and the rules and regulations attached to it, workers understand they would achieve higher goals of helping drug users to improve their life quality. Different environments, culture, resources, and historical developments of official policies can make

workers from the same sector understand their professional commitments in different ways.

Also, social, health and police outreach workers, from Amsterdam and Porto Alegre, perceived their role was not recognized in its importance by their office-based colleagues. Their way of manifesting this was affirming the difficulties and skills required to access users and situations when searching for them actively, instead of waiting inside a facility. Outreach workers feel they are closer to users and to 'the real facts' than their office-based counterparts. This is attributed to spending more time in the streets and with users and knowing better about their life context, environment and behaviour.

> NL18: Outreach worker is a bridge figure between the official aid there is and the street. Because the official institutions, like the municipal health service, they give them [users] methadone, they give them heroine and give them also primary health aid; but the distance [between them and users] is really big. We fill in that gap. So we take them with us to [services]… we can translate. They are both speaking Dutch, but there are two different types of Dutch: the street Dutch and the formal Dutch. We know them both, so we are some kind of a translator. (Amsterdam, social worker)

By using the analogy with translator, care outreach workers criticise their perceived inefficacy of specialized knowledge to reach and welcome users, and especially the most vulnerable ones, in a more integrated way. Here outreach tries to produce an inversion on the established power relations calling attention to the importance of their own – and more street-based- knowledge in comparison with the technical knowledge of their office-based fellows. This is what Foucault calls resistance: creating possibilities of transforming and reversing power relations (Revel 2002). Resistance happens where there is power. The very analysis of power, for Foucault, requires observing micro-level resistances, where power effects can be seen (Foucault and Gordon 1980). By affirming their knowledge and closeness to users, outreach workers resist medical-specialized-office based knowledge. They call attention to and praise tacit or street-knowledge, which they perceive is not found in this technical circle. Very often care outreach workers accompany users to other services to ensure they will attend and receive a good service. They exercise their role as translators to help the user in finding better ways to tell a story, ask for help and behave according to service rules and office-based workers expectations.

Interesting to note these power relations are not perceived by most of the health and office-based workers. The few who did (all from Porto Alegre), think this reflects the type of population assisted: since social and outreach workers tend to assist the most vulnerable users, and there is social prejudice towards these users, the same prejudice reflects back on people working with them. Social workers would receive less consideration, therefore, because of features of the population they assist, not due to their own specific knowledge.

In the case of the law enforcement field and the communications between military (outreach) and civil (office-based) police workers, military police feels their actions and judgement are not valued by their civil police colleagues, as well as by other actors in the criminal-investigation scene (such as judges and attorneys).

> BR10: Because there is a loophole, you know? […] You [military police workers] approach the citizen who was selling the drug, the citizen throws the drug on the floor, and walks a block. Then you see him around the corner, you catch him, and you found the drug on the floor. You take him to the civil police station […]when he will testify for drug trafficking, his attorney will ask you 'So, you caught him with drugs in his pocket or with the drug on the ground?' 'Yes, I caught him with the drug on the ground'. 'Ah, then you have not caught him selling drugs, you have caught him with drugs on the ground'. 'No, but he was there with another person and that person ran away'. 'No, but then that other person that was there and ran could have thrown the drug on the ground' […] There seems like a joke! You're there, you're seeing they are selling, they are dealing, then because you did not catch them with drugs in his pocket […] They make fun of you, it's a joke! (Porto Alegre, law enforcement worker)

As it was mentioned in chapter four, the dispute around which cases are considered to be of drug use or drug dealing are one of the challenges police workers finds in Porto Alegre. In these cases, similar to what happens with care outreach workers in relation to office based care workers, military police workers from Porto Alegre feel their version of the story is not considered by their civil colleagues. They believe, however, they would know better how to judge what is happening because they are closer to events. Civil police workers, on the other hand, believes to have more specialized knowledge and technologies to define the truth.

> BR07: I used to totally ignore military brigade's version. We [civil police workers] used to joke about it, that they [military police workers] used to

> come with a ready text: 'Ah, we entered the slum, we saw the suspect, he fled from us, entered the house, and we chased and arrested him indoors'. That was their mote. And we [translated as] 'Oh, okay, I invaded the residence, and got drugs there'. So they fantasiz…they put a makeup ... because it is actually very difficult for you to catch a blatant trafficking. You can only catch blatant trafficking after an investigation. You have to camp on site, you have to infiltrate, it's a whole thing... (Porto Alegre, law enforcement worker)

In the case of police, thus, disagreements on who knows better is recognized by both outreach and office based workers.

Networking patterns and discretion

This chapter analyzed the connections between health, social and law enforcement workers in their daily approaches to drug users in the cities of Amsterdam and Porto Alegre. It brings together interview and direct observation data to reveal how workers move between decision-making territories, their rationalities on why to develop or not a network with other actors, and the challenges they face when collaborating or not with each other. By analyzing these three sectors, instead of only one, the research brings together the points of view of the different workers involved in networking and produce a more nuanced picture on how and why networking occurs in practice.

Tables 12 and 13 summarize the main networking patterns found in Amsterdam and Porto Alegre, respectively. In the city of Amsterdam, street level workers seem to be very close to official policy ideas of integrated networks. Overall, workers from all sectors describe networking positively by emphasizing the idea of chains: workers and services are integrated into a chain where one link connects to the other and anchors users to services. In Porto Alegre, on the other hand, the emphasis is on the inefficiency of the connections, and the idea of a network built with too many holes, through which users can fall and not be connected to services. The main differences between the cities in terms of network structure can be seen as availability of resources, but the differing network dynamics and rationalities underlying the contact between social, health, and law enforcement workers suggest differential resources are not the sole cause of differences in networking.

The very different patterns of network dynamics between workers in the studied cities can be explained both by the differences in terms of resources and ways in which services are organized (structure of networks) and the negotiations workers make between different interests and goals to decide upon collaboration (rationality of networks). When describing their (non-)partners and the reasons why they decide to network or not, street level workers participating in this research use network rationalities (Musso 2004) as justifications to validate their decisions. These decisions involve negotiations between perceived benefits in terms of achieving workers' professional goals, assisting users in their needs, and guarding the interests of the organizations workers are into.

Table 12:
Chained networks in Amsterdam

	Social/ health	Care/ law enforcement
Dynamic	Chains	Chains
Rationality	Benefits for users; Avoid users misuse of the system ; Avoid conflicting activities; Lower work load, better success rates	Less nuisance and criminality (le); Care continuity and protection from users' aggression (ca); Avoid conflicting activities (ca); Increase users' access to care; Lower work load, better success rates
Structure	Case managers and outreach workers (job description); Working hours dedicated to networking	Community policing (job description); Joint programs and integrated units Local guidelines
Net. drive	Organizations + workers + (users)	Organizations + workers + (users)
Dilemmas	Information exchange; Who knows better	Information exchange;

Workers from the three sectors in Amsterdam share rationalities of networking that lead to interpretations of collaboration as balancing the differing needs of organizations, users and of their professional commitments. In the case of connections between social and health care, part of the rationalities of networking are around benefits for users, with health workers being considered drug treatment providers and social workers the social benefit managers. Networking is also understood as avoiding conflicting activities between sectors and services, and helping workers to decrease work load and achieve more successful rates. Interestingly, besides enhancing circulation of information between workers, and movements of users and benefits in the territories, networks are also

seen as positively increasing control over users: it avoids users misusing the system, and increases the chances of 'rescuing' back – not always willingly- users who slipped out of care.

In the case of connections between care and law enforcement workers, interpretive beliefs that keeping users inside care is helpful to decrease public nuisance and criminality, influences police workers' willingness to collaborate with social and health workers and push drug users into care. Care workers, on the other hand, see networking with law enforcement as useful to keep safety and control inside facilities when needed, and as a helpful hand in pushing users into care. Both sides feel that their work complement each other, lowering their work load and achieving better success rates for their organizations Thus, networking allows achieving a balance between organizational, professional and users' needs. Although not directly put in such terms by workers, the structure (Musso 2004) of the network seems to make a great contribution to worker satisfaction through the rationality that it sustains. As mentioned earlier, workers from the care sector mentioned having specific hours from their schedule available for networking. Also job descriptions for community police workers include contacts with care services. Besides, joint programs and integrated units provide an environment in which care and law enforcement workers meet each other daily, reinforcing attitudes of networking among care and law enforcement workers.

In Porto Alegre, differently, military police workers do not have as a job description the contact with care services. In addition, a rationality which doubts the success of drug treatment and perceives a lack of resources and vacancies in social and health services for users, demotivates police workers from networking with care. A history of conflict (since the military dictatorship in the country) and divergent goals complement the non-networking scenery. For care workers, keeping a distance from law enforcement workers (here police workers and Tutelary Counsellors) is considered crucial to protect the bond and trust they developed with drug users they assist. For them, decreasing public nuisance is not a goal to be involved with, since it is not perceived as helping users. Not networking, thus, is understood by both care and law enforcement workers as facilitating the achievement of their professional commitments and the needs of the users they assist (given that here, drug users are not considered by Porto Alegre police as their 'main clients'; as these are the

non-drug using citizens instead). The structure for these networks is less strong when compared to Amsterdam, with only one program – PROERD- which despite being officially recognized, still suffers some prejudicial opinions inside the police organizations (as explained in chapter four). The national policy including law enforcement in a network with care to fight crack (Brazil 2011) is also more recent in comparison to the local guidelines in place in Amsterdam, and was only being put in place during the fieldwork period of this research.

Table 13:
Holed networks in Porto Alegre

	Social/ health	Care/law enforcement
Dynamic	Holes	No network
Rationality	Benefits for users; Lower work load, better success rates; OR, Diverting time from assisting users	Contact with police harms trust with users (ca) Care is not effective and not enough (le) There are no shared goals
Structure	Outreach workers (job description); National and local guidelines – *matriciamento*	PROERD, community police training National policy
Net. drive	Workers + users (for networking OR not)	Workers + users (for not networking)
Dilemmas	Short circuit between basic and specialized care Who knows better	Trust with users (in connections)

Networking within the care sector in Porto Alegre shares some similarities with Amsterdam, but there are also many differences. Networking among these sectors is mainly justified by increased benefits for users. Here also, health workers are mainly understood as drug treatment providers, although basic health is also part of expectations of social workers in Porto Alegre. Social workers are also interpreted by their health colleagues as benefit manager, but contrary to their Amsterdam colleagues, they are not satisfied with this position. Lowering work load and increasing success rates are also seen as potential benefits, but sometimes, lack of structural resources and available time for networking might lead users to take a different position, efforts in networking are seen as diverting time from assisting users. A special challenge between the types of care workers is related to differences between basic and spe-

cialized care facilities and workers. Here, specialized services are perceived as a 'bottle neck' by workers from basic services, with their specialized colleagues being seen as the ones who keep 'most needy' users out of care due to their discretionary choices by creaming for the 'most deserving' and compliant individual cases. For specialized workers, however, the situation is provoked by claims that many cases are emergencies and lack of knowledge about constraints on the parts of their basic care colleagues.

Different networking patterns create different dilemmas for street level workers in Amsterdam and Porto Alegre. These, consequently, make room for different discretionary choices and decisions across the ocean. Interestingly enough, if 'holed networks' explicitly produce dilemmas for workers, 'chained networks' produce dilemmas as well. At the end, an integrated network might not be described only in a positive way. Well-connected networks, as in Amsterdam, increase the need of sharing information about users. What type of information to share and with whom is left to workers' discretion. When deciding what to do, street level workers try to balance respecting ethical behavior according to professional secrecy laws, with what is considered to be beneficial for users and acceptable to the colleagues they network with. When the balance is not possible, workers may choose different strategies. They can, for instance, hide information from their colleagues in order to protect users, focusing at this moment on users' needs, even if this might hinder networking efforts, increasing their work load and decreasing possible successful rates for their organizations. Workers might also bend professional and organizational guidelines and exchange information which was supposed to be secret, in order both to sustain the network and get benefits for users. Finally, workers might also disregard users' needs by hiding information from them or using information without users' consent to benefit organization and secure partnerships.

In this type of chained networks, the two outcomes – both circulation and control - proposed by Musso (2004) are enacted in street level policy practice. It increases not only circulation of users' information and access to care, but also the control governmental agencies have over drug users. Information sharing about users in Amsterdam can be seen as creating a virtual *panopticon* where users feel perpetually observed and controlled, losing their autonomy and room for negotiation with workers. This, in the end, may produce the unintended outcome of dependency on work-

ers and welfare. A 'controlled circulation' may facilitate resource management and greater satisfaction in work processes for street level workers. Also, it may increase care access for users and assure a more integrated assistance. However, when the rationality behind networking is focused too much on control, users' rights to choose their life styles is inhibited, and both workers and users may lose sight of the objective of enhancing life quality and decreasing dependency for drug users.

In the case of Porto Alegre, networking rationalities focused on medical knowledge as only solution for drug use eventually builds a net with short-circuits on drug treatment services. Short circuited places end up flooded while users fall out of care through the holes. This, ultimately, hinders a more effective use of the welfare system, and a less integrated way of assisting drug users. The higher position in the knowledge hierarchy attributed to workers specialized in drug treatment in Porto Alegre not only influence the room for negotiation different types of workers have in the network, but also the dynamics of the networks. Networking rationalities focused on medical knowledges as the only solution for drug use, encourages instrumental emergency attitudes among workers. A network clustered around abstinence drug treatment services creates flooded services and holes through which drug users slip out of care.

The most vulnerable users (usually homeless and/or with heavy drug use) may have to travel to central nodes of in-patient treatment programs, and then, lacking a supportive setting for users when in-patient treatment finishes, end up being back on the streets and into heavy drug use. This, ultimately, creates an ineffective drug care system in which many intended beneficiaries from a harm reduction approach suffer unintended physical bodily damage. But it is also an unintended outcome, that less systematic screening and information sharing and looser networking creates holes that give users more room for maneuver and associated rights to decide upon their lives, and escape the State's *panopticon* gaze.

In both Porto Alegre and Amsterdam, differing cultures and regimes of surveillance produce networking outcomes in which people who use drugs may have negative, unintended experiences. In Amsterdam, too effective networking between workers may chain users to services reducing their rights to, and responsibilities for, self-creation. In Porto Alegre, ineffective networking may leave holes through which drug users with needs for care of their individual bodies may fall, though they may retain

greater rights to social autonomy. A more holistic approach to drug users in which the differing roles of social, health, and law enforcement workers are valued separately, but equally, may produce networking with less dysfunctional misrecognitions.

Notes

[1] Even though these studies and WHO's definition are focused on the health sector, this chapter expands to include social and law enforcement sectors as well.

[2] The Pan-American Health Organization (PAHO) refers to the *'Redes Integradas de Servicios en Salud'* (literally, Integrated Networks of Health Services) (OPS 2010), and Brazilian documents from PAHO refer to the '*Redes de Atenção à Saúde'* (Networks of Health Care) (Mendes 2011). In general publications from WHO and in reports from the WHO Regional Office for Europe, the term loses the word '*rede'*, or 'network', becoming 'Integrated Health Services' (WHO 2012, Waddington and Egger 2008). The same meaning, however, is kept.

[3] This concept of the authors will be further analysed in chapter six of this thesis.

[4] The networks described refers to the workers and services participating in this research, but also go beyond this scope when workers included partners outside this frame.

[5] Even though these services were created with a social function of protecting children's right, they ended up having an image and being used by their law enforcement power. Therefore, they were included in this research as being from the law enforcement sector.

[6] As it was explained in chapter 2, basic and specialized refer to different levels of care complexity, which is the way public health and social care is organized in Brazil. Basic services participating in this research were social and health outreach work teams, basic health services and walk in centres. Specialized care services are shelters, and drug clinics with in and outpatient treatment.

6

Governing drug users

6 Governing drug users

In their daily task of transforming official drug polices into practice, street level workers spend most of their time meeting, approaching and thinking about drug users. As it was already shown in previous chapters, the degree of importance street level bureaucracy scholars attribute to 'clients' in shaping workers' discretion varies. While some give them a secondary role (Lipsky 2010), others contend that clients are actually at the centre of discretionary decisions workers take daily (Tummers and Bekkers 2014, Maynard-Moody and Musheno 2003). For Lipsky (2010), since clients of street level bureaucracies are basically non-voluntary, they are seen as lacking power to influence workers' discretion. They are not considered to be an important source of reference for workers in their discretionary decisions.

When clients are seen as having a secondary role, workers' dilemmas are understood as being mainly on how to cope with organizational rules and goals for distributing benefits and punishments to users with the less possible effort. When clients are perceived as central, instead, workers would focus on how to fulfil users' needs with the challenges imposed by limited resources and rules coming from organizations. The main elements in these approaches are the same, but the focus on what drives workers' discretion is different. As chapter four described, in relationship to organizational support and resource constraints, workers' drives are more nuanced than being solely either self-interested or citizen based. Now the research considers the implications for workers' attitudes and behavioural discretionary choices towards people who use drugs in their daily practices. What are variations between the cities and the professions studied in this research? These are the questions this chapter intends to explore.

When describing their daily activities, especially the ways in which they deal with non-compliant users, street level workers participating in

this research usually emphasised the professional goals they wanted to achieve with the people with whom they are working. Ultimately, the justification for workers' discretionary decisions towards users was defined as being directed towards a professional commitment to changing these people's behaviours. In daily interactions, street level workers would make use of the resources and support available and build strategies to 'manage' drug using people towards outcomes consistent with their professional aims. Based on professional definitions of problems related to drug use, plus perceptions of individual drug users' possibilities and limits, workers build goals and guide users towards those goals. This resembles process governance (Colebatch 2004) in which official policies are mobilised at street level to shape, validate and explain the actual processes through which people are governed. Street level workers are key-figures implementing different ways of governing people as clients, citizens, and criminals through the welfare and law enforcement systems offered by the State.

The main strategies used by workers in their daily interactions with users and the dilemmas arising from them are described in the following pages. The focus is on how workers use their discretion to decide upon various strategies, and what drives them in their choices. Interactions between workers and users are analysed both from in-depth interviews and observations, to propose more a complex interpretation of workers' behaviour. For this matter, to the contributions brought by street level bureaucracy theories, contributions of governmentality studies (Dean 2010) are added to analyse workers relationship with users. When relevant, the different contexts in Amsterdam and Porto Alegre in terms of territories, interpretive beliefs, support and constraints from organizations, and possibilities of networking are taken into account to reveal their influence on workers' choices of different modes of governing users. The next subsection provides a brief account of the concepts used in the analysis, and subsequent pages describe the main strategies and the dilemmas workers face.

Discretion and governing others

Working with people on a day to day basis forms the chronological core of the definition of a street level worker's territory. When describing the relationship workers establish with the people they assist, street level bureaucracy scholars attribute different degrees of importance to 'clients' in

shaping workers' discretion. According to Lipksy (2010), clients are not a primary reference group defining street level workers' roles. Given clients non-voluntary status, street level bureaucracies would have nothing to lose by failing to satisfy clients; rather, they might be even rewarded sometimes for reducing clientele numbers. Lipksy explains that demand is always higher than supply possibilities, and therefore

> …the fact that some clients are disaffected by the quality or level of service means only that their places are taken by others who need the service and are willing to accept the costs of seeking it (Lipsky 2010:55).

If this perception is accurate then it has implications for the quality of workers-client interactions. When people using drugs do not comply with the rules, for instance, guilt can be attributed to them, and such people may be labelled by workers as 'socially disorganized', dropouts', incorrigibles'. For Lipsky, power relations between workers-users are 'unidirectional', where relationship is primarily determined by the priorities and preferences of street level workers (which are affected by the their formal job descriptions)(Lipsky 2010:56-9). Due to the nature of their jobs, street level workers engage in discretionary attitudes to process people into clients, assigning people to categories for treatment, and treating them into these categories. Lipsky describes four basic dimensions of control workers may exercise over the people as 'clients': distributing benefits and sanctions; structuring interactions (by establishing time, frequency, circumstances of interaction); instructing people how to behave as 'clients' (for instance how to be properly deferential or what to expect from the service); and allocating psychological rewards and sanctions in interactions on the basis of personal judgements about 'worthiness' (Lipsky 2010:60). If such responses are found, then workers would be focused on finding ways to decrease their efforts and increase self-benefits, rather than being concerned about what people using drugs need to progress.

From a contrary standpoint, Maynard-Moody and Musheno (2000) put the perceived interests of people using services at the centre of workers' discretionary decisions. As already explained in chapter four, these authors describe street level workers as 'citizen-driven': if they perceive people as worth the effort, they will increase their work load and circumvent the rules in order to satisfy what they perceive as those people's needs. Such researchers claim that street level workers try to orient

themselves towards people they approach by attributing identities to them, based on social features such as race, gender, age, ethnicity, sexuality and religion. Workers assess clients' identities and also individual moral characters and also how clients react during encounters with them. Stereotyping and stigmatizing identities coming from the social environment have a role in initial encounters, which may be based on fear and prejudice (Maynard-Moody and Musheno 2003). The longer term the relationship with citizens, greater the chances that street level workers see common ground and assign more complex identities to people. Attributed identities, however, are not necessarily fixed: depending on client's behaviour or new information workers find out about them, the ascribed identity and its consequent judgement can change. An old prostitute with health problems, for instance, may be at first judged as pitiful and deserving help; but, as soon as she is found to be drunk and pregnant, her assigned identity may change to one of an irresponsible person who deserves punishment (Maynard-Moody and Musheno 2003).

When asked about their practice with users, workers participating in this research justified their actions in terms of offering solutions to perceived problems. These definitions were based on their interpret beliefs about what would be best to do with drug users, and passed by negotiations around organizational support and challenges, and varied networking patterns. These patterns of practice led the present study to use a combination of theoretical inputs from street level bureaucracy and governmentality studies to analyse workers relationships with people who are drug users. While the first theories provide tools to analyse how street level workers cope with insufficient and inappropriate resources and goal; the second theories provide tools to consider the 'less concrete' forces driving workers behaviour and defining their professional commitments, including beliefs which define perceptions of problems and solutions for drug use.

As chapter three has shown, when describing their interpretive beliefs around drug use, street level workers define what is seen as a problem to then work out solutions they can carry on as street level bureaucrats. Their activities derive from professional visions and have certain ideas embedded about drug users and what is possible and/or desirable to achieve with them. The steps followed by workers when trying to define what to do resemble the imperatives proposed by Foucault (2004) and Dean (2010) to analyse, respectively, , both internal attempts to govern

the self, and external different mentalities of government. These four aspects become four questions workers have in their minds which define: what is considered to be a problem in drug use, or 'what we seek to act upon'; how to deal with drug use, or 'how we govern'; how users are seen when they are being governed in such a way, or 'who is the subject under governance'; and what they aim at, or 'why to govern'. The aims workers have and the solutions they propose to drug use are usually central to define their professional commitment, or the ways in which they perceive their role as street level workers. While some assume a more authoritarian role towards users would be more effective to achieve the desired aims, other assume that more liberal or comprehensive attitudes would be the way to act.

In the field of governmentality studies, official policies are understood as ways of labelling thoughts about the way the world is and the way it might be: policies are used to shape, explain and validate the processes of governing (Colebatch 2004). The concept of 'governmentality' emphasizes the connection between government and thought: government is seen as a thoughtful activity in which different forms of knowledge and rationalities arise from and inform the ways in which one governs (Dean 2010). As the ones who carry on policies in the front-line, street level workers can be seen as the main agents pursuing different goals around how people should behave.

The analysis of governmentality proposes to deconstruct the ways in what people do, think about and question, the ritualized ways and routinized practices found in specific places at particular times. When using this framework to look at street level workers' discretionary choices, this can be understood as analysing the rationalities underpinning why workers decide to adopt certain behaviours and strategies towards users: what is defined as a problem, what is given as a solution to be implemented and with which aims. In this context, when deciding upon problems, aims and solutions regarding drug use and transforming official policies into practice, street level workers are deciding upon different ways of governing users.

Depending on the type of governance chosen and the relationships involved, the governance of others can produce enhancement of self-governance or relationships of domination. The first one increases the capabilities and autonomy of individuals and collectives, while the second restrains it (Dean 2010). Here, liberal and disciplinary techniques of

government are implied. While disciplinary techniques operate through individualization, separation and control, liberal techniques of governance operate through the maintenance and promotion of certain forms of individual liberty.[1] For Dean (2010:15) liberal government works through the freedom or capacities of the governed; freedom is considered necessary, and a technical mean to secure the ends of government. In the drug field, liberal techniques are those related to regulating drug use through strategies that govern freedom, in particular, strategies that rely on autonomous choices of individuals and that are careful not to govern too much (Bull 2008:142).

Some critical studies in the drug field have used the concept of governmentality to analyse drug policies and, more specifically, methadone maintenance programs. When looking at a broader picture of drug policies, such studies interpret legal and medical frames as related to more coercive disciplinary practices, while harm reduction is seen as more committed to human rights and more liberal strategies of governance(e.g. Acselrad 2000, Pauly 2008, Rigoni 2006). But other researchers, when looking at specific harm reduction practices with a medical aspect such as methadone programs, claim that these programs operate through a mix of disciplinary and liberal practices (e.g. Keane 2009, Bull 2008, Bourgois 2000).

The ways in which various mixes of governance practices can help to understand social, health and law enforcement workers' discretionary decisions in 'governing' drug users in Amsterdam and Porto Alegre are described in the following pages.

Strategies of governance

Street level workers from Porto Alegre and Amsterdam reported and were observed to use different governance strategies to approach drug users and try to change their behaviour in the desired directions. Bonding, rewarding, guiding, controlling, rules enforcing, threatening and punishing were common strategies used by workers in both cities. The same worker could be seen using different strategies in different situations and periods of time, and even with the same user. Therefore workers do not operate simply on a simple, pragmatic case by case basis: there are also overarching strategic choices that workers use to make decisions for a particular strategy over other possible ones. Even though the main strat-

egies used by workers to govern users' behaviour could be found in both cities, and in all professional sectors, the extent to which they were used in each city and by each sector varied. In their descriptions and activities, workers valued different techniques. The very different territories, organizations, interpretive beliefs and types of networking found in the different sectors and cities explain these variations. The following pages describe these variations paying attention to the main strategies used by workers in each city, organization, and professional sector, and the aims they have when choosing a specific strategy for a particular case.

Welcome! Bonding as a starting point.

Bonding is one of the strategies workers may use to achieve their aims with users. Bonding was regarded as a fundamental strategy mostly by care workers, and specially in Porto Alegre. Although some care workers from Amsterdam also mention it, they do it in lower extent when compared to their colleagues from Porto Alegre. Police workers, in general, do not mention bonding with users as a strategy used to achieve their goals. In Amsterdam, however, some community police workers mentioned bonding as a good way of achieving respect and collaboration from users in the streets.

In a practical sense, bonding is pursued through frequent and open conversations, kindness, jokes, playing games together and, especially in Brazilian cases, by body language such as hand shaking, pats on the back and taps on the shoulder. Bonding relates to the process of establishing a close and good relationship with users, through frequent contact and attention to users' life and problems. This is understood as caring about users and investing in their possibilities of doing better in life. A desirable consequence of the bonding process is achieving users' trust, which is seen as the main requisite to start any type of care. Having users' trust is the way for workers to have access to a more accurate narrative about users' life, problems, and situation of drug use. Bonding is also seen as helping to make the user feel welcomed and not afraid of accepting and staying with services.

> BR06: [...] so, [we have to] at least to establish bond. Not to oblige [the user] to do anything that is against his will […]. But, to be allowed to come back the other day to build this willingness to access something, a protected place, or just to get some information. Because when you approach a kid you don't know, the kid is afraid of giving you [information], because

> he thinks you are from the Tutelary Council[2], and that if he gives the mothers' name the social assistant is going to his house and he is going to be beaten [by the mother]. So street children are very well trained, they don't give information to you easily. You have to get their trust so they can give you, and this can take some months. (Porto Alegre, social worker)

In principle, to achieve bonding, workers try to distance themselves from disciplinary techniques, where control would be the main focus. In wider society, illegality of drug use and societal prejudice towards users constantly put users at the centre of attempts to change, control and punish their behaviour. Since street level workers are imbued with power to interfere in users' lives, mistrust becomes very present in users-workers relationship. To break this, workers think, first users need to feel safe and believe workers are there to help, rather than to judge.

Besides being a way of achieving trust, care workers from Porto Alegre emphasize that bonding is also a way of achieving citizenship gains, such as increasing users' participation in services and society and creating in them a feeling of belonging.

> BR40: ... one of the first things that caught my attention when we started to assist was how people effectively bonded with this place and with the team. I think this mostly happen because people feel good here, they feel they are treated well, you know? They feel that here is a place where workers know their name, where they are respected [...] and that creates the bond. I think the main thing we achieve is to rescue the notion of subject... of person... 'I'm not one more product of something, or, a drug addict, a beggar, a prostitute', you now? No, 'I'm a person, and I'm being looked in an integral way; I'm respected. Sometimes I can come dirty, sometimes I come starving, but everyone treats me like an equal'. You know? 'There is a place to be me here'. (Porto Alegre, health worker)

Most drug users in this research are part of this double marginalized population for being both users and having poor economic conditions. They are, and feel as outsiders in relation to mainstream society. By bonding with users, street level workers try to create proximity, or at least, to decrease the distance that is there because of poverty, migration, drug use, and low status in society. This can promote in users a feeling of belonging, of being valued, which is understood by workers who use this strategy as enhancing in users a willingness to accept care, and to take care of themselves.

When using bonding as a strategy, workers can be seen as adopting what governmentality studies would call liberal strategies of government: those which work through the agency capacities of people, relying on more autonomous choices by individual users. For the workers participating in this research, these would be usually related to solutions which offer combinations of harm reduction and human rights frames, such when workers offer activities promoting reflexivity and participation of drug users to enhance their 'willingness' for care. These were found, for instance, in open drug treatment places which promoted meetings, groups and/or individual guidance, and also in the work of outreach workers who try to use bonding as a way for users to get their life back into their own hands. The tone of the approach would be usually to listen first to the user and what exactly was bothering him/her at that moment - housing, drug use, debts, or private relationships – and then help the user to reflect upon how they could, together, act on the problem (as a combination of how the user and the worker perceive of what the problem is and what could be done about it). These encounters are understood to help users to reflect upon their life choices and their addiction, and to make their own decisions as much as possible.

Sometimes, however, bonding can assume more controlling directions, even if disciplinary techniques are not used in an open manner. This may include using individual or group conversations to 'convince' or in more extreme cases 'brain wash' users to change their behaviour in the direction desired by the worker. This was found, for instance, in some groups in open drug treatment places in Porto Alegre where the health worker in charge would use the group as a 'teaching space' to tell users about the bad effects of drugs and why they should stop using them. Similarly, (although in a stricter approach) this was the approach found in police workers working in PROERDs. Workers would go to children's classes to show images of drug users who were very sick or famous people who died from overdose, together with messages of complete abstinence as a way of prevention. In these cases, medical and moral frames were mobilised as persuasive techniques.

When bonding is used more as a 'convincing' tool rather than a reflexive one, 'hidden' disciplinary governance strategies are present, and the idea of externally regulated 'order' is more at the centre than the idea of a self-promoted 'care'. When used as a strategy for belonging and participation, bonding promotes a perception of users as citizens. If used as

a persuasive strategy, bonding leads to perceptions of users which are closer to the patient who needs to be told what to do by an external person, although still, with some autonomy for decision.

Another difference regarding bonding strategies is related to individual/group focus in each of the cities. While in Amsterdam bonding tends to be done in an individual level, in Porto Alegre is tends to happen also in a collective level, in the groups many care workers offer to users. This leads us to the next strategy.

Benefits. We give you this...

Once users are inside the system, another form of governing their behaviour is through the use of welfare. Benefits can serve both as a way of providing users with a better life-quality, and of pushing them towards the desired changes. Even if in very different conditions of quantity and quality of resources, both Amsterdam and Porto Alegre offer benefits such as shelters, food stamps, bus tickets, walk in centres, basic hygiene and nutrition, basic health care, drug treatment, guidance, and activities.

Differences in the availability of benefits in the two cities shapes the ways in which distribution is organized, the extent to which benefits are considered central for behavioural changes, and the type of benefits used to promote changes. In Amsterdam, concrete benefits are the core of an approach to change behaviour, mainly, for workers from the care sector. In this city, concrete benefits are considered central for behavioural changes:

> NL 23: [methadone and heroin prescription]… is the best way to keep in contact, to stay in contact with these clients, which are so difficult to find, hé? For health care they are a very, very difficult group of patients, because the only reason they come here is for money or the drugs. (Amsterdam, health worker)

In general terms, health workers from Amsterdam make use of methadone and heroin on medical prescription to change users' behaviour, while social workers in the city use mainly financial benefits, housing and work. In this sense, benefits are used as part of the governance strategy in Amsterdam both to promote a more supportive setting for users, and to offer drug treatment. While in the first case usually a psychosocial frame is involved in combination with others, in the second the medical frame is present. The extents to which these approaches use more liberal

or disciplinary governance strategies depends on workers' discretionary choices, users' reaction to workers' approaches, and the different types of change aimed to be achieved. Changes are usually planned in steps and in different activities such as work, addiction, housing, relationships.[3] User rooms and night shelters, for instance, promote small changes in users' behaviour, such as improving basic personal hygiene and care, providing small activities to make money, lowering aggressive behaviour and promoting social integration with peers. Methadone and heroin projects and abstinence based clinics, on the other hand, focus on addiction control, and more 'permanent' shelters focus on learning how to live in a house in a more independent way. Approaches are more individualized, using one-to-one guidance combined with rules to achieve the desired changes, as following section will explain. One-to-one approaches are understood as more effective and respectful of users' privacy in Amsterdam.

In Porto Alegre, concrete benefits are used by care workers as well, but, in workers' descriptions of their activities with users, the focus is usually on workers' guidance and conversations they offer to promote changes. When coming for a drug treatment, for instance, users are not offered methadone or heroin. Instead, they are asked to participate in groups where various types of discussions will take place: how to manage prescribed medication, talk about spirituality, leisure activities, family, or more specifically their relationship with the drug. These are understood here as 'conceptual' benefits workers have to offer, in opposition to the concrete benefits offered more extensively in Amsterdam. These discussions are understood to require a good extent of bonding. Here, the very different conditions of the cities in terms of welfare resources certainly plays a role: while in Amsterdam workers have concrete benefits to negotiate behaviour with users, in Porto Alegre this happens in a lower extent, and workers sometimes feel they have only 'themselves', their attentiveness and their knowledge to offer.

Similar to bonding strategies, using benefits to change behaviour can assume different perspectives. Groups, for instance, can create a more directive environment, such as when workers assume a 'teaching' role giving centrality to the worker as the one who knows what users should do. On the other hand, groups can be performed as a reflexive strategy, when the experiences of other users is seen as potentially constructive to promote change and a sense of sharing and belonging, and where work-

ers and users interact in a dynamic way. A collective approach, in this case, carries an ideology of increasing users' participation and potential for self-organization as a group, which are both ideals coming from the Brazilian collective health approach. Depending on the workers and his/her main interpretive beliefs, groups can be more or less directive, and users can be given more or less space to build their own interpretations and promote their own ways of life. In any case, the group strategy, different from the individual strategy, tend to favour the power distribution for users instead of workers. Because of the sharing of experiences and information among users, it tends to leave more room for users to negotiate their needs, and to promote self-care in directions that arise from their own logic and experiences, rather than simply following prescribed ways of living from workers.

But you have to follow the rules...

When benefits mediate the relationship between street level workers and users, rules and control come along with them. Regulating access and dispensation of benefits are forms in which street level workers hope to achieve sustainable changes in users' lives. Direct observations by the researcher were a great method to get in touch with the practical operational rules and the different forms of control and care they represent.

In Amsterdam, out-patient drug treatment programs are the most used way by health workers to change users' behaviours. Rules in both methadone and heroin prescription programs involve having specific times for users to get their doses; urine screening to check for drug use other than the prescribed ones; a certain number of appointments with the doctor or case manager; a certain number of times users have to go to the treatment centre to get their drugs; and the use of drugs under workers' supervision.

> NL27: […] Because you have to use the methadone. Once you get somebody involved on the methadone program the only thing you can really use to change their behaviour is that they have to come here to get their methadone. […] that's a very effective way of getting people to do things, and if they don't do it they will have to come every day (laughs). And then suddenly they will. How better your behaviour, how much free you can get. (Amsterdam, health worker)

The possibility of being 'freer', as mentioned by this worker, means users are allowed to have takeaway doses (only possible for methadone), which implies they are considered trustworthy and responsible enough to control and administer their own drug dose. The drug as a benefit, thus, serves to shape and control users' behaviour. From Lipsky's perspective, setting up a time, frequency and circumstances for encounters with users can be seen as strategies workers develop to structure the interactions between them and the clients, as a way of controlling them. A similar perspective is brought by critical drug studies which have interpreted methadone maintenance programs as ways of controlling drug users (e.g. Fraser and Valentine 2008, Bull 2008, Bourgois 2000, Keane 2009). For Bull (2008), methadone maintenance programs can be a contemporary analogue of the Foucauldian *panopticon,* since they regulate users through techniques of surveillance and practices of standardisation and individualization, acting as a normalizing discipline. A look into a heroin prescription room, actually, also resembles a *panopticon*: users are sitting in an orderly and aseptic room, receive their meticulously controlled and tagged drug doses on a metallic tray, and are being observed by health workers through windows and CCTV cameras during the drug taking process. Receiving and using the drug occurs at specified and predetermined slots of time, and to be able to enter the facility, users have to pass through metal detector doors and sometimes body search by the security guards who stand at the entrance (see pictures 47-8).

For Bull (2008), methadone programs act through a coexistence of both disciplinary and liberal techniques of governance. They operate by both imposing discipline for some users, and enhancing self-government of drug use by establishing a supportive environment where users are freer to make choices themselves. Since programs are concerned with self-discipline and control of passions, says the author, they are seen as enhancing personal attributes and capacities consistent with being good citizens. The rules implied in these processes create formalized and rigid sets of relationships between users and workers, as well as between workers and the organizations stating and enforcing these regulations (Bull 2008: 139). Drugs on prescription and a rigid set of rules are the main mediators of these health workers' relationships with users. Here are operating in combination harm reduction, public order and medical frames.

Less formalized and rigid relationships can be found among social workers and drug users from Amsterdam. In shelters, walk in centres, and user rooms interactions are less mediated by a medical frame, and more by a psychosocial one with the dispensation of social benefits together with personal day-to-day interactions and contacts to try to promote a supportive setting for users. Benefits acting as mediator for governance are financial support, housing and shelter, nutrition, health insurance, and the right to use a user room or a walk in centre.

Also in social services, a set of regulations, and a mix of disciplinary and liberal techniques of government can be observed. Financial benefits, for instance, are directly used to pay for users debts, nutrition, housing and health insurance, without a possible choice of users in this regard. After bills are paid, drug users receive a small weekly allowance (around 35 euro) to pay for other expenses, including their drugs. Benefits and expenses, thus, are strictly controlled, and may even include enforced savings account when a user is about to get a social house, for instance, and will 'need to' buy new furniture. Users going through these processes always complained they lack freedom to choose how to spend their money in other ways, for instance, buying new shoes or clothes. Disciplinary techniques, thus, constrain users' freedom, even though there is an understanding from street level workers that receiving benefits is a matter of choice: if one wants the money, s/he needs to comply with the rules attached to it.

Recent changes in benefit policies in Amsterdam, also requires that users work some days a week in order to keep receiving their financial benefit; they can get a bonus if they work, and can lose part of the benefit if not. For those users who are not receiving benefit, there is also the possibility of choosing to work in daily activities offered by low-threshold facilities, such as cleaning the facility, picking paper in the streets or cooking; these pay them around five euros an hour. Being chosen for these activities, require following certain rules: not begging, talking to people or entering shops if working in the streets; not using drugs while working; not having fights or arguments at work; being on time; and executing a certain number of hours and days. Not following the rules may mean not being allowed to perform that activity for a period of time.

Staying in shelters also brings rules users are expected to comply with: be clean, not to fight or be aggressive, have a good relationship with

roommates, be there at certain times if they wish to eat, sticking to a list of maximum five visitors who are allowed to stay up to 2 hours (including intimate visits). In user rooms, bringing their own drugs, not carrying weapons, not dealing drugs, and staying one hour outside the room before coming back (to prevent drug dealing inside), are some of the rules. Sheets containing the rules are, in general, hanging on facilities' doors, and are more or less empathically repeated by street level workers. This 'regulated freedom' in social services is pursued through control techniques such as: watchers in rooms to apply punishments in case rules are not obeyed; windows from where workers can observe users' behaviour and rules' compliance (again, similar to Foucault's *panopticon)*; and cameras to monitor users' behaviour. More invasive control strategies such as body search and metal doors are usually not part of social services, but some were obliged to hire security guards to prevent users from causing nuisance to the surrounding neighbourhood.

Not all is discipline in a mode of governance based on regulated freedom: techniques to enhance self-control and care are considered fundamental to achieve the desired controlled life for users, as Amsterdam workers aim when explaining their interpretive beliefs. In cases when users increase debts and cannot manage to live on the weekly allowance, despite the controls over it, budget counsellors can help them to manage their finances. If users are not able to keep their rooms clean or to have an acceptable level of personal hygiene when in shelters, social workers can teach them how to wash clothes, do their beds, and have more acceptable patterns of behaviour in general. In the case of daily activities, both street level workers and a user who might be designated as the activity manager, can help out users who cannot follow the rules, guiding them on how to dress, manage time, behave at work. These close-guidance activities are understood by workers as helping users to achieve a more independent and controlled life.

While most street level workers emphasise the 'enhancing self-care' as a way of achieving a controlled life part of Amsterdam's system, many drug users emphasize the disciplinary one. For them, as well as for the users' representatives participating in this research, once users 'enter into the system', there is no freedom to choose the ways in which they want to live their lives. Enjoying the benefits from welfare is perceived as bringing along high costs in terms of liberty and personal choice. Some users contacted, however, reported being pleased: the control over their

lives is considered a fair price to pay for the benefits they get. Also, some street level workers have criticisms of disciplinary techniques, and see too much regulation. These tend to be outreach workers. When compared with their office-based colleagues, outreach workers are less focused on rules and control, but emphasize bonding and enhancing self-care; once users get inside services, rules become more central in Amsterdam.

In Porto Alegre, services' rules present a different pattern, and a comparison with Amsterdam allows interesting reflections. Not to mention the full absence of prescription and substitution drugs, the rules users need to comply to access services are, in general, much stricter in Porto Alegre than in Amsterdam. No health or social service in Porto Alegre allows drug use inside its premises, and entering while intoxicated is also forbidden. In-patient clinics for drug treatment such as Therapeutic Communities or detox require the user to be completely abstinent, including alcohol and cigarettes. Out-patient clinics, in general, are usually flexible in choosing a main and most harmful drug to stop taking (generally crack), while allowing the use of others, outside the boundaries of the service. In night shelters, users need to arrive at a certain time to queue in order to get the vacancy. Even when the vacancy is secured and users have a more 'permanent' stay, shelters have a time limit to enter and to leave the premises, and daily attendance is necessary not to lose the right to use the place. Fixed times to eat, wake up, and leave the shelter during day time are also part of the rules. Men and woman are usually separated in shelters and only together in case of families with children, when there are special family rooms. Having sex is forbidden inside shelters, due to the fact that rooms are all collective, and users are not allowed to receive visitors.

Interestingly enough, neither Porto Alegre workers focus on the enforcement of rules in descriptions of daily activities, nor this was observed during fieldwork to the same extent as in Amsterdam. Paradoxically, the stricter rules in Porto Alegre lead neither to street level workers spending more time in enforcing rules, nor to an increased control over users. Since many users cannot comply with strict requirements to access and stay in care, they are actually kept outside services. The queues and strict time schedule in shelters, for instance, make difficult for users to combine work with the possibility of having a bed. Many users work in informal activities picking up paper and aluminium cans in the streets to

sell, but this job is better done during the evenings, when there is less traffic for them to use their push carts. Sleeping in daytime or arriving late evening, however, is not compatible with a shelter's schedule. Also, the fact that partners are kept separated in shelters (unless they form a 'stable' family with kids), prevents some users from being willing to access these places. For instance, pregnant crack users may prefer to sleep under a viaduct with their partners than alone in a shelter. Users sleeping outside such institutions, can be seen as 'free' from both coercive disciplinary and caring liberal governance of health and social workers, but at risk from the 'gaze' of police workers.

Strict rules for accessing support means only the most compliant users will be seen inside 'care' institutions. Creaming strategies towards the easiest or 'most deserving' users in Porto Alegre prevents workers from having to enforce the rules as a strategy to change behaviour. More resources in Amsterdam, together with low-threshold facilities, makes managing rules attached to benefits a more important task for care workers. In Porto Alegre, as it was already mentioned, concrete benefits for users are not available in the same quantities than in Amsterdam. Workers use, instead, 'conceptual' benefits such as groups and meetings to promote discussions and reflexions through their relations with users in an individual, but mostly, in collective contexts.

Both social and health care services in Porto Alegre promote individual therapy, appointments with case managers, alongside a variety of groups for psychotherapy, occupational therapy, or to debate issues such as health, drug addiction, medication control, and social care. According to their care plan and availability, users are required to participate in certain groups and have a number of appointments to check their development. Frequency of attendance and active participation in activities are used as ways of trying to change users' mind-set and behaviour. Furthermore, the collective approach is understood as important also to promote integration and participation of users, with peer-based shared knowledge and support. Some outreach workers use the group approach, either to promote leisure activities such as football followed by informal discussions, or more formal therapeutic groups based on community therapy approaches. In some social and health services in Porto Alegre, assemblies of users and workers are carried out on a weekly or sometimes monthly basis. These are meant to debate service rules, activities, and relationships between workers and users. From these meetings,

changes are supposed to be implemented, with assemblies working as a participatory mechanism, giving an element of social control over services and workers by users.[4] In Porto Alegre, thus, disciplinary strategies are more severely applied as criteria to access services. Inside them however, liberal strategies mix with disciplinary ones in different levels either to promote reflexivity or to convince users to change their lives in a certain direction. This happens, however, for a more 'disciplined' group of drug users who can cope with the strict rules to access and stay inside, at least in the case of specialized services and their high-threshold rules.

You do this or… Threatening as a strategy

When trying to enforce rules and facing non-compliant drug users, threatening is one strategy workers can use. For care workers, this strategy is used after other interventions have failed, and comes as a warning, before the decision of giving a punishment. A threat is actually, a way to avoid punishing at that given time: the strategy is warning users that if they do not do something they have been asked to do, they will lose something else. Losing freedom, rights or benefits were the most common threats found among street level workers working with non-compliant drug users, in Amsterdam and in Porto Alegre. The common aim they have is either to push users into care, or to keep them in care.

More specifically in Amsterdam, threats were related to going to prison, losing financial benefits, being suspended or expelled from a service, not being able to work in a certain activity for a while (therefore, not getting money from it), or not getting prescribed drugs such as methadone and heroin.

> NL30: [...] And they also need us very much, right... when they do not behave well we say [using a threatening voice] Beware...today you are not going to take your heroin...!' (laughs). (Amsterdam, health worker)

> NL28: … So, she was thinking that they [care service] wouldn't help her anymore. But I knew that they wanted to get her inside. Then […] I made an appointment for her and they were very happy of course (laughs). And when she came, I said: 'I had to do a lot of talking, they didn't want to, but I convinced them that at this time, you are willing to make it a success. But when you go there, you have your appointment, when you go there and you make a mess of it again, you make a fool of me. And if you do that I'll get you when I can get you. I'll follow you and I'll make your life impossi-

ble!' (laughs). I almost committed a crime there… (laughs) (Amsterdam, law enforcement worker)

Law enforcement workers in Amsterdam used disciplinary threats as a strategy to push users into care before punishment was necessary; while in Porto Alegre law enforcement threats were less related to care access, and more to prison or immediate harsh treatment.

In Porto Alegre, threatening was less frequently reported by care workers than in Amsterdam, but threats were, in general, more serious. When used, threats were related to enforced treatment, going to youth prisons or losing the right of taking care of your child, in case of crack mothers. This later was the most frequent threat.

BR15: She wanted to give up, and then I just said to her 'look, your luck is that we like you'. I didn't know what else to say... 'Your luck is that we like you, because the way that you are going, if we didn't like you, you would be screwed', I told her. Because she's a person who promises things and doesn't do it. She has this situation with her children ... and what will happen to this baby if she doesn't treat herself?[drug treatment] I said so to her, 'Look if you do not treat yourself, this baby, you will not even look at him when he is born, he will be taken from you when he is born'. (Porto Alegre, health worker)

What is interesting to note in these cases is that he use of threats is not necessarily a strategy used by workers when they judge users to be worthless extra efforts, as Maynard-Moody and Musheno state (2003). Instead, threatening is usually used to push users into a desired behaviour, being that drug abstinence, frequency in drug treatment or better behaviour inside a shelter. When used as a way of avoiding or postponing punishment, threatens are actually considered to be done 'in favour' of users' longer term interests.

The fact that Amsterdam workers reported using threatening much more than workers in Porto Alegre has some possible reasons. One is that in Amsterdam, workers had this strategy facilitated by having more resources they could withdraw. It was not uncommon for workers in Porto Alegre to consider that many users 'have nothing to lose'. By that they meant users have already lost family contact, job, money, house, friends, and have 'nothing else' in life. The few benefits provided by welfare services were not seen as enough to push users to change.

Now is enough! Time for punishment

Punishment comes, in general, when other strategies were not successful to achieve change, and it brings forward a more intense use of disciplinary techniques of governance. Here also workers' behaviour present variations from what Maynard-Moody and Musheno (2003) claim to be a dichotomous choice between liberal and disciplinary governance strategies. When facing frustration for not making a real difference in people's lives through liberal strategies, street level workers do not necessarily respond by deeming these people unworthy and then focusing solely on the application of disciplinary rules, punishment or denying help. This would represent a judgement of hopelessness by workers towards users. Workers participating in the present study, indeed, may deem users as difficult or hopeless for some time, but punishing is definitely not a 'giving up' strategy. Rather, it is a correctional strategy used to keep investing in users with liberal intent: a disciplinary investment in trying to change behaviour by correcting or extinguishing non-desired attitudes. Punishment (and threatening punishment), thus, are only part of strategies workers use to keep educating users.

The frequency with which workers use punishment can vary a lot. Similar to the use of rules and threatening, punishment is reported more frequently in Amsterdam than in Porto Alegre, excepting from police workers in the latter city. In Amsterdam, punishment use varied across categories of workers. Social workers mentioned to use it the least, while office-based health workers and law enforcers used it more frequently. According to social workers, they always try to help users first, but sometimes, they need to set a limit. Only office-based social workers working in shelters and those managing financial benefits mentioned punishment strategies.

> NL37: I always try not to do it [give a sanction], but, … I call clients to come here, to talk to them first, that's what I do 2 times. […]Ok, if it happens again then I have to give a sanction, and then I will do it, yeah. Because I cannot always stay on his [user] side; I'm doing it for him, but if I don't give him a sanction, he is going to take that like 'she doesn't care, because she doesn't worry about it, I can do whatever I want'. (Amsterdam, social worker)

User rooms and walk in facilities have punishments such as suspensions and expulsions when users don't follow the rules. However, more

than punishment, flexibility of rules occupy most of these workers time, thoughts and speech. This will be analysed in a further section in this chapter.

Office-based health care workers in Amsterdam make use of different strategies to punish. Those working in clinics with drugs prescription use methadone or heroin in the punishment system. If users misbehave, miss an appointment with the doctor, or skip getting their drugs for one day, or if their urine screen test is positive, for instance, they get punished. This is done either by decreasing their methadone or heroin dose, by quitting it, or by not allowing users to take methadone home, or requiring them to go to the treatment centre more often.

> NL27 - Ahn… it could be something as simple as ahn… that they need to be going to a specialist in the hospital and they cancel the appointment and are not showing up, not showing up, then you might say to them 'OK, now, look, this isn't a responsible behaviour and irresponsible people can't also have methadone in their… own care, and until you show me you can go to this appointment and blablablablabla, you will have to come more frequently'. (Amsterdam, health worker)

Law enforcers from Amsterdam mentioned using punishments to push users into care. As it was already mentioned, for police workers, when users are getting helped, they do not need to commit crimes to get their drugs because they have either prescription drugs or social benefit to buy illicit drugs, and they also do not need to use drugs or sleep in the streets, as they can be in a user room and in a shelter. Therefore, by getting users into care, police workers are fulfilling their role of decreasing nuisance and crime, and keeping public order. Giving users 'tickets' is a widely used strategy. Most commonly mentioned tickets given in the streets were related to open drug use, nuisance, sleeping in the streets, 'useless hanging around', urinating in canals, not having a valid ID. A ticket corresponds to €50 fine or 2 days in prison; as users in general do not have money to pay for the fee or decide not to spend money on the fine, prison is usually the punishment they take. Police workers accumulate tickets until the time in prison will be significant, so they can have a bigger influence on users.

> NL06: When it is getting winter, when it is getting cold, they are coming to the police workers station: 'I want to sit my penalty, sir'. That is the situation. Now we say, 'No, you got your ticket and you got your fine but we

> will collect it'; and we will collect it until 6 month, because in one or two days you got no influence at them - do you understand? -, but when you got people for half year, you get them to where you want. When you go to prison for six months, it can be two or three month, when you accept the help. That is the biggest solution for everything. To get people in prison so they have to accept the help[5]. (Amsterdam, law enforcer)

Workers in Amsterdam, law enforcers included, agree that prison is not the best punishment to change a users' behaviour. Therefore, alternatives are usually offered, such as drug treatment or community work. In this regard, the already mentioned ISD policy is seen as a good option. One year drug treatment and rehabilitation are offered as a choice instead of two years imprisonment. Another form of punishment police workers have is the restraining order, which has a direct link with fighting public nuisance. When users commit fault in a restricted area and get caught by the police workers, they get restraining orders. The first fault, the user is sent out of the area for 24 hours; this can be repeated three times. On the fourth time, users get a restraining order of two weeks; in the fifth a month, and in the sixth three months. After these three months they are allowed back in this area, but if they commit nuisance again, they get again three months exclusion.

In Porto Alegre, punishments from law enforcement workers were, for instance, prison for drug related crimes and displacement for homeless. In care services, punishment could mean having to face mandatory drug treatment or losing rights to children, especially in the case of crack using mothers. Suspension or expulsion from a service, where users lose their vacancy in a shelter or drug treatment centre were also possible when users were repeatedly disregarding the rules. Relating to users with 'cold', uncaring attitude was also a way of punishment, which could be combined with violence in the case of police. Probably because of creaming strategies applied to select users to participate from services, care workers from Porto Alegre reported a lower use of punishment strategies when compared to their colleagues from Amsterdam.

I give up

The issue of changing users' lives is directly related to a reflexive question: to what extent can work really produce changes in users' lives and surrounding settings? Sometimes, after repeatedly trying to achieve changes without perceived success, street level workers start to believe

they do not make a great difference in these people's lives. This, then, is a great reason for frustration and emotional suffering.

Frustration often leads to the idea that working with drug users has a 'shelf life': is not good to spend your whole working life doing this type of job. Indeed, turnover is perceived as high in drug-related services in comparison to others. When not able or not willing to quit a job in the drug field to cope with frustration, workers perceive the risk of becoming insensitive to people's suffering. Workers can assume a cynical and detached attitude, where 'it does not matter anymore' the user in front of them and his/her feelings and problems. Otherwise, workers may get too irritated and not able to professionally assist some users, may be emotionally 'burnt out', and/or may ask for a temporary leave. Alternatively, when workers felt exhausted more specifically with one or two users, they might just ask another colleague to assist those 'cases'.

The relationships workers establish with drug users over time present some contradictions to Maynard-Moody and Mushenos' (2003) statements. According to them, longer terms relationships with citizens would produce greater chances that street level workers see common ground and assign more complex identities to people, leading to positive outcomes. In the drug field, however, stereotyping and stigmatizing identities may become stronger with time, depending on users behaviour and the extent to which workers can achieve their goals. Many times initial contacts between workers and users are good, and workers believe in possibilities of change and improvements in users' life quality and behaviour. At a certain point, however, workers may get frustrated for not achieving changes, and users are placed into categories of difficult, unbearable or, in worst case scenarios, hopeless, at least for some time. Expectations towards users are lowered and, as Lipsky (2010) stated, workers can engage in self-interested behaviours of attributing guilt to users for the failure feelings the workers have. This is understood here as a self-protective strategy workers use in order to cope with work frustrations. A giving up strategy, however, not always brings benefits to workers, as Lipsky would state, and certainly do not bring benefits for the organizations they work into. 'Giving up' workers might be labelled by colleagues and/or bosses (and users) as 'lazy', 'non-collaborative' or 'sick', and develop a pattern of psychological damage through non-adaptation to more caring expectations in their work places.

Overall, giving up was a deviant 'strategy', meaning it was not used by the majority, but by few workers from Porto Alegre and Amsterdam; although more often by workers in the first city. Possible reasons for this slight difference are the higher difficulties perceived by workers from Porto Alegre in terms of strict rules and threshold in care services, lack of resources and support from organizations, goals perceived as conflicting, holed networks and an environment where violence and socio-economic conditions of users are far more serious than in Amsterdam. Another reason, connected to the expectations workers have towards users (or the aims workers want to achieve with their activities), might be the main type of approach chosen in the cities. A higher focus on harm reduction strategies and low-threshold services in Amsterdam means workers do not expect users to stop using drugs, and rather offer safer options for users to continue use. In this way, they can perceive smaller changes – such as a user being able to shower and shave twice a week - as important achievements. Lowering expectations, in this sense, can be beneficial for workers to cope with frustration. In Porto Alegre, on the other hand, workers more often expect users to be completely abstinent from drugs, or expect that users who are dependent of crack cocaine can stay off the drugs in order to occupy a shelter or benefit from another service. These workers often complain that users relapse into drug use very often, and/or arte not able to comply with rules. They tend to feel their efforts have been in vain, which leads to a high level of frustration in their jobs.

Governance dilemmas

When trying to change users' daily lives not all goes smoothly for workers. When using this array of bonding, benefits, rules controls, threats, punishments or desistance, workers face many doubts. All dilemmas are somehow related to the question on where to draw limits. While defining limits can be a self-protective strategy from workers, it can also be directed to fulfil users' needs. The main dilemmas mentioned and observed in workers' relationships with users are the focus of the rest of this chapter.

Bonding and boundaries

Porto Alegre care workers focus more on bonding as a way to get in touch with users, and this strategy is usually considered positive. Am-

sterdam workers face greater dilemmas to bond. A daily challenge relates to setting boundaries between professional and personal life. The dilemma is how far from the office to take bonding and worries about users. This can relate to practical issues such as giving users a car ride or not, or doubts about sharing personal information with users such marital status and private address. Also emotional issues are perceived to arise when mixing professional and personal, more specifically the burden of taking home worries about users. The more bonding, the more workers suffer emotionally from users' problems. At the same time, the greater the bond with users, the stronger the feeling of reward workers get from helping and achieving results. The more distant, the less dilemmas workers have in terms of applying threats and punishments.

Amsterdam workers are more concerned with keeping professional distance from users. One strategy used to set bonding boundaries is to emphasize separations between workers and users. This is done by simple verbalizations referring to divisions between 'us' (workers) and 'them' (users), and through concrete separations through keys, doors, and lockers to which just workers have access. To hold the keys to access certain rooms, kitchen, or wardrobe gives workers more power to control the possibilities of circulation of users in apparently shared spaces. Also, separated toilets for users and workers make clear the distinction between 'us' and 'them'. In some cases, bonding boundaries could be broken by playing a game together, watching soccer, or learning how to play guitar with users. These are the moments when the relationship becomes closer, and where being strict with rules might start being difficult.

> NL01: [...] Because the most difficult thing in this work is to tell people no! Because you have to be professional on a personal base! And that's always the most difficult thing when you talk about how to keep your professional approach with people you see every day, with people you are involved with, you are personally concerned about, you know what happened to them. I mean, that's always the bridge you have to make, and it is nothing more shitty to see someone having a nervous breakdown because someone on his family died…, and then the first thing they wanna do is to fuck themselves up with an enormous amount of dope, and then they are not allowed to go into the user room, but they say, 'Yeah, my mother died, and let me go to the user room'. And then you have to think: 'yeah, you are not allowed to, but, can I leave you can I not', I mean, 'is it good for you

now or not?' But of course that's terrible that your family died, you know? (Amsterdam, social worker)

At the same time that bonding might be considered important for caring, a closer contact with users is understood by workers as creating more difficulties to enforce the rules. Putting boundaries on bonding, thus, can be considered a self-protective strategy, which ultimately may also help workers to comply with organizational rules.

Rules for rule breaking

Attempts of governance by street level workers usually produce attempts at resistance by users. At the same time that workers try to shape users' behaviour by using different strategies, users resist governance attempts by not complying with workers' demands. Every service for drug users has rules. These rules, however, are based on general expected behaviour, and cannot predict how to deal with specific or unplanned events. When the surprise event happens, workers use their discretion to create a way of handling the situation. If using threatens and punishment are possible ways of dealing with non-compliant users, another way of dealing with rules that users do not follow is by making rules flexible.

When compared to their colleagues from Porto Alegre, Amsterdam workers spend more time in deliberating about rules and the grounds to break them. The main events triggering these debates among care workers are drug use, drug dealing and aggression inside facilities. Not complying with set times to eat and wake up in shelters, or rules related to work activities were also mentioned and observed. Assisting users who would not have a right to be treated (in that place) under the law is also part of daily dilemmas for care workers. Law enforcers debate less about rule breaking, as in principle, they claim to follow the law; though some admitted to be flexible in the quantity of substance allowed for personal use, and when to give tickets or when to arrest users.

In the processes by which workers make a decision on breaking rules it is possible to highlight some basic questions underlying their reasoning. Curiously, the process includes creating certain rules to guide rule breaking. At first, there is an evaluation of how unpredicted events conflict with rules; in the next step, an evaluation of which rules can be made flexible and which not. In case flexibility is considered beneficial to deal with the situation, workers will dedicate some time to think and de-

liberate with colleagues on how much deviance could be permitted. In this process, problems possibly arising from rule breaking are also taken into account. Finally, reflecting upon the question of how to make rules flexible is not always what comes first; sometimes, an immediate response will be elaborated after the event is over and action taken. Justifications for bending the rules are very often expressed in terms of better meeting workers' professional goals with users, or, achieving what they consider to be best for the users they assist, which may or not be consistent with what users would think themselves.

Various scholars contend that when street level workers bend the rules, this is usually in the interest of their clients (Evans 2013, Maynard-Moody and Musheno 2003). That was, indeed, the case of various workers in this research. In the case of care workers, for instance, one of the main reasons given for breaking the rules is related to including and keeping users in caring services; or at least, not excluding them. For workers who decide to break the rules, it is more important to have users inside the system by being tolerant and changing behaviour step by step, than being strict in keeping to the rules and possibly pushing users away. Tolerance of drug use and drug dealing inside facilities are an example of that in Amsterdam, and in Porto Alegre, tolerating entering facilities under influence of drugs. Tolerance of aggressive attitudes and assisting users without documents or whose region is different from the one designated to receive a service are examples of bending the rules to favour users in both cities. Bending rules, in these cases, will probably not make workers' life easier, but since the effect of the rule is not seen as beneficial for the user, workers bend it.

> NL37: Some case managers are a lot tighter than others, and I always try... Because I know they don't get a lot of money every month, and they have a lot of debts, most of them have a lot of debts, they get weekly money, so they get money from their budget consultant every week and it is not much, it can be 50 euro every week. Yeah, I cannot live with 50 euro every week! So if I give them a sanction of hundred euro, and they only get 600 hundred every month that means that the 50 euro they get a week, or sometimes is 20 euro a week, will be 10 euro! Yeah, then they can go do stupid things, maybe shoplift or whatever, or maybe go to the subway without a card and then they get a ticket again... that makes the problem only bigger! So I always try to make sure I don't have to do it, I talk to

> them, but if I find out, 'nee, he is playing with me….' then… (Amsterdam, social worker)

In other cases, by bending the rules workers can find a balance between users' needs and their professional needs in terms of achieving their goals, but also keeping network partners or a good relationship with users to make their work easier and more pleasant. In these cases, a police worker can allow users to have a corridor to walk inside an area from where they were expelled, when their treatment centre is located there, both as a way of keeping the user under treatment – which decreases public nuisance and increases users' life quality, from their perspective- and as a way of keeping a 'good neighbour' policy with their health care partners. It can be also that the user just gave the police worker valuable information, so the worker ignores a minor misdemeanour such as smoking cannabis on the streets.

Other times, yet, workers might bend a rule because they perceive the effort required for enforcement as excessive.

> At a certain point of the conversation with Jan [social worker] inside the facility, Carl [user] enters the bathroom in front of us. He has a plastic bag with a shape that looks like a syringe, with something else. He takes a long time, like 10 minutes in the bathroom, and goes out asking for cotton and soap. Then some more minutes and he goes out, visibly high. […] Jan keeps talking to me as if nothing has happened. […]After a while I ask him if he always suspend people when he sees that they are using drugs in the toilet; first he says yes. Then I confront him with the situation saying that Carl seems to be injecting still, and he says 'I shouldn't say that but sometimes you have to do like this', putting his fingers open in front of his eyes 'otherwise is not good for you, you are the whole day on this, is not good for you'. (Amsterdam, fieldwork notes)

Cases of more delicate rule bending are found in Amsterdam. Few workers mentioned giving substances to users (alcohol or crack) when they are too agitated, so workers could perform their tasks. With users becoming calmer workers could, for instance, take them into appointments for social benefits or making a new ID without the user being aggressive towards other workers, which would ruin their efforts.

An important factor in the decision to allow a rule to be broken is to consider the problems it might bring because of how others will interpret this act. Governing others is a two-way relationship: both the per-

son governing and the one under governance are subject to rules and forms of authority (Dean 2010). It is possible, for instance, that neighbours around the facility get bothered by nuisance caused by a broken rule, or that a co-worker disagrees with tolerating that disobedience in particular. Workers actions are also bounded by the rules and guidelines from their organizations, and have to take them into account while choosing strategies on the ground. If workers do not reach an agreement on what to tolerate or not, they may end up havening different reactions to the same fact and/or user, which triggers users' reactions and feelings of unfairness. It can also be that users benefitting from tolerant behaviour will always want the rule to be breakable for them, or that other users will ask for the same tolerance for themselves. Workers referred to the feeling of being constantly observed and judged by users in their acts and choices regarding rules they apply. In general, users point to concessions previously made to others, or rules that were applied in different ways by the same or other workers. At this point, is possible to perceive the reversibility of power relationships by users' resistance: power is not only an unidirectional force where street level bureaucrats determine user' experiences as Lipksy (2010) claims. Users' resistance can challenge governance control by workers, and can push workers to take certain discretionary choices instead of others. When making decisions about bending the rules, workers have to take into account all these interests.

Defining violence and its limits

Limits to rule breaking are physical violence or a serious verbal aggression where workers are afraid for themselves or others inside the place, or get seriously offended. Given the particular characteristics of drug policy and the drug use field, fear of violence and danger are a constant part of street level workers' job; not only for police, but also for social and health workers. Use of drugs such as crack and heroin are strongly connected to illegal activities which make these drugs have a social image of violence, aggressiveness, and danger.

Interestingly, what is considered to be violent, or aggressive in Amsterdam, is very different from Porto Alegre. The ways in which workers define what represents a risk and what type of behaviour should be governed present distinct patterns. In Amsterdam, workers mainly worry about the possibility that a violent act happens, more than face actual attitudes of violence from users. Some care workers mention past events

where users threatened workers with a knife, threw a stone at a glass door, or were physically violent to other users. These events, however, did not happen so often, and were usually mentioned as something that happened with colleagues, not themselves. Workers worry, however, this could happen again, and take these events very seriously. What they face daily, nevertheless, are verbal aggressions by users, mainly inside, but also outside services.

> NL27: You go to periods when you are paranoid and you go out on the streets and you don't feel safe to go there alone because somebody is after you. […] there is one man that keeps on threatening me. He blames me for his treatment; he is an illegal foreigner and he is still living here. I didn't stop his treatment I just happened to be, he was in my caseload when his treatment was stopped. So he blames me for it, so every now and then he pops around, and pops up again and starts threatening to have me killed and this and that and… you know, I can joke about it too, but when does happen, you get a bit paranoid. I doubt he will have me killed, but you never know when he is going to jump behind me somewhere on the streets; I mean, I've seen him alone on the streets and he starts screaming and yelling at me no matter where I am or who is around; that's embarrassing. But you never know if he is going to pull out a knife or whatever. Now, well, I haven't seen him in quite a while (knocks three times on the wood and laughs). (Amsterdam, health worker)

Amsterdam workers handle users' verbal aggression by trying to de-escalate users' aggressive behaviour. This contradicts what Maynard-Moody and Musheno describe: for them: when confronted, street level workers would tend to escalate the conflict (2003: 148). In a field where aggression and violence are understood as being very present, de-escalation methods are perceived as necessary by workers, as well as by their organizations. In Amsterdam, de-escalation methods were said to be widely taught in training given to care workers: workers are supposed to always try to calm down an aggressive user by talking and not taking anything personally. In general, this method is applied to verbal aggressions. Decisions on punishments or bending the rules are taken by a joint deliberation among workers involved in the case, which considers the feelings of fear and discomfort workers experience faced with the users' behaviour. In case of physical violence inside the service, police workers are called. To help preventing violence, some health facilities have also metal detectors or automatic shutters in windows between

themselves and users; some also do searches on users to remove potential weapons. Some facilities have guards at the entrance. In abstinence based units, isolation cells, rooms 'to stay quiet', and safety teams specialized in handling aggression are part of the prevention scheme. All these can be understood as 'separation' strategies which are part of the service structure, and are meant to protect workers from potentially aggressive users. These built-in separations make it easier for workers to enact what Lipksy (2010) would call 'structuring interactions': establishing limits and rationalizing the relationship with the people they assist as a way to create boundaries, and teach the client on how to be a 'good' client. The presence of these separations in care services in Amsterdam is an example of the materialization of a public order frame in combination with a harm reduction and a medical one.

When compared to Amsterdam, the level of violence to which users and workers are exposed to in Porto Alegre is much higher. Curiously, the type of violence that mostly worries workers happens outside services and against users, in the streets or in neighbourhoods where users live or frequent. Violence outside services and performed against users, mostly by dealers or gangs related to drug traffic, are a main worry for workers in Porto Alegre. Very frequently, users start working for dealers in order to pay for their drugs or previous debts. A common path, according to workers, is that they get involved with more debts, property crimes, violence, and end up having lives threatened, so they cannot go back to their neighbourhoods. It is very common for workers to mention users coming with wounds from shooting, knife cuts or other violent injuries, or having lost users killed by drug traffickers. These situations are usually understood as demanding action, a state of things which cannot continue and which asks for governance. Sometimes, as it was already described, workers might develop a strategy of changing the service's function, using detox clinics to place users at risk on the streets and try to provide them with a safe space.

Violence crosses the paths of street level workers from Porto Alegre also in other ways. Drug dealers have a direct influence on neighbourhood relationships, and for care outreach workers this mean for certain periods of time they will not be allowed to work, or, will be advised not to enter the neighbourhood. This is done to protect workers when tensions between gangs, competing dealers, or dealers and police workers are too high, and risk of shootings and killing is increased. It also means

that, to have access to a certain neighbourhood, care workers have to ask permission from dealers, directly or indirectly, and end up committing to an implicit pact: even when they know who the dealers are, they pretend not to. One does not disturb the other's work: workers accept dealers power inside neighbourhoods, do not denounce them and do not disturb their business, and in exchange get permission and protection to work with more vulnerable users. Care workers' professional commitments, in this sense, are around helping users, rather than fighting drug trafficking as would be the case for police. If any dilemma arises in this regard, is more related to harms drug dealers might cause to users than about fighting dealers 'per se'.

Police worker' situation in Porto Alegre regarding violence and its limits is somewhat different from that of care workers: they both suffer and (might be asked to) perform violence. Brazilian police workers are known for being violent, especially in poor neighbourhoods. Non-compliant or confronting behaviour from users is seen as a sign of need for governance. Disciplinary techniques are the most used. Some police workers mentioned using verbal aggression, kicks or more serious beatings, and even shootings 'to scare' and as approach techniques with uncooperative or violent users. Some of these techniques are said to be taught during police workers training. Police workers are also very often targets of violence from neighbourhoods and users. Attacks on police cars, aggressive behaviour from citizens and shootings during gang fights are common experiences for police workers working in slums. Besides the violence they face daily in their work, even outside working hours they can suffer revenge from people they have arrested. To protect themselves, most police workers have private guns for outside working hours, and never walk unarmed in the streets. The use of aggressive techniques is understood, by many police workers, to be a necessary form of self-protection: users and other deviants will just respect them in the streets if they show they can be tough and violent. Besides, as explored in chapter four, being violent can be a way of being accepted by chiefs and colleagues who are embedded in a military culture.

In the case of care workers in Porto Alegre, violence inside care services is a minor source of worry when compared to Amsterdam, although violence is actually much more serious and visible in the first city. In the case of Porto Alegre, violence is not about a possibility, but something that actually happens and very often: physical violence towards

workers like punches, knife cuts, broken chairs, stones, or violence towards services' premises like broken windows are mentioned by workers and were observed during fieldwork. In the streets, outreach workers mention having been threatened or hit by rocks (in case of those working with homeless youth), and even face shootings between police workers and dealers in confrontations.

> BR09: ...the kid was with a new sneaker, and the other kids were trying to steal his sneaker to sell it [...] so they came to me saying 'blábláblá, and let me open this fucking door that I wanna leave'; and the biggest of them came to punch me. Then I had to hold him, to immobilize, and he was a big kid, he was 18, but I could manage holding him in the floor, to immobilize, and then the others came and threw chairs on my back… and the service guard was just looking, cause he was afraid of the kids… and I looked at him like 'hey, aren't you going to help me to hold the guy?' (Porto Alegre, social worker)

In cases of more serious violence like this, workers mentioned becoming scared of users after the event, and may ask to making the working place more secure or end up taking sick leave due to psychological effects. In some cases, this may lead workers to assume a 'given up' position as a tactic of emotional self-protection. In fact, some workers actually denied fearing violence or being affected by it, what can be a self-protection strategy towards violence and frustration at work: what workers call 'becoming cold'.

Maynard-Moody and Musheno (2003) address the issue of violence when talking about the work of street police workers. In this case, they affirm that a significant part of police workers' discretion involves assessing whether the person being confronted poses a threat to the worker's safety. Feelings of fear and danger would tend to lead workers to dehumanize that person, classifying them into stigmatized identity categories as criminal. What the present study found is that, even though this might happen, and not only with police workers but also with care workers, there are other possible responses. At least for the workers approaching drug users in this research, a clear self-protection strategy was withdrawing from physical and emotional contact with users as a way to avoid aggression, violence and frustration in their work.

Similar to Amsterdam, verbal aggression also happens in Porto Alegre, but for workers in the later city this is regarded as more usual or less

threatening than their Dutch counterparts. Both verbal aggression and physical violence are dealt with using de-escalation methods – in Porto Alegre's case, not based on training, but on workers' experiences at work. When de-escalation does not work for physical aggression, care workers first ask help from the team (to split a users' fight or to defend oneself from physical violence), and only call police workers in more extreme cases. Calling the police workers to intervene is left as a last option, since it is understood as a way to provoke users' violence towards workers rather than preventing it. Interesting, that even if in Porto Alegre actual violence is much higher than in Amsterdam, workers put much less emphasis on their descriptions of their activities and experiences when compared to Amsterdam.

How much responsibility to expect from a user?

When working to change users' behaviour, some workers can also face a dilemma related to how much responsibility to give to users for self-care. How much can be expected or asked from a person who is dependent on drugs? How to deal with the tension between teaching a user how to live a more controlled and independent life without reinforcing dependent behaviour?

In Amsterdam workers have the idea, in general, that users should be responsible for their acts. Rationalities used by care workers and law enforcers, however, suggest some differences. Law enforcers assume users have full responsibility for their actions, and therefore, have to assume faults they commit. Care workers dedicate themselves to help users to achieve or to recover responsibility. They perceive themselves as having a role in guiding users towards a responsible life by teaching them how to behave properly: living in a house, paying the bills, working, taking care of their health, and controlling drug use. Users, however, are not expected to be totally responsible immediately: there are workers to guide them on how to do personal hygiene, cleaning, paying the bills, making appointments and controlling use. Also rules were made flexible when it was realized users could not comply with them: first drug prescription programs and then user rooms were made available for users who cannot stop using drugs, and later, drug use started being allowed inside shelters. In this process, both techniques to enhance self-care and to discipline users operate. In a first glance, thus, the main pattern for Amsterdam care workers seems to be one of enhancing users' self-

governance. Yet, this is done in a way where workers have a lot of power to determine the directions of choices users' should have.

In Amsterdam, most workers usually think is necessary for users to have someone to 'take them by the hand'. Treatment plans are based on life changes and users are seen in need of close guidance. The limit between guidance and control, or the frontier between reinforcing users' responsibility and reinforcing dependence, however, is highly subjective. From users' representative's points of view, users do not have a voice on their own life plan: the plan is the same for everyone.

> NL21: […] I think what, also, would help is if clients could, together with the social worker, make a plan. I think it would be nice if people could be more independent. And really have a say on their own plan.
> Researcher: And they don't?
> NL21: Not so much, no. Everything is being decided for them. Like 'this is best for you', and they take it. And 'Oh, you want something else? Oh, sorry, we have a waiting list; it's not available for you.' (Amsterdam, users' representative).

The risk with very tight plans and close guidance is that users end up without freedom of choice, and instead of enhancing self-care, plans might produce a dependent behaviour.

In Porto Alegre, one-to-one guidance from workers is done to a much lesser extent than in Amsterdam. Lack of human resources have a role on this difference: there are much less workers available to allow taking users by the hand. As it was already explained, influence happens mostly through bonding and 'conceptual benefits' working with groups and reflexivity. The types of techniques workers use and the postures they adopt define different directions for discretionary choice in Porto Alegre. When workers try to convince users to change their behaviour, they assume a more disciplinary strategy in which users are perceived as people in need of control, although keeping some autonomy for their decisions as citizens. Here, there is a similarity to the 'controlled freedom' operated by workers in Amsterdam, even though in the latter city, workers provide users with more concrete benefits. Other times, however, workers from Porto Alegre question themselves about how much they should intervene in users' lives. These were some care workers who would have dilemmas and question themselves about users' freedom, privacy and autonomy.

> Researcher: [...] when do you think that an intervention from you, as a worker, is justifiable?
> BR31: I think there are two indicators, one is easier and the other more complicated. The easier is when the person asks for help. Ah... in some way he realizes that has crossed the line of a good measure, and is in a trip, in a way of living… and wants to get better […] And the second indicator is when I, in a more autonomous way, look at that life, and that way of existing, that subject and say: 'wow, this guy needs help'. There is something there of a... I authorize myself to intervene without the other asking me to do that, in a way I am getting myself into his life, right? Full of good intentions, full of health promises […] that's something I question myself a lot, [if] I authorize myself ... to do an intervention, to get myself into the others' life, even if I'm hired to do that. In a certain way, I'm fulfilling a function that society expects from me... (Porto Alegre, health worker)

Porto Alegre workers with this type of dilemma were the ones defending users' autonomy, and criticizing workers that are, in their perception, too controlling. The difference here is between work with users so they can build up responsibility and make safer choices for their lives, or take decisions for them when they are perceived as endangered and having no conditions of being responsible for self-care. The more workers assumed users could take more responsibility, the more dilemmas they would have in choosing disciplinary techniques.

A very common dilemma among care workers in Porto Alegre, for instance, is when to insist on someone having treatment for tuberculosis or drug use because of risk to others; mothers using crack cocaine are a special challenge for this last decision. Deciding whether to push a pregnant crack user into treatment or taking the children from a crack user mother is a great concern for workers. While on one side, workers are willing to acknowledge the woman's right to autonomy and possibility of self-care, on the other they perceive their role as workers to protect the children. The decision involves judging to what extent the mother is able to take care of the children. What is considered care, however can be highly subjective. For some workers, in any case, pregnant users or users who are mothers should be in mandatory treatment or have their children taken from them.

> BR15: Now we have a case that we put the children into custody, because we tried everything, until she said she wouldn't go anymore [to care]. We went there to get her and she was saying she wouldn't go anymore. And

> we were going again, making another appointment, and she was not there, she ran away. Then we came to know that her oldest son, 8 years old, was making oral sex with an adult…How are you going to leave this child in this risk situation? No, you have to oblige. And it seems the only thing she still manifests is the desire to be with her children. And she says that if her children are taken from her, she will die. [...] But we have to try to save the children! (Porto Alegre, health worker)

In these cases workers feel squeezed between the principle of a mother's right to care for her child and their professional commitment to protect children at risk from unsupportive mothers. Even if workers would, most of the time, choose to protect the child, the dilemma would be there and decisions might be postponed to give the user a chance, until the situation of the mother is considered to be totally out of control. In other cases, workers realize that the child care users can offer at a certain moment might be enough, despite being far away from the type of care they would like the users to have:

> BR21: Actually in no moment we called the Tutelary Council. […] and when they took the decision of running away to the streets, they left the baby with someone they trust, with all the orientations on how to take care of the child, give medication, etc. Then we started to see that there was some care there; not the care we idealize, but a care inside their possibilities. (Porto Alegre, health worker)

Respecting users' choices and possibilities can be a hard decision to be taken when there is a risk of harms being done to other people. It is a struggle between respecting users' agency and the professional commitments of helping people. At the same time, respecting users' limits is seen as a key factor to help them build self-care. A good level of self-care, ultimately, should assure also care for others, but definitions on what is an acceptable level of care of the self and others have to be negotiated.

Discretionary patterns for governing users

Based on the analysis and interpretation of interviews and observations with workers participating in this research, this chapter mapped some patterns of behaviour of workers when facing drug users daily. According to workers descriptions of their activities and relationships with users, as well as researcher's observations from these, the definitions work-

ers hold about what is best and possible to do are at the core of the discretionary decisions they take daily when facing drug users.

In general lines, when looking at choices workers make in Amsterdam and Porto Alegre on how to govern users, it is possible to see a main discretionary behaviour line. First, workers expect users to change in the desired direction by being enrolled in a care program and being given certain benefits. In this ideal situation, users will change by following the rules and limits set up in programs, and run by workers without any big challenge. Organizations, workers and users' needs would be met in a balanced way in this situation. Most of the time, however, workers find it hard to achieve this balance, and other pathways become necessary. Workers may try make some rules flexible for users, hoping the situation will adjust. If this strategy does not work, or the flexibility required is perceived as too high, threats and punishment for users may follow. The more driven by users' needs, the more investment on avoiding punishment and respecting users' time and wishes, while looking for changes. The more driven by the rules, the more investment workers will make for users to follow the plans made by organizations, and more punishments will be given. At the extreme, workers may get completely tired of repeatedly trying to achieve some changes in users' lives without success, and may withdraw from their responsibilities with users. This is not necessarily a way of getting advantages from the system, but a way of searching for self-protection against suffering and frustration.

When looking closely, however, differences are found across cities and sectors given the variations in workers' territories in terms of resources, socio-economic condition of the population they assist, workers' job prescription, and the interpretive beliefs they hold. Not only due to their professions, but also to the specific conditions they find in the cities, workers' discretionary acts with respect to users assumed different features in the two cities. These variations are summarized in Tables 14 and 15. The Tables summarize the governance strategies and their main differential features when comparing both cities, the professional sectors involved in their use, examples of activities related to each strategy in the cities studied, and the techniques resulting from the strategies. The explanatory text around the Tables contribute to a discussion about the main dilemmas workers face regarding their relation with users and how these happen in different ways in Amsterdam and Porto Alegre. The main frames around the use of each strategy are also summarised.

In general terms, Porto Alegre care workers tended to use more bonding than workers from Amsterdam. Bonding is understood by workers as strengthening trust with users, and helping to get access to a more accurate narrative of users situation. In the case of Porto Alegre, bonding was also understood as promoting a sense of belonging and acceptance for drug users. In both cities, outreach workers tended to have a stronger focus on bonding than their office based colleagues. Only in Amsterdam, however, law enforcement workers - community police officers - also mentioned bonding as a strategy, which can be explained by the different policing style and job prescription for these workers.

Overall, when using bonding as a strategy, workers tend to be driven by their perceptions of users' needs: they open room for users to talk about their life and the way they see it, and also propose their own solutions for the problems they perceive. The strategy, thus, assumes connections with a human rights framing. Sometimes, however, workers can use bonding as a tool for convincing users to do what they think is best for them. This was found, for instance, in some cases of groups in Therapeutic Communities or outpatient drug treatment in Porto Alegre which were used as a space to teach users why/how they should become drug abstinent, or change totally their behaviour, according to workers' prescriptions. Medical and coercive frames here were more often combined as a disciplinary strategy. The more open to users views, the more bonding is attached to liberal strategies of governance. The more attached to the views of workers, the more disciplinary techniques are combined with the liberal ones, even if users may still keep some degree of autonomy.

A differential feature between the cities is that bonding tends to be done on one-to-one basis in Amsterdam, while in Porto Alegre collective group strategies are more common. Groups that care workers promote with users in open drug treatment centres, walk in centres or in parks are examples of collective bonding. Even though groups can be used in a more directive way, they usually provide an opportunity for a better power balance between workers and users, since users have space to exchange their own views and experiences.

Bonding brought dilemmas mostly for workers in Amsterdam, who were caught up in doubts about how to keep boundaries between professional and personal life. Strategies to create bonding boundaries included 'structuring interactions' (Lipsky, 2010) such as verbal and physi-

cal divisions (in the case of office-based workers) between workers and users; some of these, structurally build in facilities' spaces. When creating boundaries for bonding, workers from Amsterdam were driven by self-protection strategies of preventing emotional suffering by getting 'too soft'. This, ultimately, would also help them to enforce organizational rules despite meeting users' resistance.

Table 14
Amsterdam's main governing strategies

Strategy	Differential feature	Sector	Examples of activities	Drive	Strategy 'tone'
Bonding	Individual	Some care and police (outreach)	Conversations, kindness, playfulness, attentiveness	Users	Liberal
Benefits	Concrete	Most care (office based)	Methadone, heroin, housing, benefits	Users + workers + (org.)	Disciplinary +liberal
Rules	Low-threshold	Most care	Specified times to get drugs; urine screening; work for benefits; behave in facilities	Workers + (users)	Disciplinary +liberal
Threatening	Frequent lighter	Most care and police	Prison/fines (police); losing benefits; service suspension or expulsion	User + worker	Disciplinary
Punishing	Frequent lighter	Many care Most police	Lose (part of) benefit; lose takeaway drug doses; service suspension or expulsion; fines (police)	Worker + organization (+ user)	Disciplinary
Giving up	Less often	Few care and police	Alienated withdrawal; sick leaves; ask for substitute in a case	Workers	Avoidance

In the case of using benefits as a strategy for changing users' behaviour, a different pattern of bonding was found: Amsterdam care workers tended to use it more than their colleagues from Porto Alegre. Also, office based workers tended to use more benefits as exchange tokens in both cities, than outreach workers. The fact that care workers are managing welfare benefits, while police workers manage punishment for misbehaviour explains why the latter did not use benefits as a main strategy.

Table 15:
Porto Alegre's main governing strategies

Strategy	Differential feature	Sector	Activities	Aims	Strategy 'tone'
Bonding	Collective	Most care (specially outreach)	Group debates, conversation, playfulness, attentiveness, hands shaking, pats on the back, taps on the shoulder	Users	Liberal Liberal + disciplinary (convincing)
Benefits	Conceptual	Many care (mainly office based)	Groups to debate addiction, homelessness, medication management, health, etc.	Users + workers + (organizations)	Disciplinary +liberal
Rules	High-threshold	Most care	Not being drug affected to access service; entrance and leaving time restrictions and not having visitors in shelters	Workers + (users)	Disciplinary +liberal
Threatening	Occasional serious	Many care Some police	Prison; loosing child's rights, mandatory treatment	User+ worker	Disciplinary
Punishing	Occasional serious	Some care Most police	Losing child's rights; loosing freedom; harsh treatment /violence (police)	Worker + organization (+ user)	Disciplinary
Giving up	Frequent	Some care and police	Alienated withdrawal; sick leave; ask for substitution in a case	Workers	Avoidance

The differences in terms of welfare resources in Amsterdam and Porto Alegre play a role both in the intensity of use of disciplinary and liberal strategies. While Amsterdam workers mention the use of more concrete benefits, Porto Alegre workers use more 'conceptual' benefits, usually based in the relationship between workers and users (thus, bonding), and the exchange between users given the collective approach. While in Amsterdam workers play with prescribed drugs or basic needs to push users to a certain behaviour, in Porto Alegre workers rely more conversations and debates, which are seen as benefits as much as bus tickets or food stamps. When benefits are used as a way of providing a more supportive setting, combinations with the psychosocial frame are usually present. When the drug is used as a benefit, as it happens in the case of Amsterdam, the medical frame comes into the picture.

The use of rules as a strategy also showed variations across cities. In Porto Alegre, in general, the tendency for care workers is not to focus on rules inside services, but high-threshold criteria of access already sets up boundaries for users to get in. High-threshold rules to access facilities helps workers from Porto Alegre use creaming strategies to choose the 'most deserving', or those users considered to be easier and more compliant. In Amsterdam, on the other hand, low-threshold facilities direct the focus towards enforcing the rules inside services. In this context, care workers tend to have more dilemmas around rule breaking in Amsterdam.

Given the specific feature of allowing drug use inside facilities in this city, one dilemma workers face is related to regulation of drug use and drug dealing inside services. In meeting this dilemma, contrary to what Maynard-Moody and Musheno (2003) postulate, different postures can be assumed by workers; they do bend the rules for meeting users' needs, but there might be also other reasons for workers to decide to behave more in tune with the self-interested behaviour mentioned by Lipsky (2010), or a combination of both. Workers might bend the rules driven by users' needs to be included in (or not expelled from) care. Also, they might bend the rules to combine users' perceived needs with a professional need of keeping a strong partnership, as in the case of police workers who allow users to have a 'corridor' to a drug treatment centre inside a city area from which the user was excluded due to misbehaviour. Finally, it can also be that workers decide to bend the rules to decrease their work stress, as when they 'fool around' and pretend they are not seeing faults committed by users because enforcing the rules at that point would generate a stressful situation for them.

If bonding, benefits and rules are mostly used by care workers, threatening and punishing are strategies often used by law enforcement workers; although threatening can also be an important strategy for care workers. Some difference in the use of these strategies can be seen across cities. Firstly, while in Amsterdam threatens and punishments tend to be used more frequently, but to be 'lighter', in Porto Alegre they tend to have harsher consequences for users. Another related difference, is that threatens and punishment in Amsterdam tend to be more focused on losing benefits, while in Porto Alegre they tend to be focused on losing rights. Amsterdam users are punished with losing their takeaway drug dose or part of a financial benefit, while Porto Alegre users are punished

with losing rights to their child and being forced to get into abstinence-based drug treatment. This difference, perhaps, relates to the fact that Porto Alegre workers do not have so many benefits to use as a bargaining counter with users, when compared to their colleagues in Amsterdam.

Regarding the use of threat and punishment by law enforcement workers, a main difference is that while Amsterdam police workers use these strategies to push users into care, in Porto Alegre users are mainly pushed into the prison system or other types of enforced activities. In any case, disciplinary techniques are at the core of punishment strategies, used with the aim of curbing what is considered a bad behaviour. Threatening strategies, on the other hand, are a chance workers give to users before punishment occurs. Although it uses a disciplinary technique, it still gives users a certain room for choice.

An important dilemma arising for workers in both cities in making decisions around the use of rules, threat and punishment relates to defining what is acceptable or not in terms of aggression and violence. Here again, differences can be seen across cities, with Porto Alegre workers having a higher tolerance towards aggression and violence than their Dutch counterparts. Although violence happens at much higher levels in Porto Alegre, including physical violence towards workers, workers from Amsterdam tend to be more concerned about the possibility of violent acts. In the latter city, facilities have more in-built separation structures to protect workers: metal detector doors at the entrance of drug treatment clinics, shutting windows, and guards in front of some shelters. Apart for structural protection in Amsterdam, workers from both cities deal with violence trough de-escalation methods, contrary to what stated by Maynard-Moody and Musheno (2003). De-escalation and help from colleagues are used as forms of self-protection. However, in extreme cases where workers feel physically and/or psychologically harmed, they might assume a 'give up' position.

When giving up, workers tend to become distant from users, either by alienated withdrawal ('fooling around') or getting busy with paper work to avoid encounters, or by clearly asking colleagues to assume a case they feel they cannot handle. As a last resource, they can ask for sick leaves. In both cities, giving up was a more extreme position, but possibly given the worse conditions in Porto Alegre, it happened more often in this city.

In the end, both liberal and disciplinary techniques are used by street level workers in a mix of strategies when aiming at changing users' behaviour. When considering the governance strategies adopted by workers, from bonding to punishment, liberal and disciplinary strategies can be seen in a continuum, from a focus more on liberal to a focus on more disciplinary, with different combinations in-between. The more liberal, the higher the tendency the strategy combines human rights and harm reduction frames. The more disciplinary, the higher the tendency they form combinations around coercive and public order frames. In the middle, medical and psychological frames might assume different perspectives depending on the combination chosen. The tensions between a public order and a harm reduction approach can be represented in these techniques and the ways workers use their discretion to decide upon governance modes. Here, black-and-white definitions of public order approach as using exclusively disciplinary techniques and harm reduction exclusively liberal techniques do not suffice to explain workers practices. Rather than thinking about drug users' governance in two completely different and opposed ways of either enhancement of self-care or domination and dependency, it is more fruitful to think about it along a continuum, as a complex shifting pattern of human relationships.

When focused on self-care enhancement, modes of governance tend to produce more autonomous and integrated citizens. When focused type of guidance which takes the power of decision from users to centre it on workers, modes of governance tend to produce citizens who are dependent, who feel they are morally wrong, and/or who identify with having a deviant position in society. The first practices reflect governance for autonomy, while the others reflect governance for dependency, deviance and delinquency. The more a mode of governance uses liberal techniques, the more it tends to value the production of users' autonomy. The more governance uses disciplinary techniques, the bigger the tendency to produce 'docile bodies' and increase users' dependency on workers, services and welfare system as a whole.

In this sense, it is interesting to note that depending on the modes of governance chosen by workers, this does not only produce different practices by individual workers, but also imposes different identities on drug users. This relates to workers dilemmas on how much responsibility a user can assume. In Amsterdam, care workers try to balance responsibility with guidance, using benefits and rules to push behavioural change

with lower expectations than in Porto Alegre. Users, however, are not given much room for choice once receiving benefits. In Porto Alegre, workers divide themselves between the ones who use bonding and conceptual benefits with a disciplinary tone to persuade people to change, and those who make use of these strategies in more liberal ways, to promote users' self-responsibility and reflexivity. These are the workers having more dilemmas on how much to intervene in users' lives without explicitly consulting these users as citizens. While the last ones tend to be strongly influenced by perceptions of users' needs and users' responses to those decisions, the first tend to find mixtures of strategies that include influences from their own professional ethics and the rules and regulations of the organizations that employ them as workers.

Notes

[1] These concepts are inspired in Foucault and post-Foucauldians, and in more recent approaches on governmentality such as Patt O'Malley's (1999) and the debate of Ulrich Beck defining the emergence of a 'risk society'. See Ulrich (1992) *Risk Society: Towards a New Modernity*. London: Sage.

[2] Tutelary Council is responsible for child protection in Brazil, and act on restraining parent's rights when there is a perceived lack of care for the child. In this quote, the worker describes a common situation in which kids are on the streets using drugs or just walking around with visible lack of personal hygiene and bad nutrition. They can be asked by workers about their parents and Tutelary Council can act with a restraining order against the parents and put the child in a shelter, for instance.

[3] Especially in social care, facilities are increasingly working with the '8-fasenmodel', or the 8-phases model. This is a method of individual counselling to clients to work on 'achievable goals', and to be structured in collaboration with users. The model proposes eight stages in the counselling process, going from the application phase, or first contact between the client and social worker, acquaintance between the client and the institution; building assistance to the client; analysis of the functioning of the client at eight habits; planning a support plan; implementing it; evaluating the implementation; and completion. The 8 habits through which clients are evaluated and plans are built to achieve changes are: 1. living situation of the client; 2. financial situation; 3. social functioning (relationship with environment, family, relatives, social workers and relationship with justice); 4. psychological functioning (including any psychiatric illness and addictive behaviour); 5. sense of purpose (what motivates the client to live); 6. physical functioning (physical condition of the client and self-care); 7. practical work (op-

erational and technical skills, language skills); 8. daytime activities (work, social activation, hobbies, studies, activities) (NIZW 2010).

[4] Assemblies are also happening in some facilities in Amsterdam, but they are not mentioned by workers as something important; in this city, users are the ones mentioning assemblies. Both in Amsterdam and Porto Alegre, users reported that even with these meetings, their needs and complaints are not taken into account in a sufficient way, or, in worst cases, not at all.

[5] Interesting to say that the conditions of imprisonment in the Netherlands are very much different from Brazilian one. Even some users approached during fieldwork said to see prison in a positive way in the Netherlands: a place where you can study, work , and have time to organize yourself.

7

How discretion varies across territories

7 How discretion varies across territories

Street level workers' discretion defines the ways in which policies happen on the ground. It is a fundamental capability workers needed and used to cope with the gaps between the goals and expectations as stated in official policies and the actual resources and conditions they find to implement them at the street level. Through discretion, workers negotiate and shape the meanings and goals embedded in the policies they work with, creating new understandings and practices for policy in the streets. In these discretionary processes, workers combine creativity and professional skills to create possibilities for policies to happen.

The present study describes and analyses the range of discretionary decisions workers take to negotiate and choose between care and order in their daily approaches with users of the so called 'problem' drugs (crack cocaine and heroin). Discretionary processes are compared between law enforcement, health and social workers working in the field of drug policies in two cities across the Atlantic ocean: Amsterdam (in the Netherlands) and Porto Alegre (in Brazil). The data analysed allowed to investigate *the dilemmas street level workers encounter in their daily interactions with drug users, and how do they develop strategies to cope with them.* By comparing two cities with distinct histories of drug use and official policy developments, plus clear differences in the resources available to street level workers, this research has shown that discretion is shaped by similar underlying processes in the different contexts, though with differing outcomes. The descriptions offered by the participants, together with the observations made by the researcher, provided room for analyses which combines and challenges theories from the fields of drug policies, street level bureaucracy and governmentality literatures.

In the following pages, this concluding chapter describes, first, the main findings and theoretical contributions from this research. Then, the main patterns of discretionary practice found among street level workers

are described, and first steps towards a typology of workers' decisions are offered. Lastly, different meanings of care and order produced by workers' discretionary actions are debated, and consequences for users are indicated with implications for official policies.

The nuances of discretion

Building on workers' testimonies in the cities of Amsterdam and Porto Alegre, this thesis has analysed the dilemmas street level workers encounter in their daily interactions with drug users, official policies, and fellow workers inside and outside their own professions and how they develop strategies to cope with these dilemmas. Dilemmas and strategies of workers from health, social and law enforcement sectors were analysed using seven conceptual framings which address different sub questions of the study (see page 13 for an overview of the questions). Chapter two analysed the histories of drug policy influencing the territories of workers in the different cities (question 1). Chapters three and four focused, respectively, on patterns of workers' interpretive beliefs towards drug use (question 2), and of the types of strategies workers develop in dealing with both support and constraints from their organizations (question 3). In chapter five workers' interpretive beliefs and organizational contexts were further developed to explore the different patterns of collaboration (or networking) workers create in the different cities, within and between professional sectors (question 5). Finally, the decisions workers choose to take when working with drug users (question 6) were the focus of chapter six. The strategies workers use to cope with the challenges they find in all these areas (question 4) were cross-cut throughout the chapters. Similarly, the different political histories of Brazil and the Netherlands and the very different material resources available in Porto Alegre and Amsterdam (question 7) were analysed for their influences on workers' discretion as they became relevant in each chapter.

By analysing discretionary practices across two cities and three professional sectors, the present research found that discretionary practices are shaped in different ways by different environments. The study approached discretion by combining theories from the fields of drug policies, street level bureaucracy and governmentality. The analysis and interpretation of data, coming from testimonies on a variety of reported experiences and direct observations of street level workers, benefited

from the theoretical approaches, but also allowed to challenge some of the concepts brought by the scholars.

When listening to workers' experiences, and observing (or participating in) their activities, many interesting dilemmas and strategies were seen as coming from the ground. Workers have to take daily decisions in order to cope with uncertainties and work pressure they find on practice. These decisions, as Lipksy (2010) stated, effectively become the public policies they carry out. They are what a street level bureaucracy approach (e.g. Lipsky 2010, Evans 2013, Maynard-Moody and Musheno 2000) calls workers' discretion. In this research, building on the fieldwork data, it is found that discretion is a fundamental aspect of street level workers' daily tasks in both Porto Alegre and Amsterdam. The research findings support what street level bureaucracy scholars call 'the continuation perspective' (Evans and Harris 2004), which claims that even with the changes in general governmentality processes which took place over the last 30 years, discretion remains important in putting official policy into practice (see also Lipsky 2010, Evans 2013) and is possibly even increasing due to the escalation of inconsistent national legislation and local managerial rules (Evans and Harris 2004).

Going beyond finding that street level workers have significant degrees of freedom in decision-making, analysis in the present study is also concerned with *how* this discretion is exercised. This analysis focuses on the judgment aspect of discretion, and how the different decisions workers make and strategies they find to put official policies into practice shape the ways in which drug user care and order practices appear in practice on the street. The study of two comparative cases, in this context, allows this research to explore the impact of different socio-economic and historical contexts on workers' local opportunities to exercise discretion and patterns of discretionary choices.

Table 16 summarizes the main findings answering the research questions, as seen across the chapters. The explanatory text that follows highlights and interlinks some of the features illustrated on the Table by presenting four examples on how features interact and the variations found in the cities shape workers' discretion in different ways.

Table 16:
Main findings

	Main features	Amsterdam	Porto Alegre
Territories	Actual drug polices	Harm reduction Public health +public order	Harm reduction Public health +public order
	History of drug policies	Decriminalization of use, substitution treatment	Criminalization of use, mandatory treatment
	Broader policy influences	Public health Community policing style	Collective health movement Military dictatorship
	Drug problem	Open drug scene Past – heroin epidemics	Open drug scene Present- crack epidemics
	Drug use today	Crack and heroin	Crack
	Drug users	Older, basic needs provided	Younger, poorer conditions
	Services	Low-threshold care Community police	High-threshold care Military police
Interpretive beliefs	Main frames adopted	Harm reduction + public order + medical (or) psychosocial	Medical+ human rights + Harm reduction (and/or) psychosocial (and/or) coercive
	Main solutions proposed	Drug control in open place Supportive setting No action (controlled cases)	Crack abstinence/ other drugs' control in closed/ open place Supportive setting (as complement) Enhance users' will
Organizations	Perceptions of challenges and support	Resources and (some) compatible goals as support	Resources, conflicting goals and government instability as challenge
	Main strategies	Following rules, bending rules	Referring to specialist, prioritizing, paying to work, opposing rules
	Main drives	Organizations+ workers+ (users) Postures 1,2 and 3	Workers + (users) Postures 2 and 5
Networking	Main strategies	Social + health + law enforcement	Social + health // law enforcement
	Main rationalities	Mutual help: Police push users to care Care avoid public nuisance	No benefit : Police harms trust with users Care is not (helpful) enough
	Main dilemmas	Information exchange Who knows better (care)	Short circuits - basic and specialized services (care) Who knows better
Relation with users	Main strategies	Bonding and 'conceptual' benefits (care) Punishment (police)	Concrete benefits and enforcing the rules (care) Threatens and punishment (police)
	Main dilemmas	Bonding boundaries Rules for rule breaking Defining violence	How much responsibility to expect from users Defining violence

Example 1: interpretive beliefs, territories and networking

In defining problems and solutions for drug use, and in implementing them with users, workers have to choose between different framings of drug use in its social contexts, including criminal law enforcement, to public health, to individual health, to citizen/human rights as framings shift from a primary concern with order to a primary concern with care (see Table 1 in Chapter one and Table 5 in Chapter three for an overview on different frames in drug policies).

As this research has demonstrated, in their discretionary decisions, street level workers do not adopt mainly or exclusively only one of the frames - coercive, moral, medical, psychosocial, harm reduction and human rights - as has been claimed by some scholars in the drug field (e.g. Pauly 2008, Acselrad 2000, Queiroz 2007, Humphreys et al. 1996). Nor, are they driven solely by normative beliefs and judgements about the users they encounter based on general societal views of good and bad character, as some scholars from the street level bureaucracy field claim (Maynard-Moody and Musheno 2003). Rather, workers judge users' worthiness and feasibility of specific actions on their individual merits, and use professional judgements to define what is best regarding drug use in each case. In these judgements, workers' interpretive beliefs are built by combining different frames to propose concrete solutions to perceived problems, mixing wider social/cultural values, official policy pronouncements, organizational resourcing priorities, and sectoral professional guidelines.

Three approaches to drug use were conceptualised as being offered by street level workers in both cities, those focused on actions on the drug, on users' setting, or context, or on users' personality or 'set'. Solutions focused on the drug (for an overview on all drug focused solutions, see Table 7 in chapter three) range from full support to total abstinence (sometimes in an mandatory way), to solutions that believe on users' self-responsibility for a controlled drug use or 'no action' when users are perceived as living orderly lives. These solutions often combine a medical frame with harm reduction, coercion or human rights frames, depending on the specific context. Solutions focused on setting (see Table 8) range from providing users with basic needs to treating their families and providing them with other activities than drug use, here also, possibly in an mandatory way. These usually combine a psychosocial frame with harm reduction and/or public order. Finally, 'set' focused solutions (see

Table 9) present extremes of focusing on users' moral will to become totally abstinent, on one hand, to enhancing drug users' political participation as citizens with rights on the other.

In Amsterdam workers from all sectors tended to combinations of harm reduction and public order frames, either with medical or with psychosocial frames: offering drug substitution treatment in open places in the first case, or basic needs and paid daily activities in walk in centres, user rooms and shelters in the second case. The higher availability of resources in Amsterdam, encouraged workers from this city to offer setting focused solutions to drug use more frequently than their peers in Porto Alegre. In Porto Alegre, workers interpretive beliefs tended to be more spread across the care and order spectrum. Towards the care end of the care and order spectrum, care workers propose combinations of harm reduction, human rights to propose a higher reflexivity of users towards drug use, life quality and society participation. In between care and cure, other care workers add to the harm reduction and human rights frame also a medical frame to propose reflexivity together with abstinence of the main drug of abuse (generally crack). In this sense, care workers from Porto Alegre show somewhat greater concern with rights than their peers from Amsterdam. At the other extreme, however, police workers in Porto Alegre especially tend to advocate coercive approaches through mandatory labour, and some care workers trough mandatory abstinence treatment by users.

Territorial differences in terms of histories of official policies resulting from development of perceptions of a drug problem, types of drug use, and services available also have influence on the different combinations of care and order underpinning exercises of workers' discretion. At the times harm reduction as official policy were established, the political contexts in the two cities were complex at street level.. In Amsterdam, the emergent harm reduction approach encountered drug policies which were already flexible towards drugs use (with the division between hard and soft drugs), and the idea that public health should have primacy over law enforcement in the case of drug use. In Porto Alegre, on the other hand, the approach faced two different and opposed forces: on one side, repressive policies towards drugs inherited from the military dictatorship (which prescribed mandatory drug abstinence and/or prison for drug use), and on the other, the collective health movement, which emerged from the care sectors as a human rights criticism of public health as a

public order issue and an exclusionary health care system centred on specialized medical approaches in a context of great inequality. These extremes in the political context of Porto Alegre facilitate extreme positions and the choice of coercive approaches by law enforcement workers, and human-rights driven choices by care workers connected to a collective health paradigm. In Amsterdam, a previous policy of tolerance towards drug use allowed an early availability of drug substitution treatments, and interpretive beliefs which combine harm reduction with a medical frame, allowing the prescription on medical grounds of otherwise illegal drugs.

At the time of harm reduction becoming official policy, injected drug use was a main problem in both cities, and a syringe exchange program was the first harm reduction strategy adopted. Since the drug injected in Amsterdam was mostly heroin, users could also benefit from drug substitution treatment with methadone, and later, prescribed heroin. The existence of methadone as a drug substitute for heroin, made a medical framing appropriate for harm reduction in Amsterdam (and more widely in the Netherlands). In Porto Alegre, on the other hand, the injected drug was cocaine, for which there is no substitute found so far. The fact that no 'cocadone' is available meant a medical frame in Porto Alegre (and wider Brazil) tended to be abstinence-only treatments, viewing harm reduction strategies as potentially ineffective.

Territorial differences, together with differences in interpretive beliefs also shaped workers networking pattern in different ways in the studied cities. These differences influenced workers' rationalities in deciding whether it was possible or useful to network with colleagues from other professions and organizations. The main networking patterns are very different between the cities: while in Amsterdam care and law enforcement workers work together, in Porto Alegre workers find strong reasons not to network (see Table 12 for the main pattern of networking in Amsterdam and Table 13 for networking in Porto Alegre, both in Chapter five). A longer history of collaboration in Amsterdam, together with a community policing style facilitates the joint approach. In Porto Alegre, a history of military dictatorship in one hand and of a collective health movement on the other drives workers apart.

In the case of care workers, in Porto Alegre many workers believe that once a crack user gets in touch with the care system, the most urgent action (or the only possible one) is to refer him/her to a drug

treatment clinic. As crack is perceived as being extremely addictive, harmful, and difficult to control, many workers give priority to abstinence-based solutions in in-patient drug treatment or, alternatively, outpatient clinics. This ends up creating short-circuits around specialized services, which get fused by excess demand. Services specialized in drug treatment in Porto Alegre, therefore, work with high-threshold rules for access and staying in care. Strict rules to access these services create dilemmas for workers on how to connect basic and specialized care in Porto Alegre. In Amsterdam, on the other hand, low-threshold drug treatment services are more at ease with drug use inside facilities. However, the close networking between social, health and law enforcement care create dilemmas for workers on how to decide on what type of information to exchange.

Example 2: resources and strategies with organizations and users

In the relationship with their organizations, workers from Amsterdam in all three professional sectors felt more supported than workers from Porto Alegre (see Table 10 in chapter four for a comparative overview). In terms of resources, Dutch workers felt supported by the number and availability of services offered for drug users, the resources they have to perform their activities inside their services, as well as training and know-how on how to perform in practice. For workers in Porto Alegre, however, these resources were considered insufficient. These differences shaped workers' discretionary choices when coping with organizational challenges and dilemmas in the relationships with users.

In relation to their organizations, five different postures were found to be assumed by workers. The extent to which workers feel supported by their organizations and the rules they convey was a fundamental feature defining workers' discretionary choices. When workers believe the system is able to respond to users' needs, and is feasible in terms of what is asks from them as professionals, they tend to follow organizational rules and goals (posture 1). Most of the times, however, workers perceive the tensions between organizations' demands, citizen needs, and their own limits as workers, and try to accommodate their actions to meet different needs as much as possible. The path they choose, more often, is to try to accommodate users' needs and their own interpretive beliefs and comfort as workers (posture 2). Another response, is to give less importance to users and their needs, and more to their organizational

rules and expectations, combined with their professional needs and interpretive beliefs (posture 3). In these postures, even perceiving these combinations as difficult, workers regard as possible the negotiations.

In the fourth and fifth postures, however, negotiations are seen as too costly or impossible to make. When workers disbelieve the system's capacity for effective action in users' lives, and the meaningfulness of policies for the clients they assist assume a critical importance, workers try to cope with the gaps by increasing their efforts. They will be driven by the needs of the users they assist, opposing organizational rules, and often increasing work and efforts for themselves beyond required (posture 5). However, when workers disbelief the system in terms of changing users' life, and also perceive it as making unrealistic demands upon them, they might try to take personal benefits out of it (posture 4) (see Table 11 in chapter four for an overview on postures and strategies).

In general, workers from Amsterdam found it easier to find a balance between organizational, professional and users' needs than workers from Porto Alegre. Although the majority of workers, in both cities, perform negotiations which combine their needs as workers with the demands of their organizations and/or with the perceived needs of users, extreme postures in choosing between competing demands are found more often in Porto Alegre.

Lack of resources in the Brazilian city were believed to lead workers to adopt, more often than their colleagues from Amsterdam, certain self-interested strategies (posture 4) such as alienated behaviour and avoiding approaching users, or becoming corrupted and accepting bribes; this last behaviour being more common in the case of law enforcement workers. On the other hand, the challenges workers face in Porto Alegre and the interpretive beliefs workers have regarding drug use lead them more frequently to adopt other strategies. The clear socio-economic differences when comparing Amsterdam and Porto Alegre impact also on their work conditions (see Table 4 for a comparative overview) and the challenges they face regarding the living conditions of the drug users they approach. To deal with challenges of a welfare state perceived as not having enough resources leads workers from Porto Alegre to use strategies such as 'paying to work', which were not reported or found in the case of workers from Amsterdam. In these cases, workers might be user-driven (posture 5) and pay from their own pocket for bus tickets, food stamps or workshop material to work with users when their

(and partner) services do not offer such services. Workers also, might engage in worker (/user)-driven strategies (posture 2) of paying for materials to enhance their own work conditions. Police workers buy private guns to be protected from violence outside their working hours, and many times both police and care workers pay for their own coffee-machines, toilet paper, or fans at the work place.

Workers' discretionary choices, thus, are very much nuanced. They are neither mostly focused on a self-interested behaviour (Lipsky 2010), not by the needs of the citizen being approached (Maynard-Moody and Musheno 2000, 2003). Rather, both concerns for the self and for others are part of and are combined in workers decisions.

Example 3: relations with users, organizations and interpretive beliefs

Finally, workers discretionary choices and drive may also vary according to different interpretive beliefs held by workers have, leading them to adopt different strategies when dealing with users. The six main strategies used to deal with drug users (see Tables 14 and 15 for Amsterdam and Porto Alegre, respectively) were used in different intensities and with differential features by workers in both cities. Both lack of resources and interpretive beliefs around collective health and human rights for users make care workers in Porto Alegre more prone to use bonding as a strategy than their colleagues from Amsterdam. With bonding, mostly, workers adopt a human rights frame, seeing people who use drugs as citizens with rights. Bonding, however, can be used in a more coercive manner by workers who adopt more explicitly a medical frame and an abstinence-only solution to drug use. In these cases, conceptual benefits such as groups to debate a variety of issues around drug addiction and life can be used to 'persuade' users to change behaviour instead of promoting reflexivity and participation of users as in the case of workers who adopt a human rights frame.

In Amsterdam, a higher availability of resources, encourages workers to use concrete benefits as exchange tokens with users to change behaviour. Availability of concrete benefits, together with the low-threshold characteristic of care services, lead workers to use rules attached to benefits as a way of keeping users on track. Since care workers from Porto Alegre do not have so many concrete benefits to use as tokens with users, the threats and punishments they apply are more related to losing

rights than to losing benefits. This makes punishment and threats more frequent, but lighter, in Amsterdam and more occasional, but more serious, in Porto Alegre.

Another example on how different environments shape workers' discretion relates to the policies for displacing users to less visible places. What is interesting to note also is that in the so-called 'laissez-faire' Amsterdam, concerns with decreasing public nuisance are at the very core of a harm reduction approach for both 'care' and 'order' workers. In both cities the idea of having a drug problem is historically related to open drug use in public. When drug use moves out of the 'ghettos' of society, and mixes with wider lack of opportunities and poverty, and non-drug using citizens start getting disturbed by the presence of drug use in the streets, a drug problem is perceived that requires combinations of public order and public health responses. When drug-related criminality rises and the situation in understood as out of control, a drug epidemic is recognized and coercive measures are seen as 'necessary'.

In Amsterdam and Porto Alegre, a first reaction from the government in cases of perceptions of a drug epidemic, is to use police workers' disciplinary power to displace users to less public areas. With the very different living conditions of users in the cases studied, (homeless) drug users in Porto Alegre are much more visible in the streets than those in Amsterdam. Even so, a distinct difference between the cities is that the need for 'clearing the city' is much more at the centre of street level workers' function in Amsterdam, than in Porto Alegre. In Amsterdam these approaches are accepted by workers from all sectors as beneficial both to drug users and to society at large. A welfare system which provides low-threshold facilities can deal with drug users who are not able or not willing to stop using drugs, when they are displaced away from non-drug using citizens' eyes into those facilities. This leads care workers from Amsterdam to assume decreasing nuisance is part of their professional commitments. As a consequence, workers tend to engage more easily in punishment strategies to curb nuisance than workers from Porto Alegre. Together with law enforcement workers, care workers from Amsterdam see 'clearing practices' as compatible with care for drug users, and as a way of combining the needs of users, official policies, their organizations, wider society, and their needs as professionals.

In Porto Alegre, on the other hand, even some police workers criticise policies to 'clear' the streets of (homeless) drug users. While for care

workers, 'clearing' is perceived as outrageous, for police 'clearing' is perceived as useless to curb nuisance or reduce crimes, since there are no places available in which to push displaced users. Neither police nor care workers see 'clearing' policies as useful to achieve their professional aims. And care workers do not have decreasing public nuisance as part of their professional commitments. This leads workers in Porto Alegre to use, more often than their colleagues in Amsterdam, discretionary strategies of opposing rules emphasising public order, either openly or by prioritizing activities which are considered more useful for meeting both professional goals and users' needs. In an environment where workers feel less supported by their organizations, less attention tend to be paid to organizational needs in discretionary decisions. The focus tends to be on the needs of users and/or workers themselves.

In this sense, the findings of this research mirror the perspective offered by Evans (2013) that discretion may reflect both concern with the self and others, and may also reflect different perspectives on problems and solutions for a specific issue. Professional commitments are an important factor defining workers' discretion. As professionals, street level workers have ideas – or interpretive beliefs- on what is considered to be a problem, for instance, regarding drug use, and what are the possible solutions for it. Not all workers in a given professional field, though, may agree on what is considered a 'best practice', at least not in disputed fields such as drug use and official drug policies. This demonstrates the importance of looking at the ways street level workers frame problems and solutions regarding drug use in order to fully understand the decisions they make in their discretionary practices.

Discretionary patterns of practice

Looking at the various discretionary processes that each one of the 80 workers participating in this research experienced, valuable lessons can be drawn regarding patterns of response. The differences between cities and countries in terms of socio economic conditions and welfare resources, history of drug policy, development of a drug problem, work conditions, and services available are various. To say the least, Amsterdam is in a developed country, with a liberal history towards drug use, while Porto Alegre is in a developing one, with a repressive history regarding drug policies. Considering workers from three different sectors also contribute to broaden the analyses' scope: social, health and law en-

forcement workers are part of very different organizations, each one with its own history, policies and work culture. Development and cultural differences and the formal service division between sectors is a useful entry point to analyse discretionary variations, but most characteristics identified in this research cut through these boundaries. They reveal greater complexity in discretionary choices that socio-cultural-economic features and organograms might suggest. This broadened scope by the study of two cities is, thus, an important added value in this research.

Based on the range of responses found among street level workers, the following pages describe, first, the main differential patterns between the studied cities and sectors. Following that, cross-cutting similarities are integrated to propose a typology of discretionary actions performed by workers on the ground.

Main differential patterns of cities and sectors

When looking from a comfortable distance, law enforcement, health and social workers approaching drug users in the cities of Amsterdam and Porto Alegre, present very different discretionary patterns. These differential main patterns carry a stereotypical image of workers' behaviour in the studied cities, and are far from representing the full range of responses workers have. Even then, they can be claimed as the main mode of thoughts and actions one can see in a first look. They correspond to (and combine) the responses described as being given by 'many' and 'most' workers across the chapters when aggregated in different cities and sectors. These patterns are now described. In general lines, the three sectors of workers from Amsterdam present a similar main pattern of interpretive beliefs and action, while in Porto Alegre two main patterns can be differentiated by dividing workers into care and law enforcement sectors.

The stick and carrot approach in Amsterdam

In a broad view, care and order in Amsterdam walk hand in hand. Meanings and actions guiding these approaches are carefully negotiated by workers to achieve a feeling of having control over the drug problem. Workers believe this success was achieved through a tight network between the care and the law enforcement sectors.

The main motto for street level workers from Amsterdam is that 'when drug users are in, outside is clean'. Similar interpretive beliefs re-

garding what to do with drug users are shared by workers from all three sectors. Solutions workers give to a considered problematic drug use focus mainly in combinations of actions on drug and setting. These combine, in different intensities, statements coming from the coercive, psychosocial, harm reduction and medical frames. In general, workers from the health field in Amsterdam tend to focus on the combination between harm reduction and medical frames, not to achieve abstinence, but to use illegal drugs as prescribed medicine. Methadone maintenance and heroin prescription clinics are the most mentioned places in this regard. Drug treatment is considered a very important part of the success for users to achieve control over their drug intake. Drug treatment without protected spaces for drug use and basic needs for users, though, are considered not to be enough.

Investments on setting are said to be very important in Amsterdam. User rooms, shelters, walk in centres, outreach work teams, places providing daily activities, benefits and employment, are available for users who are both currently in abstinence and those who are not willing or not able to stop using the drug. This part is the work of social care, whose tendency is to combine harm reduction with a psychosocial frame: users' setting is improved without necessarily asking for drug abstinence. By being given benefits and following rules, drug users are supposed to achieve what most street level workers in Amsterdam call a 'controlled life': not bothering others with nuisance; being productive, to a certain extent, or at least not a complete burden to welfare; achieving a controlled use of drugs; and acting according to what is considered normal patterns of behaviour.

A fundamental differential point in Amsterdam is that an important part of the justification of care services relates to its public order effects. The drug as medicine offered in a controlled way, together with protected places where users can consume drugs and stay out of the streets, collaborate to achieve a city clear from 'junkies' and crimes, at the same that improves users well-being. For law enforcement workers, especially, users inside shelters, walk in centres and user rooms, and having assured their basic needs, are seen as having no need for committing crimes or making nuisance. Therefore, investing in low-threshold care serves the purpose both of securing society's safety as well as improving drug users lives.

The tendency of law enforcement workers thus, especially community police officers, is to combine public order with a harm reduction frame. Rather than being perceived as an approach that could even incentivize drug use (as in Porto Alegre military police workers' perception, for instance), Amsterdam police workers see harm reduction as beneficial to 'clear the streets', decrease nuisance and curb crimes. A good part of law enforcement workers' role keeps focused on maintaining public order, but this is mainly pursued by pushing drug users into care. When despite all benefits and care provided users refuse to follow the rules inside a service, still provoke nuisance, or commit crimes, a coercive frame assumes the focus of workers, although still combined with medical and psychosocial frames. Punishment is carried out by both care and law enforcement workers, usually with the aim of keeping or pushing users into care to achieve behavioural changes.

Surprisingly for a known as laissez-faire country, street level workers from Amsterdam are much more at ease with punishing users than workers from Porto Alegre; at least in the care sector. The availability of resources, the networking patterns of workers and the ways services are structured influence on these variations. Netherlands has social protection policies that prevent absolute poverty, different levels of inequality and urban violence. Since workers perceive Amsterdam welfare system as providing users with basic needs and, thus, concrete possibilities for not committing crimes, using drugs in the streets or being a threat to public order, punishment is considered to be fair when users do not follow the rules. Besides, the fact there exists a network between care and law enforcement workers, implies that goals and meanings of order and care were negotiated. Elements of public order where introduced (or reinforced) in the care concept, while elements of care were added to the goal of public order. Finally, many care facilities in Amsterdam work with a low-threshold perspective and accept drug use inside their premises under certain rules, which brings special challenges for care workers to manage potential drug dealing and unexpected behaviour as a result of drug use. These challenges lead care workers from Amsterdam to be more focused on enforcing rules and using threatening and punishing in daily interactions with users.

Carrots here and sticks there in Porto Alegre

Porto Alegre workers present different main discretionary patterns when compared to workers from Amsterdam. In general terms, care and order are perceived as opposite and separate actions in Porto Alegre. Networking presents diverse patterns of response between care and law enforcement workers, and is seen by both sides as unfeasible and undesirable. Care workers perceive police workers as violent and strict towards drug users and homeless population, and fear their contact with police workers might ruin the trust they have built with users. Since trust and bond are perceived as a fundamental feature to bring and keep users in contact with care in Porto Alegre, this is something not to be risked. Similar as their care workers colleagues, police workers from this city think networking would not help them develop their work, and could even harm their activities. Care workers are perceived by police workers as judgemental and not helpful when workers have to deal with violent situations. Ultimately, their goals of helping and assuring order are understood as being too different to be negotiated.

Despite these differences, care and law enforcement workers tend to agree on the ways they define the problems regarding drug use. All sectors convey a feeling of a crack epidemics, and of a drug problem which is out of control. Most workers believe that the main complications leading to a problematic drug use involve the drug and an unsupportive setting. Overall, crack cocaine is believed to have very strong chemical powers, which would lead users to drug dependency. An unsupportive setting deprived from reasonable socio-economic conditions, and with 'unstructured families' is understood to help the problem to get bigger, together with the lack of resources organizations offer for workers to tackle the situation.

When trying to provide solutions for these similarly perceived problems, again the differences between care and law enforcement workers from Porto Alegre stand out. Overall, both social and health workers from Porto Alegre tend to assume a discretionary pattern of 'emergency drug care'. Even though drug and setting are the main perceived problems, main patterns of response focus on drug solutions. Mostly, the aim of drug abstinence through in-patient clinics is pursued in hospital emergencies, detox programs, Therapeutic Communities; alternatively, the aim of drug treatment in open clinics is pursued in the Caps ads. Here, harm reduction, medical, and in the last case, human rights frames are

mix in different patterns depending on the aims workers have. Solutions based on setting, such as shelters, walk in centres, basic social assistance, outreach work or treating users' family are mentioned as well, but mainly understood as complementary to drug treatment. Bus tickets can help users to get to the treatment centre, basic nutrition and clothing help them to be able to keep in treatment, and a supportive family can help them to manage or abstain drug intake.

The networks built among care workers, thus, have structures and dynamics guided by rationalities which focus on medical knowledge and drug abstinence as the most important solution for drug use. In Porto Alegre, this eventually builds a network among care workers which is full of holes, from one side, and short-circuits from the other. While drug treatment services, and especially the abstinence based ones, are overloaded for insisting and repeated access, there are holes in between these places and low-threshold care. Short circuited places end up flooded while users fall out of care through the holes. Besides that, the threshold to enter specialized care services in Porto Alegre is much higher than in Amsterdam. Drug treatment clinics and shelters from Porto Alegre, in general do not allow the presence of drugs inside facilities, and are uneasy about access under drug effects. Moreover, for all services excepting drug treatment places, users have to dispute vacancies with the non-drug using population, which makes harder for users to cope with rules and threshold based on non-drug using behaviour. Once inside services, however, rules are more easily made flexible than in Amsterdam. When situations considered to be too endangering for users' own life (such as in extreme low self-care or violence, or yet, in the case of crack mothers), a coercive frame might also be applied. Mandatory drug treatment, then, is pursued by care workers as a punishment to push users into care. As one can perceive from these patterns, even though apparently care and order are seen as opposed, some mixes and negotiations are made by workers on the ground.

Assuming a different pattern of response, law enforcement workers from Porto Alegre tend to go for an approach where they believe 'drug uses are sick, but is still needed to use the stick'. Most police workers in Porto Alegre mention to have changed their opinions towards drug users from seeing them as immoral marginal to see them as people who are sick and might need help. However, in general terms, these interpretive beliefs do not lead police workers to push users into care, neither to drug

treatment, nor to shelters or walk in centres. The crucial point influencing police workers' decision of not investing in care for users comes from their daily practice. Since these workers report to see, repeatedly, users going to drug treatment centres, and few weeks or days after, being back into the streets, drug use, homelessness, nuisance, and crimes, they tend not to believe drug treatment is effective. When facing orders to displace (homeless) users from public areas, police workers encounter lack of vacancies in shelters, and high-threshold rules which they perceive users cannot follow. Taking these conditions into account, police workers tends to focus on set solutions, where users are expected to be abstinent from drugs by making a self- effort to develop their own will. A strong will is understood as the only way to resist the strong addictive powers of crack cocaine (or, ultimately, resist even starting to use drugs) and to cope with unsupportive setting of poverty and unstructured families. The role for street police workers regarding drug use, thus, resumes to push users into this will power by punishing deviant attitudes of crimes and nuisance, and stopping the availability of drugs in society (by curbing drug traffic). For police workers in Porto Alegre working in prevention programs such as PROERD, the role is to prevent children from using drugs by applying a mix of coercive and psychosocial frames in which drugs are presented as having a strong and destructive addictive power, which require persuasion to develop children's wills to resist possible peer pressure and abstain from use.

Apart from the differences, and connected to the main patterns of response care and law enforcement workers have in Porto Alegre, an interesting variation in relation to workers from Amsterdam refers to their positioning regarding 'clearing policies'. Both care and law enforcement workers from Porto Alegre do not applaud repressive measures for 'clearing the city' of drug users and homeless. If care workers focused on the perceived outrageousness of these actions, police workers focus on its perceived uselessness to keep social order. Taking (homeless) users out of a place in the streets without having another place for them to stay and sleep, and without benefits or work which assure them basic needs, will just temporarily displace them and the problem for another area. Both care and law enforcement workers perceive the inefficacy of these actions for users and society.

Main types of discretionary choices

Beyond the already expected differences in the patterns of response of workers, similarities were found across cities and the three analysed professional sectors. When looking close to the ground, and considering the differences and deviant[1] patterns of response workers present in every city, a wider range of response can be seen.

As this research has demonstrated, uses of workers' discretions is more nuanced than only self-interested or citizen based. The different combinations workers produce while trying to balance their professional commitments with official policies, perceived needs of users, and the aims of their employing organizations will influence how they ultimately act with users on the ground. The interpretive beliefs workers hold on what to do about drug use, and the networking patterns workers create, showed variations between the two cities studied, as well as between the different professional sectors. Together with the variations in resources and support given by organizations, all these differential features brought a varied set of challenges and dilemmas for workers, shaping their discretionary practices in different ways. Not only differences, however, can be seen when looking at the cases. When observing workers' discretionary choices from a distance, shared patterns in use of discretionary postures was observed . By clustering the responses and patterns analysed along the chapters, it is possible to see, roughly, four main discretionary 'types'. These were purely created based on the analysis of grounded testimonies and direct observations, and can be found summarized in Table 17.

Types are not understood here as personality traits street level workers would have, but more as states of mind and action they can assume in various occasions. In this sense, a single worker is not necessarily connected to one of these discretionary types and applies it to every user and situation s/he meets. Rather, the same worker can go through different discretionary patterns in the various situations s/he finds in the streets, and chosen patterns for similar situations might also vary across time.

The main features of each type are now described considering workers' responses in terms of: solutions for the drug problem, ideas they hold about users, main frames guiding their interpretive beliefs, the main features driving their discretion when considering resources and organizations, their main networking pattern and the main types of relationship they establish with the users they assist.

Table 17:
Discretionary types

Types	Engaged	Benefit-managers	Advisers	Order watchers	Frustrated
Solution for drug problem	Set oriented	Setting oriented	Set/drug	Drug oriented	No solution
Ideas of user	Citizens	Victims	Deviant/ Patient	Patients and/ or criminals	(Mixed)
Main frames	Human rights	Psychosocial	Coercive, medical, moral	Medical and coercive	(Mixed)
Main drive (needs)	Users (path 5)	Organ., worker, and users (path 1); worker and users (path 2)	Organization and worker's (path 3)	Organization and worker's (path 3)	Worker (path 4)
Networking pattern	Users' organizations and care	Social and health care	Social and health care, police if necessary	Police and medical	No or little networking
Governing pattern	Bonding	Benefits as exchange tokens	Bonding, conceptual benefits	Enforcing rules and punishing	Distance (give up)

Engaged

When street level workers assume engagement as a discretionary pattern, this means they are primarily committed to a willingness of making their actions meaningful for the people they assist (posture 5). This means they might increase their work load, do tasks beyond formal requirements, and even oppose rules they believe are not useful for users. These workers, in general, consider drug users as citizens, and tend to adopt a human rights approach towards drug use, possibly combined with a harm reduction frame. Besides considering that drug users are citizens with the right to have health care, engaged workers also tend to consider drug users as political citizens whose voices should be heard. When networking, these workers are inclined to have drug users' organizations and associations as partners, as well as other organizations involved with cultural or sportive activities. The usual social and health services are also considered, but these workers tend to have a broader understanding on what determines users' well-being and health.

In general, engaged workers tend to propose set focused solutions for problematic drug use. Changing behavior is understood as a matter of learning how to be critical about one's own choices in life. For that, workers tend to focus in developing a bonding relationship with users. Bond is considered as base for users' changes towards enhanced self-care and responsibility, pursued through relationships of trust and conversations promoting self-reflexivity. Developing users' agency, is understood as the way to achieve well-being, political participation, and, if wished, a controlled use of drugs. In this last case, together with a human rights approach, a harm reduction frame is also part of workers' interpretive beliefs. As these workers have a fundamental respect for users' choices, they might assume positions possibly considered extreme by other workers, in order to provide care without restraining the freedom of users. This is the case, for instance when workers allow crack mothers to stay with their children under what would be considered 'non-satisfactory care conditions' by mainstream cultural ideas. They may also defend users' rights to sleep on the streets because they do not feel respected in shelters. These workers, in general, hold criticism towards societal norms of behaviour, and might be criticized by colleagues for that, and for being 'too engaged', which may be considered non-professional. When looking at the different activities performed, engaged workers can be more often found among those performing outreach work in care services, than in office-based activities.

Benefit managers

When workers act as benefit managers, they tend see drug users as victims of a non-supportive environment. Lack of employment, housing, basic nutrition, lack of sanitary conditions and leisure areas in their neighbourhoods, and 'unstructured families' which could not give them the necessary care are seen as important features leading to a problematic drug use. In this sense, benefit managers tend to assume setting-focused solutions for drug use, and try to make sure users have their basic needs provided. In their networking patterns, these workers tend to focus in developing a good contact with social services, at first, but also health services are considered (even more those offering primary health care). Shelters, services offering financial benefits and employment, walk in centres where users can have clothing, shower, food, and some paid activities, outreach workers who help them to arrange their documents, are

considered good partners by these workers. Also, health facilities providing dental care, treatment for common illnesses, and groups or individual appointment related to enhancing general health are searched. In some cases, these might include also safe places for drug use, but not necessarily.

As benefit managers tend to see drug users as victims, a psychosocial frame is the mainly one guiding their actions and interpretive beliefs. When establishing relations with users, these workers tend to focus on concrete benefits as mediators of the relationship. In a more behavioural approach when compared to the engaged type, the benefit managers use welfare benefits as 'tokens' to push users for changes. Benefits, in this sense, are understood as the glue between users and services, more than bonding. Users are expected to change their behaviours mainly by having access to the benefits provided, but the rules attached to the benefits also play a role. By having shelter, for instance, a homeless user is expected to have more structure in life to be able to follow a drug treatment or have more control in his/her drug intake. By providing users with a safe place to use drugs and financial benefits, workers hope users will not have the need to commit crimes, or to use drugs in the streets. When users do not respond in the expected way, these workers friendly remind users about the rules, but usually, they tend to make rules flexible.

In their discretionary choices, benefit managers tend to be driven by their own needs as professionals, combined with the needs on the users they assist (posture 2). Depending on the extent to which they trust their organizations in terms of the rules and resources provided, they also try to accommodate organizational needs with their own and users' needs (posture 1). When looking at the different activities performed, benefit managers can be more often found among office-based workers, than among those performing outreach.

Advisers

When choosing to act as advisers, workers adopt and mix some of the features of the engaged, benefit managers and the order watcher types. At the core of an adviser type is to give recommendations to users about the right way to behave. When assuming this posture workers tend to urge acceptance or abandonment of certain ideas or attitudes. They tend to position themselves as the ones who know best what is good for the user, perceiving users as either deviants or patients: in any case, someone

who needs external guidance to know what to do. Advisers tend to propose solutions focused on the drug and on users' personality (or 'set'). They tend, for instance, to assume that self-drug control is not possible, and to propose abstinence based solutions for users, also strongly grounded on users' will to change. To achieve that, these workers tend to use bonding strategies, similar to the engaged type of response. But advising differs from engaging in using bonding as a way of convincing users to adopt the behaviours they believe to be more correct. Instead of using concrete benefits as exchange tokens for behavioural changes (as benefit managers), advisers use conceptual benefits such as group or individual appointment where discussions around different themes are proposed. Here, instead of giving space for users to develop their own definitions of what is a problem in their lives and which solutions can be pursued, advisers assume an expert role, and centralize the debate and the direction of the answers. Instead of promoting a debate with or among users, they 'lecture' about right and wrong behaviours. The main frames adopted by this type are the coercive, the medical and the moral.

This discretionary type tends to be more often found among office-based workers than among the outreach based, and predominantly in specialized services. Their networking partners tend to be care services, but when considered necessary, in case of repeatedly non-compliant users, they may also contact law enforcers. Instead of more immediately using threat or punishment against users who disagree with their ideas, as order watchers would do, advisers tend to further develop their persuasive arguments. If needed, however, they might assume stricter approaches. Since users' voices are not very much taken into account, their main drive tends to be a combination of their needs as professionals and the needs of their organizations, similar to order watchers.

Order watchers

When workers assume a discretionary pattern of being order watchers, they tend to be stricter about the rules than benefit managers. Order watchers tend to see drug users as patients and/or criminals, depending on their behavior. In any of these cases, drug users are seen by these workers as people that need external guidance and control in order to function and behave well. This is why these workers believe that by enforcing rules, and using threats and punishments when needed, they are contributing for users to change their behavior. Flexibilizing rules, thus,

tend to be difficult for these workers, and they might be known by their colleagues and by drug users as 'the strict ones'.

Order watchers tend to believe that drug addiction is the main problem leading users to homelessness, joblessness, lack of contact with friends and family, and committing crimes. Therefore, order watchers tend to offer drug oriented solutions for problematic drug use. Drug treatment, then, assumes the most important role, and medical services tend to be seen as the optimal partners. In-patient clinics such as emergency detox, therapeutic communities, or crisis units, as well as outpatient services such as methadone substitution and heroin prescription clinics are often chosen to refer users to. Especially in the case of those drug users who are not at ease with following the rules, and are seen as trouble-makers, partnership may be seen by order watchers as a way to get rid of 'the problem', by referred these users to another service. Partnerships with law enforcement workers, also, are more often pursued in this category than in the previous ones. This might be either to directly punish users for a (bad) behavior, or to protect organizations and workers' safety inside or outside facilities. Mixtures of medical and coercive frames, with or without harm reduction are the most frequent frames guiding workers interpretive beliefs and actions in this discretionary type.

In general, when making their choices on what to do about drug use, order watchers tend to consider organizational and their own needs as more important than the needs of the users they assist (posture 3). Similar to benefit managers, order watchers also tend to be more often office based than outreach workers. Exceptions to that are military and community police workers who work in the streets.

Frustrated

Finally, the last discretionary pattern depicts those situations in which workers feel highly frustrated. In these cases, workers hold a general disbelief that the current system will offer an adequate solution for the drug problem. Sometimes, after repeated tentative of making a difference in users' lives, workers get caught in a vicious cycle of seeing the same people returning again and again to them. It might be also that workers have tried everything they could, and used every resource at their disposal, but the situation with a given user did not change in a level perceived as satisfactory, or did not change at all. It might also, be that workers feel their

organizations do not give them the minimum conditions to perform their work, and perceive their condition as extremely unfair.

In these extreme cases, workers might assume a distant pattern, both from their responsibilities with users, and with their organizations. They tend to be driven by their own needs (posture 4). Workers experiencing a frustrated pattern, in general, choose behaviors of distance and avoidance s a self-protection from further suffering. They may by emotionally resigning from encounters with users and colleagues, or practically escaping work and contact. Frustrated workers might pretend they are busy with paper work to avoid users, might stay many hours inside a team's meeting room instead of the spaces where users are, might extend his/her lunch pause time to make working hours go by faster , or might fake sick leaves to avoid work environment. Very often, they may assume a rather cynical attitude of trying to get as much personal benefits as they can from the organizations they are into. Sometimes, even more extreme situations of emotional suffering leads workers to mental illnesses and ultimate withdrawal or seclusion may lead them to other activities or a more permanent leave. In these cases, giving up (or being distant) cannot be assumed as a successful self-interested strategy.

Frustrated workers, in principle, might come from any other type of pattern already described. Their ideas about users are mixed, but ideas about colleagues and organizations tend to be negative. Since they do not believe their work might make any difference, they tend to choose working patterns leading to less effort as possible. This includes do not networking at all, or keeping network at a minimum level. Discretionary patterns of this type tend to happen more rarely, but can be found in workers from all sectors and types of activities.

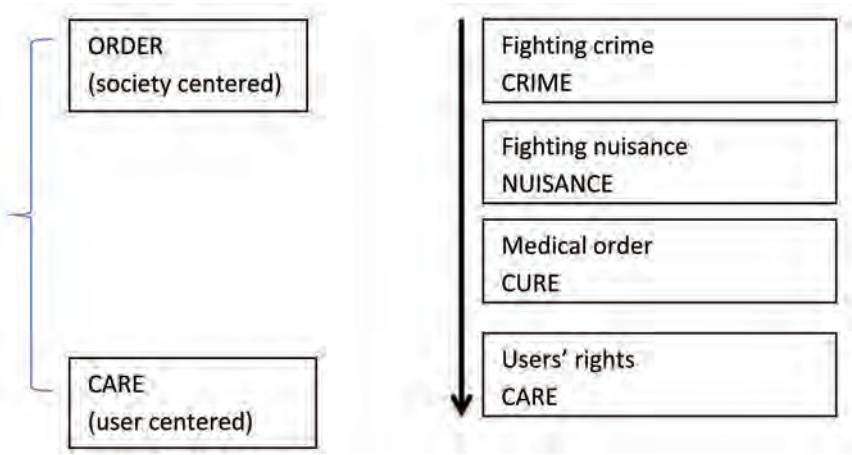
Transformed meanings of care and order

This final subsection brings back the nuances between care and order which were found in street level workers' discretionary choices across cities and sectors. Care and order are very rarely seen in their pure forms when looking at street level workers practices. Rather than completely opposed modes of thought and action, care and order are generally combined by street level workers when making discretionary choices. In these processes, the meanings of these approaches are re-built in different ways to justify and make possible street level workers' tasks with

drug users. These transformations define the ways in which drug policies are enacted in practice and, thus, have consequences not only for workers' actions, but also for the people who are the targets of their activities.

By looking at workers' discretionary practice in the cities of Amsterdam and Porto Alegre, a range of meanings and combinations between care and order was found. In the following pages, this study proposes a first tentative of clustering these variations into four main patterns varying along a continuum. These are illustrated in Figure 3.

Figure 3:
Nuances in care and order



The closer approaches are to a focus on order, the more they tend to be centred in the needs of societies. Concerns with public safety and nuisance assume the main role in defining decisions about what to do with drug users. A difference here is proposed between approaches which focus on fighting crime, and the ones focusing on fighting nuisance. While the first one tend to judge drug use as morally wrong, and something which should be completely banned from society, the second may allow drug use to take place, as long as it does not bother the 'good citizens'. While the first type tend to invest in activities to curb drug traffic, and campaigns to promote drug abstinence (starting by never experimenting drugs), the second type may support harm reduction approaches as long as they help with decreasing nuisance and crimes for society at large.

Down in the spectrum, approaches towards care tend to be centred on drug users themselves and their needs. Concerns with social and health care assume a bigger importance in these patterns. Here, again, a differentiation is proposed between approaches which focus more on medical order, and the ones focusing more on drug users' rights. When a medical approach is the focus of workers' activities, ideas of cure tend to be in the centre of the aims they want to achieve. Cure here, does not necessarily means a 'cure' from drug addiction, trough complete and permanent abstinence. It might also, refer to a 'cure' in terms of a reformed pattern of behaviour to achieve a so-called 'normal life'. By benefitting from care, users are expected to behave in acceptable ways when considering the mainstream standards of society.

In the further end of the spectrum towards care, one finds the approaches identified with a focus on human rights. Care, in this case, is understood as a way not only to assure users' rights to basic needs and health, but to have their voices heard in society. The so-called 'normal patterns of behaviour' are questioned, and users are offered the right to pursue their own ways of living. Users tend to be respected in their options of life, even when these contradict main interpretive beliefs and aims workers have regarding health and social care.

The discretionary choices street level workers make regarding which patterns to choose when enacting policies, have consequences not only for themselves, but also for the drug users they assist. As scholars (Dean 2010, Foucault 2004) from governamentality studies affirm, acts of governing others serve to produce and reproduce identities. Stereotyped and judgemental attitudes by street level workers can lead to their further marginalization from society, promoting self-fulfilling prophecies of dependency, delinquency and desistance. Attitudes of acceptance and enhancement of agency, on the other hand, can help to promote users' integration, participation and autonomy. The closer the discretionary practices are focused on a criminal approach, they tend to produce citizens who feel they are morally wrong, and/or who identify with having a deviant position in society. The closer practices are from a human rights perspective, they tend to produce more autonomous and integrated citizens.

Contributions beyond the drug policy field

Finally, the contributions brought by this thesis can go beyond the field of drug policy and can be applicable to a much wider policy area. Many of the dilemmas and strategies, definitions of problems and solutions, and transformation of approaches in practice described in this research, are potentially useful to any service where care and order are present. Conditional Cash Transfer schemes (where compliance with conditions is a coercive aspect), sex workers' policies, non-documented migrant policies, services for homeless, probation services for people convicted of crimes, psychiatric services for people labelled as mentally ill, between others, are examples of that. In these services, as well as in the ones studied in this thesis, street level workers exercise their discretion to deal with daily dilemmas on how strict or how caring they should be. They wonder about the potential effects these actions will have in the people they are assisting. They bring in their main ideas about problems and solutions in the area. They consider what their fellow workers have to offer, and take a decision upon networking with them or not. They establish relations with users and decide upon which strategies seem to be feasible and have more chance for success.

When deciding whether to use care or order, or producing the multitude of combinations among these approaches described on this study, workers transform their meanings and practices. They define what care and order are, how they can be pursued in practice, and with which aims and effects to their target populations. The theoretical tools provided and the discretionary patterns described by this thesis, may allow researchers to get insights in how and why decision between care and order are taken by street level workers in different policy fields, sectors of expertise, and geographical areas.

Notes

[1] In this study, deviant patterns correspond to (and combine) the responses described as being given by 'some' and 'few' workers across the chapters.

Appendices

Appendix 1
Informed consent

International Institute of Social Studies of Erasmus University Rotterdam - PhD program
Bonger Institute – University of Amsterdam

We would like to invite you to participate of the study *"Street policies for people who use illegal drugs"*. We are interested on investigating how drug policies are happening on a local level in the city of Amsterdam, the Netherlands, and in the city of Porto Alegre, Brazil. Your participation is very important to us, and will consist on answering some questions by an interview with the researcher. To allow a better analysis of the data, we are asking your permission to voice record the interview. All data collected in the research will have its anonymity and secrecy guaranteed on its utilization.

The researcher will be at your disposal to clarify any doubt related to the study, before and after the study takes place. You can contact the researcher trough the e-mail rigoni@iss.nl or the mobile 0627344637. If you decide not to participate or to give up during the study there will be no problems, but you must formally communicate the researcher trough the contacts above. If you have any question, please feel free to ask before you decide.

After having knowledge of all items above, I agree in participating of this study.

Signature:

Name of participant: _____

Service of participant:_____

Signature of researcher: _____

Date: ____/____/201_.

Appendix 2:
Structured questionnaire for street level workers

ID: ☐☐☐☐_

Thank you for filling out this form and participating! All questions are confidential.

1. Name of service you work for: _____
2. Sex: ( ) Masculine ( ) Feminine 3. Age: _____
4. Do you follow any religion: ( ) yes ( ) no
   Which one? _____
   If yes, how important is it for you…
   4a. In your daily life
   ( ) very important ( ) important ( ) moderately important ( ) of little importance
   ( ) no important at all
   4b. In your work with drug users
   ( ) very important ( ) important ( ) moderately important ( ) of little importance
   ( ) no important at all
5. What is the biggest educational level you have? _____
6. What was the biggest diploma you got? _____
7. Have you done other courses related to your current work? _____
8. What is your profession? _____
9. What is the name of your function in this service? _____
10. How many hours and days do you work per week?
    _____ hours per week _____ days per week.
11. On average, how many people do you assist in a day? _____ people per day
12. On average, how many of these are drug users? _____ drug users per day
13. How long have you been working with drug users? _____ months _____ years
14. How long have you been working in the public service? _____ months_____ years
15. What type of contract do you have in this service?
    ( ) civil servant ( ) employed stable contract ( ) employed temporary contract
    ( ) voluntary ( ) other _____
16. Approximately, how much is your net income in this service?
    ( ) Below €1200
    ( ) Between €1200 - €1599
    ( ) Between €1600 - €1999
    ( ) Between €2000 - €2399
    ( ) Between €2400 - €2799
    ( ) Between €2800 - €3200
    ( ) Above €3200
17. Do you have any other paid work? ( ) yes ( ) no
    If yes, what kind of work? _____
    How many hours and days do you work per week on it?
    _____ hours per week _____ days per week.
18. Approximately, how much is your net income in total?
    ( ) Below €1200
    ( ) Between €1200 - €1599
    ( ) Between €1600 - €1999
    ( ) Between €2000 - €2399
    ( ) Between €2400 - €2799
    ( ) Between €2800 - €3200
    ( ) Above €3200

Appendix 3: Topic list for street level workers

Topic list for street level workers interviews

Activities

1. Usually, what are your activities at work (and more specifically those related to hard drug users)?
2. Do you think there is/was a change in the last years in the way you are supposed to do your daily work with hard drug users? Explain. How do you fell about that?
3. Are most of the hard drug users you contact in your work:
    a. Male or female? Why do you think that is so?
    b. Dutch or migrants? Why do you think that is so?
4. When a client (hard drug user) does something against the rules of the house/ the law/ the planned treatment program, what do you do? Can you give an example? How do you fell about that?
    a. How do you decide when to suspend/arrest someone? (What criteria do you use?)

Beliefs:

5. How would you describe a hard drug user?
6. For you, what is the best way of handling (dealing with) hard drug users?
    a. (Probe: health care - abstinence, harm reduction, syringe exchange, methadone, users' room, counseling; social care – none, benefits, housing, income generation, jobs; law enforcement: arresting, receiving a fine, community work, obligatory treatment, option to choose treatment, freedom to use).
7. Do you all agree in your service about how to handle hard drug users? Please explain.
8. How do you think your work affect hard drug users? (What does it produce for them)?
9. Do you agree with current drug policy in your city? Why?
    a. Do you think this policy is changing overtime? How?
10. What means "harm reduction" for you?
    a. Do you use this in your activities? Why? How?

Interactions:

11. Regarding activities related to hard drug users, how is the relationship in your service/department with:
    a. (Other) health workers/services?
    b. (Other) social workers/services?
    c. (Other) police workers/services?

    (Probe: referrals done/received, meetings, collaboration in general, type and frequency of contact, would like to have collaboration with but couldn't)
    d. Does this have changed over time?

Work environment:

12. Regarding activities related to hard drug users, what are the good points of your institution/department? How they impact your work?
13. And what are the bad points (or difficulties) of your service/department? How they impact your work?

    (Probe: work conditions - resources, work load, health protection, training, pressure; social environment - colleagues, clients, salary, supervision, different opinions/goals, repression/tolerance)
14. Do you (and your colleagues) have/had trainings on how to deal with hard drug use?
    a. What kind of training?
    b. Do you apply these trainings on your practices? Why?
15. Have you had any health problem (or concern) related to your work with hard drug users?

Appendix 4:
Topic list for key-informants

Topic list for key-informants

1. How would you describe your involvement in drug policy in this city/country?
2. In general, how would you say that drug policy related to hard drug users have been changing in the last years in this city/country? (zoom in last 5 to 10 years)
    a. Or if you think is not changing at all, why?
3. What would you say that were the main factors helping these changes to happen (or not to happen)? Why?
4. Would you say that (changes happening in) the laws are also happening in the practice (and vice-versa)? Why?
5. Could you talk about the role of the following workers on tackling hard drug users in this city/country? Does their role have changed over time?
    a. Social workers
    b. Health workers
    c. Police workers
6. Do you think the professional relationship between social, health and police workers to tackle hard drugs use in this city/country has changed over time? Please explain.
7. What would you say are the best features of drug policy here?
8. And what would you say are the worst features (or main challenges)?
9. What would you say that is the main objective of hard drugs policy in this city/country today?
    a. Do you agree with that? Why?

Picture 1:
Historical buildings Amsterdam center

Picture 2
Yougsters smoking cannabis in a canal

Walk in centre for drug users across the canal (Amsterdam centre)

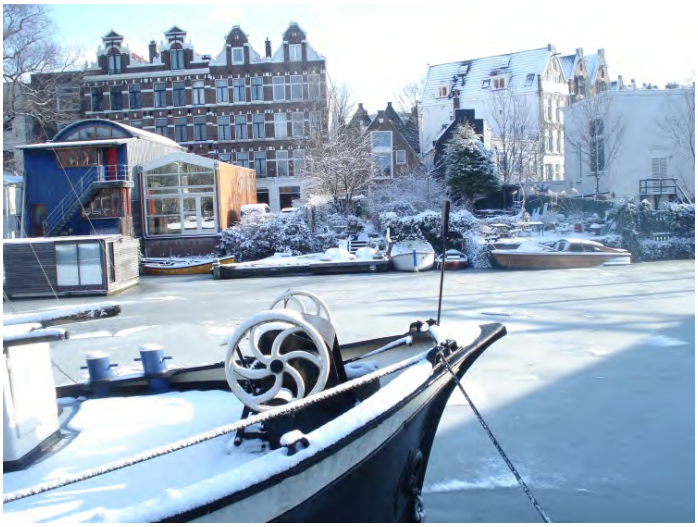
Picture 3:
Touristic shop selling utensils for drug use

Picture 4:
Old church and prostitution windows

Picture 5:
Red Light District

Picture 6:
CCTV cameras in the Red Light district

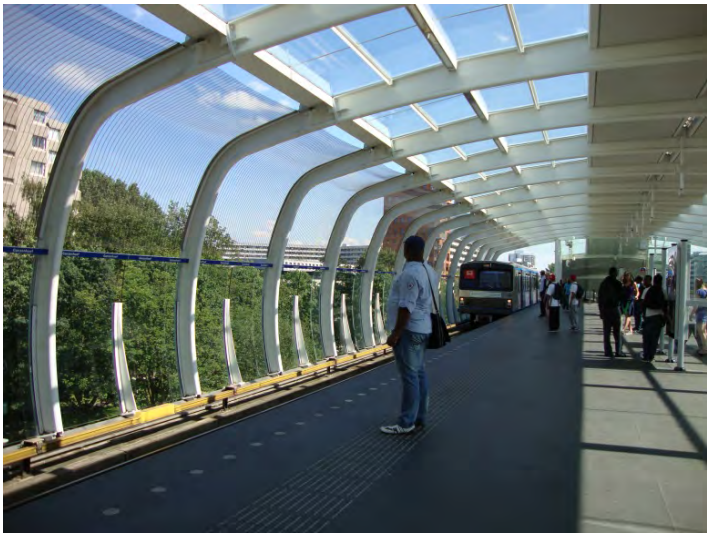
Picture 7:
Frozen canals in Amsterdam' winter 2011



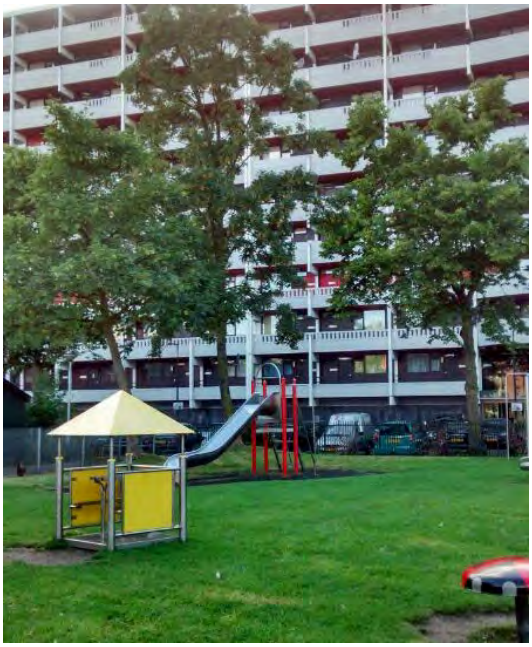
Picture 8:
Buildings in the Bijlmer

Picture 9:
Bee-heaves buildings in the Bijlmer

Picture 10:
Metro Station Bijlmer



Picture 11:
Leisure areas Bijlmer

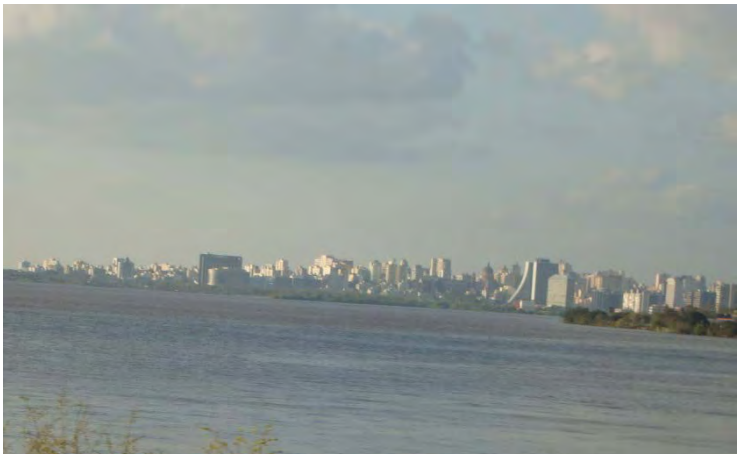


Picture 12:
Gasperplaas Bijlmer

Picture 13:
Kraieneest Bijlmer

Picture 14:
CCTV signs Bijlmer

Picture 15:
Porto Alegre seen from Guaiba river



Picture 16:
Porto Alegre historical building (city hall)

Picture 17:
Porto Alegre center

Picture 18:
Homeless in Porto Alegre center

Picture 19:
Bus stop and public market center

Picture 20:
Bus stop- informal commerce and homeless gathering

Picture 21:
Comercial center North Zone

Picture 22:
Push cart of garbage picker

Picture 23:
Slum entrace

Picture 24:
Slum

Picture 25:
Walk in center POA

Picture 26:
Leisure and workshops' area

Picture 27:
Tanks for users to wash clothes and shave POA

Picture 28:
Donation of clothes POA

Picture 29:
Walk-in center Amsterdam

Picture 30:
Walk-in center in Amsterdam

Picture 31:
User' room for smoked crack and heroin

Picture 32:
Living room shelter Amsterdam

Picture 33:
Room to smoke prescribed heroin

Picture 34:
Methadone prescription Amsterdam

Picture 35:
Reception heroin/methadone clinic

Picture 36:
Group meeting out-patient drug treatment clinic POA

Picture 37:
Material produced by users in art-therapy groups in POA

Picture 38:
Primary health care room

Picture 39:
Therapeutic community

Picture 40:
Police station Bijmer

Picture 41:
Police cars in Amsterdam

Picture 42:
Police workers and tourists in the Red Light District

Picture 43:
Police workers in the center of Porto Alegre

Picture 44:
Police station Porto Alegre center

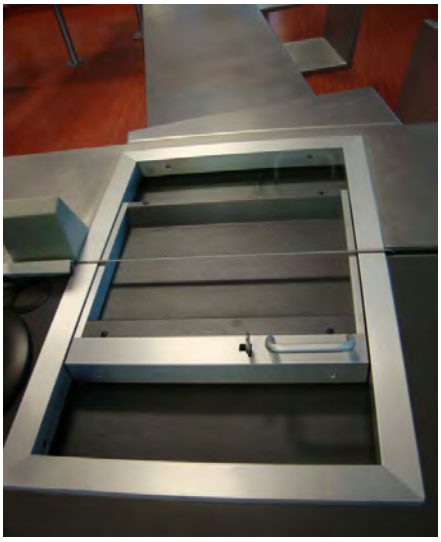
Picture 45:
Police workers and patrol cars, center

Picture 46:
Sign of 'crack no way' campaign

'Crack is such a devastating drug that can be addictive right in the first time. The brain suffers irreparable damages. The health fails and life turns into endless moments of pain and suffering. For a crack stone, the user capable of lying, stealing and getting rid of any object that can be exchanged for the drug. Even his/her own body, when there is nothing else to sell. Listen to those who suffered, the most destroyed and who repentant for having tried the drug for the first time!'

Picture 47:
Metal detector door in heroin/methadone clinic

Picture 48:
Drawer for contact between users and workers



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